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	02/27/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43047 Based on observations, interviews and record review, the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 1 dining room reviewed for resident rights. 1. The facility did not ensure CNA C and MA D treated residents with dignity and respect by referring to them as feeders. 2. The facility failed to ensure LVN A fed Resident #1 while sitting down. This failure could place residents at an increased risk of embarrassment, isolation, and diminished quality of life. Findings included: 1. During a dining observation and interview on 02/25/25 at 11:40 a.m., CNA C stated to MA E, It's goes in the feeding room. CNA C was approximately 3 feet from dining room tables where residents were sitting. CNA C stated the word assisted dining room should be used instead of the word feeder. CNA C stated, I wasn't thinking. CNA C stated referring to residents as a feeder was a dignity issue. During an interview on 02/25/25 at 11:59 a.m., MA D stated he was a feeder when asked if Resident #2 ate in the dining room. MA D stated it was a habit, but she should have stated need assistance with his meal. MA D stated referring to residents as a feeder was a dignity issue. 2. During an observation and interview on 02/25/25 at 11:53 a.m., LVN A was standing up while feeding Resident #1 her lunch. LVN A stated, just as I am when asked was that the correct way to assist a resident with her meal. LVN A stated she had never been taught another way. During an interview on 02/27/25 at 11:25 a.m., the DON stated she expected staff to say, assisted diners when referring to residents that need assistance with eating. The DON stated she expected LVN A to sit at eye level while assisting the resident with lunch. The DON stated she monitored by observations in the dining room and hallways. The DON stated if she noticed an issue they are immediately educated, and she would have the staff to grab a chair and sat down next to the resident because she would not want the resident to feel rushed or intimidated. The DON stated these failures were a dignity issue. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/27/25 at 3:10 p.m., the Administrator stated her expectations were for all residents to be respected and rights be given. The Administrator stated residents should not be called feeders' but assisting diners. The Administrator stated she expected staff to sit at eye level while assisting residents with meals. The Administrator stated she monitored by random rounds and daily correction was done if she observed an incident. The Administrator stated it was important to treat residents with dignity and respect. Record review of a feeding assistant skills review indicated LVN A completed her training on 1/31/25. Record review of a feeding assistant skills review indicated CNA C completed her training on 2/1/25. Record review of a feeding assistant skills review indicated MA D completed her training on 1/24/25. Record review of the facility's policy titled Promoting/Maintaining Resident Dignity revised 02/16/20 reflected . it is the practice of the facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect . 5. When interacting with a resident, pay attention to the resident as an individual .10. Speak respectfully to residents .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interviews, and record review the facility failed to ensure residents were free from abuse for 7 of 13 residents (Residents #3, #4, #5, #6, #7, #8 and #9) reviewed for resident abuse. 1. The facility did not ensure Resident #3 was free from abuse when Resident #9 shoved Resident #3 on 8/19/24. 2. The facility did not ensure Resident #6 was free from abuse when Resident #5 hit Resident #6 with her silverware packet on 8/28/24. 3. The facility did not ensure Resident #3 was free from abuse when Resident #4 hit Resident #3 on the back of the head 10/17/24. 4. The facility did not ensure Resident #7 was from abuse when Resident #8 hit Resident #7 on the head 12/20/24. These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: 1. Resident #3 Record review of Resident #3's face sheet, dated 02/27/25, reflected Resident #3 was a [AGE] year-old male, originally admitted to the facility on [DATE] with a diagnosis which included supraventricular tachycardia (abnormal fast heartbeat) and mild intellectual disabilities (developmental disability that affects a person's ability to think abstractly and learn new information). Record review of Resident #3's quarterly MDS assessment, dated 02/04/25, reflected Resident #3 usually made himself understood and understood others. Resident #3's BIMS score was 9, which indicated his cognition was moderately impaired. The MDS reflected Resident #3 had no behaviors or refusal of care during the look-back period. Record review of Resident #3's comprehensive care plan revised 06/20/24 reflected Resident #3 had a behavior problem as evidenced by: verbal/physical behaviors, and rejection of care. The care plan interventions included: administer medications as ordered, monitor behavior episodes, and attempt to determine underlying cause and when resident becomes agitated intervene before the agitation escalates by guiding away from source of distress, engaging calmy in conversation, or attempting to other interventions. Resident #9 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9's face sheet, dated 02/27/25, reflected Resident #9 an [AGE] year-old male, originally admitted to the facility on [DATE] with diagnoses which included COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs) and dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of the quarterly