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	03/30/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35340 Based on observations, interviews, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 6 of 6 residents (Resident #s 1, 2, 3, 5 and 6) and 5 of 5 staff (Staff NA B, NA C, MA D, NA F, and LVN G) reviewed for infection control. The facility failed to follow their policy when they did not ensure the following: -Resident #2 remained on isolation for 10 days and/or wear appropriate PPE when not in his room. -NA B washed or sanitized her hands and donned appropriate personal protective equipment (PPE) when she entered and exited Resident #1 and 2's room. -NA F washed or sanitized her hands and donned appropriate personal protective equipment (PPE) when she entered and exited Resident #5's room. -Staff NA B, NA C, MA D, NA F, and LVN G were aware who were Covid+ -LVN G was aware Resident #s 1, 2, 3, and 4 were Covid + and notified NA B. -PPE was available for Resident #6's room when facility had Resident listed on Covid+ list. This failure could place the residents at risk of exposure to COVID-19 and other types of infection. Findings included: 1. Record review of undated admission record printed on 3/30/25 indicated Resident #1 was an [AGE] year-old male who originally admitted on [DATE] and readmitted on [DATE] with diagnoses including urinary tract infection (an infection of the urinary system, which includes the kidneys, ureters, bladder, and urethra), end stage renal disease (also known as kidney failure, is a severe condition where the kidneys permanently lose their ability to function properly), cognitive communication deficit (difficulty communicating due to brain damage) and bacteremia (the presence of bacteria in the bloodstream, which can be a transient, harmless occurrence or a serious infection that can lead to sepsis or septic shock). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's order summary report dated 3/30/25 indicated an order for droplet isolation precautions every shift for 10 days; DX: COVID. Start date: 3/24/25 - End date: 4/3/25. Record review of a care plan for Resident #1 revised on 3/25/25 indicated the following: Focus: -Resident #1 had a dx of a viral respiratory infection (COVID 19, RSV, Influenza) and is a risk for: Respiratory complications (including impaired oxygen exchange), dehydration, pain and discomfort, unintended weight loss -Required isolation and was at risk for: loneliness, anxiety, and sadness due to isolation precautions. Record review of quarterly MDS dated [DATE] indicated Resident #1 was able to make self-understood and had the ability to understand others. The MDS indicated Resident #1 had moderate cognitive impairment in thinking with a BIMS score of 12 and required substantial/maximal assistance with most ADLs. Record review of progress note for Resident #1 indicated the following: -3/30/25 at 2:38am completed by RN J - Resident #1 was covid+ and was in isolation until 4/1/25. -3/28/25 at 2:00pm completed by Nurse Practitioner - Assessment & Plan: Chief Complaint: Weakness with COVID-19 isolation (Weakness), Plan: Continue isolation precautions per facility protocol until criteria for discontinuation are met and monitor vital signs and oxygen saturation every shift and notify the provider for changes. Continue PT/OT/ST services with appropriate PPE and isolation measures. -3/28/25 at 1:27pm completed by LVN H- Resident #1 continued isolation for covid. Resident #1 returned early from dialysis due to increased tiredness. -3/28/25 at 3:02am completed by RN K - Resident #1 was covid+ and was in isolation until 4/1/25. -3/27/25 at 2:11am completed by RN K- Resident #1 was covid+ and was in isolation until 4/1/25. -3/24/25 at 5:18am completed by RN K- Late Entry: Resident #1 tested positive for covid. During an observation on 3/29/25 at 12:42 pm, Resident #1 and #2 shared rooms. NA B was wearing a black colored surgical mask entered the room without wearing the appropriate PPE (gloves, gowns, N95 masks), and without washing her hands or using sanitizer. The door was left open, and NA B was observed touching the bedsheets of Resident #1 to straighten them and moved the over bed tray table, without gloves. She was then observed to exit the room without washing her hands or using hand sanitizer. There was PPE box outside of the room doorway which included N-95 masks, gowns, and eyewear. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/29/25 at 12:44pm, NA B said she was NA for the 200 hall and was working the 6am-2pm shift. She said the 200 Hall was Covid free and she had gone into all the rooms on her hall. NA B said the PPE box on Residents #1 and #2 door was for a different resident who was no longer in that room. NA B said to her knowledge Resident #1 did not have covid and tested negative on 3/24/25. She said the charge nurses assigned to each hall were responsible for notifying the NA on any covid positives residents on their hall and she said the charge nurse had not informed her on any positives, that was how she knew her assigned 200 hall was covid free. NA B said she had been trained related to COVID and was told to completely gown up and use proper PPE when entering a COVID room. Regarding what could result from her entering a COVID positive room without donning the proper PPE, she stated, she could transmit COVID to another resident. 