STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675020	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Health & Rehabilitation Center	4910 Wellington St Greenville, TX 75402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 3 (Resident #1) residents reviewed for quality of care. The facility failed to ensure LVN A assessed Resident #1 buttocks after CNA B reported that Resident #1 had skin issues. This failure could place residents of risk for not receiving appropriate care and treatment, a decreased quality of life, and pressure ulcers. Findings included: Record review of Resident #1's face sheet dated 05/22/24, indicated a [AGE] year-old female who initially admitted to the facility on [DATE], and readmitted on [DATE]. Resident #1's diagnoses included peripheral vascular disease (narrowing of arteries that supply blood to your legs and feet), Type 2 diabetes mellitus (chronic condition that affects how your body uses sugar for energy), congestive heart failure (impairment in the heart's ability to fill with and pump blood), and protein calorie malnutrition (not consuming enough protein and calories). Record review of Resident #1's quarterly MDS assessment dated [DATE], indicated she was able to make herself understood and understood others. The MDS assessment indicated Resident #1 had a BIMS score of 15, indicating her cognition was intact. The MDS assessment indicated Resident #1 was frequently incontinent of urine and always incontinent of bowel. The MDS assessment indicated Resident #1 required partial/moderate assistance with lower body dressing, taking off footwear and sitting to lying/lying to sitting. Resident #1 was independent with eating, oral hygiene, and personal hygiene. The MDS indicated Resident #1 was at risk for developing pressure ulcers/injuries and did not have any skin problems. Record review of Resident #1's comprehensive care plan dated 05/01/23 and revised on 08/28/23, indicated Resident #1 was incontinent of bowel/bladder with interventions for weekly skin checks to monitor for redness, circulatory problems, breakdown, or other skin concerns. The care plan indicated to report any new skin conditions to the physician. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's order summary report dated 05/22/24, with active orders as of 04/01/24, indicated Resident #1 had an order to perform head to toe skin assessment, document any changes in skin integrity in the medical record on Wednesday for wound prevention/early identification with a start date of 08/16/23. The order indicated to notify the physician with any changes in skin integrity. Record review of Resident #1's progress notes dated 04/22/24-05/22/24 did not indicate any documented skin issues. Record review of Resident #1's Treatment Administration Record for the month of May 2024, did not indicate she was receiving any treatment to her buttocks. Record review of Resident #1' shower sheets dated 05/15/24 and 05/17/24 indicated no change in skin color or condition. During an interview on 05/22/24 at 09:29 AM, Resident #1's family member said Resident #1's butt was raw when she arrived at the hospital on Monday, 05/20/22. Resident #1's family member said their concern was that someone should have noticed the bed sore to Resident #1's buttocks since it was large, and they should have been treating it. During an interview on 05/22/24 at 12:15 PM, RN D said the nurses checked off the skin assessments on the TAR as completed, if the residents had a change to their skin assessment. The nurses documented it in the progress notes. RN D said she was not the nurse for Resident #1. During an observation and interview on 05/22/24 at 1:15 PM, Resident #1 was currently at the local hospital. The hospital nurse said Resident #1 admitted to the hospital with redness and irritation to her buttocks. The hospital nurse turned Resident #1 over and Resident #1 was noted to have redness and irritation to bilateral buttocks and under both buttocks. During an interview on 05/22/24 at 2:59 PM, RN E said she was usually Resident #1's nurse, and no one reported to her that Resident #1 had any skin issues. RN E said there was no documentation on the 24-hour report that Resident #1 had any skin issues. During an interview on 05/22/24 at 3:24 PM, CNA B said the day she came back to work, she believed it was Sunday 05/19/24, Resident #1 was broke out. She said Resident #1's bottom was raw, and she had asked her what happened since she had no skin issues on Thursday when she last worked. CNA B said she reported it to the charge nurse (unsure of who it was), and the charge nurse instructed her to keep applying cream on her bottom. CNA B said she reported it to ADON C as well on Sunday. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/22/24 at 3:44 PM, ADON C said CNA B reported to her Resident #1 had skin breakdown, and she was applying A&D ointment (ointment used as a protective barrier to help protect skin) per the resident's request. ADON C said CNA B told her she had already reported it to the charge nurse. ADON C said she then told CNA B to let her know if they needed to have wound care look at it. ADON C said Resident #1's breakdown should have been documented on Sunday (05/19/24) when it was reported by the CNA to the charge nurse. ADON C said failure to document Resident #1's skin issues could cause them to get a fine or get in trouble. ADON C she had expected the charge nurse to have documented Resident #1's skin issues when it was reported to her so they could monitor for worsening or improvement. ADON C said Resident #1's skin breakdown not being documented could be considered neglect because the nurses would not be able to properly monitor Resident #1's skin breakdown. During an interview on 05/22/24 at 4:07 PM, RN A said she was Resident #1's nurse the past weekend. RN A said one of the CNAs reported to her that Resident #1 had excoriation to her buttocks, but the CNA reported to her that the excoriation was like it has been and she was continuing to apply barrier cream. RN A said the way the CNA reported it to her made it seem like it was not a new skin issue. RN A said if it had been a new area to Resident #1's buttock, then she would have assessed the area, completed a skin assessment, contacted the physician, obtained new orders, notified the family, and documented it. During an interview on 05/22/24 at 3:36 PM, the Administrator said any skin issues should be referred to the nurse and she expected them to follow their protocol. The Administrator said the DON was responsible for overseeing the skin issues at the facility. During an interview on 05/22/24 at 4:11 PM, the Interim DON said when a resident had excoriation there were not necessarily wound care orders given. The Interim DON said she did not believe barrier cream or zinc required a physician's order. The Interim DON said excoriation did not necessarily require documentation. The Interim DON said if the CNA reported that it was raw and peeling then she would have expected the nurse to assess, document and obtain orders if necessary. Record review of the facility's Skin Management Policy, indicated . The purpose of the policy is to describe the process steps for identification of patients at risk for the development of pressure ulcers, identify prevention techniques and interventions to assist with the management of pressure ulcers and skin alterations .6. if a change in patient condition occurs such as deterioration in or development of new risk factors or skin alterations, the license nurse notifies the physician, wound team, family or responsible party and documents follow up in the clinical record. The patients plan of care is then updated to reflect the patient's current status and care needs. Communication with the physician, patient and family are documented in the clinical record .