MDS assessment, dated 02/13/25, reflected Resident #9 made himself understood and understood others. Resident #9 BIMS score was 8, which indicated his cognition was moderately impaired. The MDS reflected Resident #9 had no behaviors or refusal of care during the look-back period. Record review of Resident #9's comprehensive care plan revised 09/23/24 reflected Resident #9 had a behavior problem as evidence by noncompliance to policies despite numerous educational conversations, resident continues to go to Walmart and buy batteries, tools and OTC inhalers and constantly states people are getting handsy with women when they are just talking. The care plan interventions included: monitor behavior episodes and attempt to determine underlying cause and minimize potential for disruptive behaviors by offering tasks or activities which divert attention. Record review of the facility's undated PIR with an incident category of abuse was signed by the Administrator on 08/23/24. The PIR reflected RN F witnessed Resident #9 shoved Resident #3 in the dining room. The PIR included a skin assessment completed 08/19/24, incident report for both residents completed 08/19/24, psychiatric assessment for Resident #9 completed on 08/19/24, psychiatric assessment for Resident #3 completed on 08/21/24, social services note for Resident #9 completed 8/19/24, safe surveys with no areas of concerns dated for 08/19/24 and a 1:1 schedule for Resident #9 completed 08/19/24. The PIR reflected staff was in-serviced promptly on abuse and neglect dated 08/19/24. Record review of the physical aggression report dated 08/19/24 written by RN F indicated Resident #9 became verbally aggressive with Resident #3 in the dining room prior to breakfast. Resident #9 was cussing and insulating Resident #3. RN F instructed Resident #9, that if his behavior continued, he would have to leave the dining room. Resident #9 continued to cuss and insult Resident #3. RN F told the resident that he would have to leave the dining room and return to his room for breakfast due to his behavior. As Resident #9 was leaving the dining room he shoved Resident #3 the back and again insulted him. RN F immediately assisted Resident #9 back to his room and he was placed on 1:1 observation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a statement dated 08/19/24 written by RN F stated she was in the dining room helping prepare breakfast. RN F stated Resident #3 was sitting at his usual table in his wheelchair. Resident #9 usually sat at another table, but that morning Resident #9 pulled his wheelchair up to the table and began trying to move an empty chair away from the table. Resident #3 became upset and told Resident #9 the chair he was trying to move belonged to another resident and she was coming back to sit in it in a few minutes after smoke break. Resident #9 became agitated and started cussing at Resident #3. Resident #9 called Resident #3 several names and told Resident #3 to shut the hell up. RN F stated she intervened and told Resident #9 that if he continued with this behavior, he would be asked to leave the dining room. Resident #9's foul language continued, and RN F asked him to return to his room for breakfast. On his way out of the dining room, as Resident #9 passed Resident #3 he shoved Resident #3 in the back. Another resident seated at another table told Resident #9 you can not put your hands on people like that, Resident #9 told her to shut her damn mouth as he exited the dining room. His agitation and foul language continued as he went down the hall to his room. RN F stated at no time did Resident #3 ever make any physical contact with Resident #9 or even attempt to. An attempted telephone interview on 02/27/25 at 11:10 a.m. with RN F, the RN that witnessed the incident, was unsuccessful. During an interview on 02/27/25 at 9:13 a.m., Resident #3 stated Resident #9 hit him on the back his neck when asked about the incident between him and Resident #9. Resident #3 stated He's mean. During an interview on 02/27/25 at 9:22 a.m., Resident #9 stated he was trying to hit me when asked about the incident between him and Resident #3. Resident #9 stated Resident #3 was overbearing and if I didn't get up out the chair, he would've kick my ass. 2. Resident #5 Record review of Resident #5's face sheet, dated 02/27/25, reflected Resident #5 was a [AGE] year-old female, originally admitted to the facility 12/14/23 with a diagnosis which included heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). Record review of Resident #5's annual MDS assessment, dated 01/10/25, reflected Resident #5 made herself understood and understood others. Resident #5's BIMS score was 5, which indicated her cognition was severely impaired. The MDS reflected Resident #5 had no behaviors or refusal of care during the look-back period. Record review of Resident #5's comprehensive care plan revised on 09/06/24 reflected Resident #5 had impaired cognition and was at risk for further decline in cognitive and functional abilities related to paranoid personality disorder, and depression adult failure to thrive. The care plan interventions included: monitor/document/report to physician any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status changes and reduce any distractions. Resident #6 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's face sheet, dated 02/27/25, reflected Resident #6 was a [AGE] year-old female, originally admitted to the facility on [DATE] with a diagnosis which included dementia (loss of memory, language, problem-solving and other thinking abilities that interfere with daily life). Record review of Resident #6's quarterly MDS assessment, dated 02/01/25, reflected Resident #6 made herself