2. Record review of undated admission record printed on 3/30/25 indicated Resident #2 was an [AGE] year-old male who admitted on [DATE] with diagnoses including displaced intertrochanteric fracture of the right femur (is a break in the upper part of the femur -thigh bone), muscle weakness (a condition where muscles feel weak or lack strength), cognitive communication deficit (difficulty communicating due to brain damage) and dementia (an umbrella term for a group of diseases that cause a decline in mental ability severe enough to interfere with daily life, encompassing memory, thinking, and behavior). Record review of Resident #2's order summary report dated 3/30/25 indicated an order for droplet isolation precautions every shift for 10 days; DX: COVID. Start date: 3/24/25 - End date: 4/3/25. Record review of a care plan for Resident #2 revised on 3/25/25 indicated the following: Focus: -Resident #2 had a dx of a viral respiratory infection (COVID 19, RSV, Influenza) and is a risk for: Respiratory complications (including impaired oxygen exchange), dehydration, pain and discomfort, unintended weight loss -Required isolation and was at risk for: loneliness, anxiety, and sadness due to isolation precautions. Record review of quarterly MDS dated [DATE] indicated Resident #2 was able to make self-understood and had the ability to understand others. The MDS indicated Resident #2 had moderate cognitive impairment in thinking with a BIMS score of 09 and required partial/moderate assistance with most ADLs. Record review of progress note for Resident #2 indicated the following: -3/30/25 at 1:30pm completed by LVN H - Resident #2 was isolated for COVID. No s/s of distress was noted. Resident #2 required frequent encouragement to remain in room due to COVID. -3/30/25 at 2:46am completed by RN J - Resident #2 was covid+ and was in isolation until 4/3/25. -3/28/25 at 1:30pm completed by LVN H - Resident #2 was isolated for COVID. Resident #2 non-compliant with isolation protocol and was frequently redirected to remain in his room due to isolation. -3/28/25 at 3:10am completed by RN K- Resident #2 was covid+ and was in isolation until 4/3/25. -3/27/25 at 2:29am completed by RN K - Resident #2 was covid+ and was in isolation until 4/3/25. During an observation on 3/29/25 at 12:42pm to 2:00pm; Resident #2 was observed sitting in the hallway in his wheelchair on hall 200 and was not wearing PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/29/25 at 1:04pm, NA F was observed on Hall 200 pushing Covid+ Resident #2's wheelchair out the way, wearing a N95 mask and going in and out several of the residents' rooms picking up lunch trays . She did not wash her hands or use hand sanitizer in between each room. 3. Record review of undated admission record printed on 3/30/25 indicated Resident #3 was a [AGE] year-old male who admitted on [DATE] with diagnoses including unilateral primary osteoarthritis of the left knee (is a condition where the cartilage in the left knee joint breaks down, causing pain, stiffness, and other symptoms), Wernicke's encephalopathy (is a severe neurological disorder caused by a deficiency of thiamine - vitamin B1), muscle weakness (a condition where muscles feel weak or lack strength), cognitive communication deficit (difficulty communicating due to brain damage) and hypertension (or high blood pressure, a condition where the force of blood against artery walls is consistently too high, potentially damaging the heart, brain, and other organs). Record review of Resident #3's order summary report dated 3/30/25 indicated an order for contact/droplet isolation precautions, with all services provided in the room every shift until 4/5/25. Start date: 3/25/25 - End date: 4/5/25. Record review of a care plan for Resident #3 initiated on 3/25/25 indicated the following: Focus: -Resident #3 had a dx of a viral respiratory infection (COVID 19, RSV, Influenza) and is a risk for: Respiratory complications (including impaired oxygen exchange), dehydration, pain and discomfort, unintended weight loss -Required isolation and was at risk for: loneliness, anxiety, and sadness due to isolation precautions. Record review of admission MDS dated [DATE] indicated Resident #3 was able to make self-understood and had the ability to understand others. The MDS indicated Resident #3 had moderate cognitive impairment in thinking with a BIMS score of 09 and required partial/moderate assistance with most ADLs. Record review of progress note for Resident #3 indicated the following: -3/30/25 at 3:14pm completed by LVN H - Resident #3 had an active infection. Resident #3 had a respiratory infection and had no symptoms of infection. Isolation precautions was in place. Resident #3 was on contact, airborne and on droplet precautions. Resident #3 resided in a private room and all services were provided in the resident's room. -3/30/25 at 1:31pm completed by LVN H- Resident #3 continued isolation for covid. No s/s of distress was noted at that