understood and understood others. Resident #6's BIMS score was 15, which indicated her cognition was intact. The MDS reflected Resident #6 had no behaviors or refusal of care during the look-back period. Record review of Resident #6's comprehensive care plan revised on 08/21/23 reflected Resident #6 had impaired cognition and was at risk for further decline in cognitive and functional abilities related to dementia. The care plan interventions included: identify yourself at each interaction, reduce any distractions and provide instructions to resident using clear voice and simple sentences. Record review of the undated PIR with an incident category of abuse was signed by the Administrator on 08/28/24. The PIR reflected LVN B witnessed Resident #5 hit Resident #6 with her silverware at the breakfast table. The PIR included a skin assessment completed 08/28/24, incident report for both residents completed 08/28/24, psychiatric assessment for both residents completed 08/28/24, safe surveys with no areas of concerns dated for 08/28/24, and a 1:1 schedule for Resident #5 completed 08/28/24-08/31/24. The PIR reflected staff was in-serviced promptly on abuse and neglect dated 08/28/24. Record review of undated witnessed statement written by Resident #10 stated on 08/28/24 she was in the dining room around 7:30 a.m. Resident #6 came in and sat at the table she always sat at. Resident #10 stated at 7:00 a.m. her and Resident #6 went out to smoke and when they came back in Resident #5 was sitting where Resident #6 was sitting and would not move when asked to. Resident #10 stated Resident #5 suddenly grabbed her silverware and hit Resident #6 on the arm. Resident #5 was then asked to leave the table by an aide, and she refused. During a telephone interview on 02/26/25 at 2:25 p.m., LVN B stated on the morning of 8/28/24 at approximately 7:30 a.m., she was in the dining room with another resident when she heard a noise and then heard Resident #6 state, she hit me referring to Resident #5. Resident #5 was sitting in the chair where Resident #6 normally sits. Resident #6 stated she asked Resident #5 to move, and Resident #5 picked up her silverware packet and hit her on her left arm. Resident #5 was questioned as to why she hit Resident #6 and she stated, she tried to take my silverware. LVN B stated she notified the DON, and the resident was assigned someone to stay with her while investigation was ongoing. During an interview on 02/27/25 at 9:19 a.m., Resident #10 stated I didn't see it, I heard about it when asked about the incident between Resident #5 and Resident #6. Resident #10 appeared to be agitated when state surveyor introduced herself. During an interview on 02/27/25 at 9:27 a.m., Resident #6 stated I can't remember why she hit me on my arm with her silverware when asked about the incident between Resident #5 and Resident #6. During an interview on 02/27/25 at 9:30 a.m., Resident #5 stated It didn't happen with me I don't think, somebody would've told me I hit her when asked about the incident between Resident #5 and Resident #6. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #3 Record review of Resident #3's face sheet, dated 02/27/25, reflected Resident #3 was a [AGE] year-old male, originally admitted to the facility on [DATE] with a diagnosis which included supraventricular tachycardia (abnormal fast heartbeat). Record review of Resident #3's quarterly MDS assessment, dated 02/04/25, reflected Resident #3 usually made himself understood and understood others. Resident #3's BIMS score was 9, which indicated his cognition was moderately impaired. The MDS reflected Resident #3 had no behaviors or refusal of care during the look-back period. Record review of Resident #3's comprehensive care plan revised 06/20/24 reflected Resident #3 had a behavior problem as evidenced by: verbal/physical behaviors, and rejection of care. The care plan interventions included: administer medications as ordered, monitor behavior episodes, and attempt to determine underlying cause and when resident becomes agitated intervene before the agitation escalates by guiding away from source of distress, engaging calmy in conversation, or attempting to other interventions. Record review of Resident #4's face sheet, dated 02/27/25, reflected Resident #4 was a [AGE] year-old male, originally admitted to the facility on [DATE] with a diagnosis which included dementia (loss of memory, language, problem-solving and other thinking abilities that interfere with daily life). Record review of Resident #4's annual MDS assessment, dated 01/02/25, reflected Resident #4 made himself understood and usually understood others. Resident #4's BIMS score was 5, which indicated his cognition was severely impaired. The MDS reflected Resident #4 had no behaviors or refusal of care during the look-back period. Record review of Resident #4's comprehensive care plan revised 04/05/24 reflected Resident #4 had a behavior problem as evidence by resident with physical aggression toward another resident when verbally antagonized. The care plan interventions included: administer medication as ordered and when resident becomes agitated intervene before the agitation escalates by guiding away from source of distress, engaging calmy in conversation, or attempting to other interventions. Record review of the PIR dated 10/22/24 with an incident category of abuse was signed by the Administrator on 10/22/24. The PIR reflected both residents were sitting in the sitting area and Resident #4 asked Resident #3 if he would move his chair into his spot. Resident #4 then pushed Resident #3's wheelchair forward from behind. Resident #3 became upset because Resident #4 moved his chair. Resident #3 then went back into Resident #4 with his wheelchair because he moved him. Resident #4 hit Resident #3 on the back of the head due to him hitting his wheelchair. The PIR included a skin assessment for Resident #3 and Resident #4 completed 10/17/24, social services progress notes for both residents completed 10/18/24, incident report for both residents completed 10/17/24, psychiatric assessment for Resident #4 completed 10/18/24, psychiatric assessment for Resident #3 completed 10/7/24, safe surveys with no areas of concerns dated for 10/17/24, and a 1:1 schedule for Resident #4 completed 10/17/24 and 10/18/24. The PIR reflected staff was in-serviced promptly on abuse and neglect dated 10/17/24. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/25 at 11:10 a.m., CNA G stated Resident #3 was sitting in the doorway of the TV room and Resident #4 rolled up in his wheelchair and pushed Resident #3 wheelchair and told him to move that was his spot. CNA G stated Resident #3 told him he was not moving that he was there first. CNA G stated Resident #4 stood up and punched Resident #3 in the back of the neck with his fist closed three times. CNA G stated her, and other staff members immediately separated the residents and took Resident #4 to his room. CNA G stated Resident #4 was placed on 1:1. During an interview on 02/26/25 at 11:41 a.m., MA E stated Resident #3 was sitting in his wheelchair in the open frame of the tv room. MA E stated Resident #4 was trying to sit where Resident #3 was sitting and he told Resident #3 to move his wheelchair and Resident #3 stated no. MA E stated Resident #4 was trying to push Resident #3 wheelchair and that was when Resident #4 stood up behind Resident #3 and punched him in the back of head/neck three times fast before staff could intervene. MA E stated it happened so fast before staff could intervene. MA E stated Resident #4 had a history of arguing with residents and usually you could verbally intervene, and he would stop. MA E stated residents were separated immediately. During a telephone interview on 02/27/25 at 11:11 a.m., LVN A stated she was sitting at the nursing station when the incident occurred. LVN A stated Resident #3 was sitting in his wheelchair right outside the tv room and Resident #4 was coming up behind him telling him to move because he wanted to sit there. LVN A stated Resident #3 did not want to move because he was already sitting there. LVN A stated they went back and forth for a few seconds before Resident #4 hit Resident #3 in the back of the head three times. LVN A stated residents were immediately separated, and Resident #4 placed on 1:1. During an interview on 02/27/25 at 9:03 a.m., Resident #4 stated he just moved his wheelchair off his foot. Resident #4 stated He's retarded I just got him off my foot, I didn't put my hands on him when asked about the incident between him and Resident #3. During an interview on 02/27/25 at 9:13 a.m., Resident #3 stated two weeks ago Resident #4 hit him on his neck because he would not talk to him. 4. Resident #7 Record review of Resident #7's face sheet, dated 02/27/25, reflected Resident #7 was a [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included senile degeneration of brain (progressive decline in cognitive functions, such as memory, reasoning, and judgement). Record review of Resident #7's quarterly MDS assessment, dated 02/29/25, reflected Resident #7 usually made himself understood and usually understood others. Resident #7's BIMS score was 7, which indicated his cognition was severely impaired. The MDS reflected Resident #7 had no behaviors or refusal of care during the look-back period. Record review of Resident #7's comprehensive care plan revised on 02/26/25 reflected Resident #7 had impaired cognition and is at risk for further decline in cognitive and functional abilities related to dementia. The care plan interventions included: monitor/document/report to physician any changes in cognitive function, identify yourself at each interaction, stop and return if the resident becomes agitated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #8 Record review of Resident #8's face sheet, dated 02/27/25, reflected Resident #8 was a [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included dementia (loss of memory, language, problem-solving and other thinking abilities that interfere with daily life). Record review of Resident #8's annual MDS assessment, dated 01/31/25, reflected Resident #8 made himself understood and understood others. Resident #8's BIMS score was 5, which indicated his cognition was severely impaired. The MDS reflected Resident #8 had no behaviors or refusal of care during the look-back period. Record review of Resident #8's comprehensive care plan initiated on 10/18/24 reflected Resident #8 had a behavior problem as evidenced by aggressive behaviors. The care plan interventions included: assist resident to a calm quiet area if starts becoming agitated, consult psych services if needed concerning behaviors and monitor resident for increased agitation. Resident #8 exhibits verbally abusive behavior at times and is at risk for harm and not having their needs met in a timely manner. The care plan interventions included: administer medications as ordered by the physician and monitor for effectiveness/potential adverse side effects, monitor behavior episodes, and attempt to determine underlying cause. Record review of the undated PIR with an incident category of abuse. The PIR reflected Resident #8 asked Resident #7 to stop going in his Christmas bag. Resident #7 went into Resident #8 bag again and Resident #8 asked him again to stop. Resident #8 asked staff for help but before the staff could move Resident #7 did it again and Resident #8 popped him on the head. The PIR included a skin assessment for Resident #7 completed 12/20/24, incident report for both residents completed 12/20/24, psychiatric assessment for Resident #8 completed 12/31/24, safe surveys with no areas of concerns dated for 12/20/24, and a 1:1 schedule for Resident #8 completed 12/20/24 and 12/21/24. The PIR reflected staff was in-serviced promptly on abuse and neglect dated 12/20/24. During an interview on 022/26/25 at 11:36 a.m., Rehab Tech H stated as she was passing by the media room, she observed Resident #7 reaching into a Christmas gift bag that was sitting next to Resident #8's chair. Rehab Tech H stated upon Resident #8 realizing that Resident #7 was reaching into his bag, Resident #8 slapped Resident #7 on top of his head stating, get out of my shit. Rehab Tech H stated her, and other staff members immediately separated the residents, interviewed the residents to see what had happened and reported the incident to the Administrator. During an interview on 02/26/25 at 11:59 a.m., OTA K stated she was walking with Rehab Tech H from a patient's room headed back to the rehab gym and as she was passing by the media room, she observed Resident #7 reaching into a Christmas gift bag that was sitting next to Resident #8's chair. OTA K stated upon Resident #8 realizing that Resident #7 was reaching into his bag, he slapped Resident #7 on top of his head stating, get out of my shit. OTA K Stated her, and other staff members immediately separated the residents, and asked Resident #8 why he slapped Resident #7 and told him it was not ok to do that. OTA K stated Resident #8 was taking to his room by another staff member. OTA K stated she immediately went to report the incident to the Administrator. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/25 at 1:23 p.m., the Social Worker stated she had just walked up to the nursing station when she witnessed Resident #7 reaching into Resident #8 Christmas gift bag. The Social Worker stated it appeared Resident #8 had swung his arm at Resident #7, but she did not know if contact was made. The Social Worker stated there was two therapist staff present and they immediately separated the residents. During an interview on 02/27/25 at 9:07 a.m., Resident #7 stated I don't recall that at all when asked about the incident between him and Resident #8. During an interview on 02/27/25 at 9:24 a.m., Resident #8 stated I hit his stupid ass because he kept going in my bag when I told him not too. During an interview on 02/27/25 at 11:25 a.m., the DON stated she was aware of the abuse allegations. The DON stated the victims did not have any changes in behavior or any type of emotional distress since the incident. The DON stated Resident #3 and Resident #8 both have behavioral disorders that was been monitored by psych services and PCP. The DON stated the social worker has tried to find Resident #8 alternate placement but at this time there was no other facility willing to accommodate him with his behaviors. The DON stated the facility tried to find alternate placement for Resident #3, but the family was against it due to location. The DON stated staff were provided education on abuse and neglect related to all allegations of abuse of neglect. The DON stated the last in-service on abuse and neglect was 2/24/25. During an interview on 02/27/25 at 3:10 p.m., the Administrator stated she was the abuse coordinator for the facility. The Administrator stated she was responsible for overseeing by frequent rounding of the halls and dining room and trying to deescalate any agitation by residents as it arises. The Administrator stated when a resident-resident altercation occurred the residents were immediately separated, and aggressor kept on 1:1 monitoring until a psychiatric evaluation was completed or PCP did an evaluation. The Administrator stated Resident #3 had a dx of mild ID and intermittent explosive disorder that could causes him to be disruptive or have impulse control issues. The Administrator stated once the facility learned of any allegation, they acted appropriately to protect all the residents. Record review of the facility's policy titled Policy and Procedures: Abuse, Neglect and Exploitation revised 09/06/24 indicated . 1. The facility provides resident protection that included: (a) prevention/prohibit resident abuse, neglect . 2. The facility's abuse prevention coordinator is responsible for reporting allegations or suspected abuse, neglect . to the state survey agency and other official in accordance with state law .

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	02/27/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, 4 of 13 (Residents #3, #4, #5, and #6) reviewed for abuse. 1. The facility did not implement their policy on reporting abuse to state agency for a resident-to-resident altercation that occurred on 10/17/24 between Resident #3 and Resident #4 2. The facility did not implement their policy on reporting abuse to state agency for a resident-to-resident altercation that occurred on 08/28/24 between Resident #3 and Resident #4. These deficient practices could place residents at risk for abuse, neglect, and not having their needs met. Findings included: Record review of the facility policy for Policy and Procedures: Abuse, Neglect and Exploitation revised 09/06/24, reflected . 2. The facility's abuse prevention coordinator is responsible for reporting allegations or suspected abuse, neglect . to the state survey agency and other official in accordance with state law .III. Prevention of Abuse, Neglect and Exploitation . A. (2.) Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes: 2(a). Immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involves abuse (with or without bodily injury) . 1. Resident #3 Record review of Resident #3's face sheet, dated 02/27/25, reflected Resident #3 was a [AGE] year-old male, originally admitted to the facility on [DATE] with a diagnosis which included supraventricular tachycardia (abnormal fast heartbeat). Record review of Resident #3's quarterly MDS assessment, dated 02/04/25, reflected Resident #3 usually made himself understood and understood others. Resident #3's BIMS score was 9, which indicated his cognition was moderately impaired. The MDS reflected Resident #3 had no behaviors or refusal of care during the look-back period. Record review of Resident #3's comprehensive care plan revised 06/20/24 reflected Resident #3 had a behavior problem as evidenced by: verbal/physical behaviors, and rejection of care. The care plan interventions included: administer medications as ordered, monitor behavior episodes, and attempt to determine underlying cause and when resident becomes agitated intervene before the agitation escalates by guiding away from source of distress, engaging calmy in conversation, or attempting to other interventions. Resident #4 (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's face sheet, dated 02/27/25, reflected Resident #4 was a [AGE] year-old male, originally admitted to the facility on [DATE] with a diagnosis which included dementia (loss of memory, language, problem-solving and other thinking abilities that interfere with daily life). Record review of Resident #4's annual MDS assessment, dated 01/02/25, reflected Resident #4 made himself understood and usually understood others. Resident #4's BIMS score was 5, which indicated his cognition was severely impaired. The MDS reflected Resident #4 had no behaviors or refusal of care during the look-back period. Record review of Resident #4's comprehensive care plan revised 04/05/24 reflected Resident #4 had a behavior problem as evidence by resident with physical aggression toward another resident when verbally antagonized. The care plan interventions included: administer medication as ordered and when resident becomes agitated intervene before the agitation escalates by guiding away from source of distress, engaging calmy in conversation, or attempting to other interventions. Record review of the PIR dated 10/22/24 reflected an allegation of resident-to-resident incident on Resident #3 and #4 that occurred on 10/17/24 at 10:50 a.m. The PIR reflected both residents were sitting in the sitting area and Resident #4 asked Resident #3 if he would move his chair into his spot. Resident #4 then pushed Resident #3's wheelchair forward from behind. Resident #3 became upset because Resident #4 moved his chair. Resident #3 then went back into Resident #4 with his wheelchair because he moved him. Resident #4 hit Resident #3 on the back of the head due to him hitting his wheelchair. The PIR reflected staff witnessed the incident. The incident was reported to the state agency on 10/17/24 at 1:20 p.m. 2. Resident #5 Record review of Resident #5's face sheet, dated 02/27/25, reflected Resident #5 was a [AGE] year-old female, originally admitted to the facility 12/14/23 with a diagnosis which included heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). Record review of Resident #5's annual MDS assessment, dated 01/10/25, reflected Resident #5 made herself understood and understood others. Resident #5's BIMS score was 5, which indicated her cognition was severely impaired. The MDS reflected Resident #5 had no behaviors or refusal of care during the look-back period. Record review of Resident #5's comprehensive care plan revised on 09/06/24 reflected Resident #5 had impaired cognition and was at risk for further decline in cognitive and functional abilities related to paranoid personality disorder, and depression adult failure to thrive. The care plan interventions included: monitor/document/report to physician any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status changes and reduce any distractions. Resident #6 (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's face sheet, dated 02/27/25, reflected Resident #6 was a [AGE] year-old female, originally admitted to the facility on [DATE] with a diagnosis which included dementia (loss of memory, language, problem-solving and other thinking abilities that interfere with daily life). Record review of Resident #6's quarterly MDS assessment, dated 02/01/25, reflected Resident #6 made herself understood and understood others. Resident #6's BIMS score was 15, which indicated her cognition was intact. The MDS reflected Resident #6 had no behaviors or refusal of care during the look-back period. Record review of Resident #6's comprehensive care plan revised on 08/21/23 reflected Resident #6 had impaired cognition and was at risk for further decline in cognitive and functional abilities related to dementia. The care plan interventions included: identify yourself at each interaction, reduce any distractions and provide instructions to resident using clear voice and simple sentences. Record review of the undated PIR reflected an allegation of resident-to-resident incident on Resident #5 and Resident #6 that occurred 8/28/24 around 7:30 a.m. per the witnessed statement written by LVN B. The PIR reflected Resident #5 hit Resident #6 with her silverware packet at the breakfast table. The PIR reflected the incident was witnessed. The incident was reported to the state agency on 8/28/24 at 10:00 a.m. The PIR stated the facility substantiate the allegation of abuse. During a telephone interview on 02/26/25 at 2:25 p.m., LVN B stated on the morning of 8/28/24 at approximately 7:30 a.m., she was in the dining room with another resident when she heard a noise and then heard Resident #6 state, she hit me referring to Resident #5. Resident #5 was sitting in the chair where Resident #6 normally sits. Resident #6 stated she asked Resident #5 to move, and Resident #5 picked up her silverware packet and hit her on her left arm. Resident #5 was questioned as to why she hit Resident #6 and she stated, she tried to take my silverware. LVN B stated she notified the DON, and the resident was assigned someone to stay with her while investigation was ongoing. LVN B stated the abuse coordinator was the Administrator and she knew the Administrator was on her way to the facility that morning, so she was going to tell her when she got there. During an interview on 02/27/25 at 3:10 p.m., the Administrator stated she was the abuse coordinator for the facility. The Administrator stated the incident between Resident #3 and Resident #4 was witnessed by several staff members including herself. The Administrator stated the incident took longer to diffuse that required multiple staff member including herself to calm both residents down. The Administrator stated Resident #3 did not respond well to other staff members, but she was one that he did respond well too. The Administrator stated she was aware of the incident on 8/28/24 due to Resident #6 been at her office door upon her arrival. The Administrator stated after Resident #6 made the allegation, she went down to talk to LVN B and she informed her of the allegation, but she expected LVN B to contact her immediately regarding the incident. The Administrator stated she did agree that the allegations should always be reported within 2 hours unless there are extenuating circumstances. The Administrator stated she was responsible for overseeing by frequent rounding of the halls and dining room and trying to deescalate any agitation by residents as it arises. The Administrator stated she was the only one in the facility who could report abuse allegations to HHSC. The Administrator stated it was important to report an allegation of abuse and neglect for safety and protection of the residents and try to circumvent other incidents of abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interview, and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source were reported immediately, but no later than 2 hours after the allegation was made, for 4 of 13 (Residents #3, #4, #5, and #6) residents reviewed for reporting. 1. The facility did not report the resident-to-resident altercation between Resident #3 and Resident #4 to the State Survey Agency within 2 hours of been notified. 2. The facility did not report the resident-to-resident altercation between Resident #5 and Resident #6 to the State Survey Agency within 2 hours of been notified. These failures to report could place the residents at risk for abuse. Findings included: 1. Resident #3 Record review of Resident #3's face sheet, dated 02/27/25, reflected Resident #3 was a [AGE] year-old male, originally admitted to the facility on [DATE] with a diagnosis which included supraventricular tachycardia (abnormal fast heartbeat). Record review of Resident #3's quarterly MDS assessment, dated 02/04/25, reflected Resident #3 usually made himself understood and understood others. Resident #3's BIMS score was 9, which indicated his cognition was moderately impaired. The MDS reflected Resident #3 had no behaviors or refusal of care during the look-back period. Record review of Resident #3's comprehensive care plan revised 06/20/24 reflected Resident #3 had a behavior problem as evidenced by: verbal/physical behaviors, and rejection of care. The care plan interventions included: administer medications as ordered, monitor behavior episodes, and attempt to determine underlying cause and when resident becomes agitated intervene before the agitation escalates by guiding away from source of distress, engaging calmy in conversation, or attempting to other interventions. Resident #4 Record review of Resident #4's face sheet, dated 02/27/25, reflected Resident #4 was a [AGE] year-old male, originally admitted to the facility on [DATE] with a diagnosis which included dementia (loss of memory, language, problem-solving and other thinking abilities that interfere with daily life). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's annual MDS assessment, dated 01/02/25, reflected Resident #4 made himself understood and usually understood others. Resident #4's BIMS score was 5, which indicated his cognition was severely impaired. The MDS reflected Resident #4 had no behaviors or refusal of care during the look-back period. Record review of Resident #4's comprehensive care plan revised 04/05/24 reflected Resident #4 had a behavior problem as evidence by resident with physical aggression toward another resident when verbally antagonized. The care plan interventions included: administer medication as ordered and when resident becomes agitated intervene before the agitation escalates by guiding away from source of distress, engaging calmy in conversation, or attempting to other interventions. Record review of the PIR dated 10/22/24 reflected an allegation of resident-to-resident incident on Resident #3 and #4 that occurred on 10/17/24 at 10:50 a.m. The PIR reflected both residents were sitting in the sitting area and Resident #4 asked Resident #3 if he would move his chair into his spot. Resident #4 then pushed Resident #3's wheelchair forward from behind. Resident #3 became upset because Resident #4 moved his chair. Resident #3 then went back into Resident #4 with his wheelchair because he moved him. Resident #4 hit Resident #3 on the back of the head due to him hitting his wheelchair. The PIR reflected staff witnessed the incident. The incident was reported to the state agency on 10/17/24 at 1:20 p.m. 2. Resident #5 Record review of Resident #5's face sheet, dated 02/27/25, reflected Resident #5 was a [AGE] year-old female, originally admitted to the facility 12/14/23 with a diagnosis which included heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). Record review of Resident #5's annual MDS assessment, dated 01/10/25, reflected Resident #5 made herself understood and understood others. Resident #5's BIMS score was 5, which indicated her cognition was severely impaired. The MDS reflected Resident #5 had no behaviors or refusal of care during the look-back period. Record review of Resident #5's comprehensive care plan revised on 09/06/24 reflected Resident #5 had impaired cognition and was at risk for further decline in cognitive and functional abilities related to paranoid personality disorder, and depression adult failure to thrive. The care plan interventions included: monitor/document/report to physician any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status changes and reduce any distractions . Resident #6 Record review of Resident #6's face sheet, dated 02/27/25, reflected Resident #6 was a [AGE] year-old female, originally admitted to the facility on [DATE] with a diagnosis which included dementia (loss of memory, language, problem-solving and other thinking abilities that interfere with daily life). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's quarterly MDS assessment, dated 02/01/25, reflected Resident #6 made herself understood and understood others. Resident #6's BIMS score was 15, which indicated her cognition was intact. The MDS reflected Resident #6 had no behaviors or refusal of care during the look-back period. Record review of Resident #6's comprehensive care plan revised on 08/21/23 reflected Resident #6 had impaired cognition and was at risk for further decline in cognitive and functional abilities related to dementia. The care plan interventions included: identify yourself at each interaction, reduce any distractions and provide instructions to resident using clear voice and simple sentences. Record review of the undated PIR reflected an allegation of resident-to-resident incident on Resident #5 and Resident #6 that occurred 8/28/24 around 7:30 a.m. per the witnessed statement written by LVN B. The PIR reflected Resident #5 hit Resident #6 with her silverware packet at the breakfast table. The PIR reflected the incident was witnessed. The incident was reported to the state agency on 8/28/24 at 10:00 a.m. The PIR stated the facility substantiate the allegation of abuse. During a telephone interview on 02/26/25 at 2:25 p.m., LVN B stated on the morning of 8/28/24 at approximately 7:30 a.m., she was in the dining room with another resident when she heard a noise and then heard Resident #6 state, she hit me referring to Resident #5. Resident #5 was sitting in the chair where Resident #6 normally sits. Resident #6 stated she asked Resident #5 to move, and Resident #5 picked up her silverware packet and hit her on her left arm. Resident #5 was questioned as to why she hit Resident #6 and she stated, she tried to take my silverware. LVN B stated she notified the DON, and the resident was assigned someone to stay with her while investigation was ongoing. LVN B stated the abuse coordinator was the Administrator and she knew the Administrator was on her way to the facility that morning, so she was going to tell her when she got there. During an interview on 02/27/25 at 3:10 p.m., the Administrator stated she was the abuse coordinator for the facility. The Administrator stated the incident between Resident #3 and Resident #4 was witnessed by several staff members including herself. The Administrator stated the incident took longer to diffuse that required multiple staff member including herself to calm both residents down. The Administrator stated Resident #3 did not respond well to other staff members, but she was one that he did respond well too. The Administrator stated she was aware of the incident on 8/28/24 due to Resident #6 been at her office door upon her arrival. The Administrator stated after Resident #6 made the allegation, she went down to talk to LVN B and she informed her of the allegation, but she expected LVN B to contact her immediately regarding the incident. The Administrator stated she did agree that the allegations should always be reported within 2 hours unless there are extenuating circumstances. The Administrator stated she was responsible for overseeing by frequent rounding of the halls and dining room and trying to deescalate any agitation by residents as it arises. The Administrator stated she was the only one in the facility who could report abuse allegations to HHSC. The Administrator stated it was important to report an allegation of abuse and neglect for safety and protection of the residents and try to circumvent other incidents of abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy for Policy and Procedures: Abuse, Neglect and Exploitation revised 09/06/24, reflected . it is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect . 1. The facility provides resident protection that included: (a) prevention/prohibit resident abuse, neglect . 2. The facility's abuse prevention coordinator is responsible for reporting allegations or suspected abuse, neglect . to the state survey agency and other official in accordance with state law .III. Prevention of Abuse, Neglect and Exploitation . A. (2.) Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes: 2(a). Immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involves abuse (with or without bodily injury) .