time. -3/28/25 at 3:38pm completed by LVN H - Resident #3 had an active infection. Resident #3 had a respiratory infection and had no symptoms of infection and was receiving medication. Isolation precautions was in place. Resident #3 was on airborne and on droplet precautions. Resident #3 resided in a private room and all services were provided in the resident's room. -3/28/25 at 1:33pm completed by LVN H - Resident #3 continued Paxlovid medication for COVID and continued isolation for covid. No s/s of distress was noted at that time. -3/27/25 at 2:00am completed by RN K - Resident #3 continued isolation covid until 4/5/25 and Paxlovid medication by mouth twice a day until 3/30/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/30/25 at 6:39pm, Resident #3 had appropriate PPE box outside room to indicate contact and/or droplet isolation precautions. 4. Record review of undated admission record printed on 3/30/25 indicated Resident #4 was a [AGE] year-old male who originally admitted on [DATE] and readmitted on [DATE] with diagnoses including dementia (an umbrella term for a group of diseases that cause a decline in mental ability severe enough to interfere with daily life, encompassing memory, thinking, and behavior), muscle weakness (a condition where muscles feel weak or lack strength), cognitive communication deficit (difficulty communicating due to brain damage), hypertension (or high blood pressure, a condition where the force of blood against artery walls is consistently too high, potentially damaging the heart, brain, and other organs), stroke, also known as a brain attack or cerebrovascular accident (occurs when blood flow to the brain is interrupted, leading to brain damage or death), and COVID - 19 (an infectious disease caused by a virus. The virus can spread from an infected person's mouth or nose in small liquid particles when they cough, sneeze, speak, sing or breathe. These particles range from larger respiratory droplets to smaller aerosols. Older people and those with underlying medical conditions like cardiovascular disease, diabetes, chronic respiratory disease, or cancer are more likely to develop serious illness. Anyone can get sick with COVID-19 and become seriously ill or die at any age.) Record review of Resident #4's order summary report dated 3/30/25 indicated an order for droplet isolation precautions every shift for 10 days; DX: COVID. Start date: 3/24/25 - End date: 4/3/25. Record review of a care plan for Resident #4 initiated on 3/26/25 indicated the following: Focus: -Resident #4 had a dx of a viral respiratory infection (COVID 19, RSV, Influenza) and is a risk for: Respiratory complications (including impaired oxygen exchange), dehydration, pain and discomfort, unintended weight loss -Required isolation and was at risk for: loneliness, anxiety, and sadness due to isolation precautions. Record review of quarterly MDS dated [DATE] indicated Resident #4 was able to make self-understood and had the ability to understand others. The MDS indicated Resident #4 was cognitively intact with a BIMS score of 15 and required partial/moderate assistance with most ADLs. Record review of progress note for Resident #4 indicated the following: -3/28/25 at 1:41pm completed by LVN H - Resident #4 had diagnosis of covid, and continued isolation. -3/28/25 at 1:32am completed by RN K - Resident #4 returned from local hospital. Resident #4 continued isolation covid until 4/3/25, and new order to give amoxicillin x1 dose. -3/22/25 at 5:51pm completed by MA D - Give 2x tablets of Paxlovid medication by mouth two times a day for COVID, for 5 days. -3/22/25 at 10:21am completed by MA D - Give 2x tablets of Paxlovid medication by mouth two times a day for COVID, for 5 days. -3/19/25 at 10:43am completed by LVN H - Resident #4 had dialysis for that day and stated he did not feel well. Resident #4 refused COVID test and rested in bed quietly with eyes closed. No s/s of distress noted at that time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/30/25 at 6:40pm, Resident #4 had appropriate PPE box outside room to indicate contact and/or droplet isolation precautions. 5. Record review of undated admission record printed on 3/30/25 indicated Resident #5 was a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (weakness or the inability to move one side of the body, rather than complete paralysis following a stroke), Type 2 diabetes (a chronic condition where the body either doesn't produce enough insulin or can't effectively use the insulin it produces, leading to high blood sugar levels) and hypertension (or high blood pressure, a condition where the force of blood against artery walls is consistently too high, potentially damaging the heart, brain, and other organs). Record review of Resident #5's order summary report dated 3/20/25 indicated an order for enhanced contact/droplet isolation precautions; all services are to be in room. Record review of a care plan for Resident #5 initiated on 3/20/25 and revised on 3/25/25 indicated the following: Focus: -Resident #5 had a dx of a viral respiratory infection (COVID 19, RSV, Influenza) and is a risk for: Respiratory complications (including impaired oxygen exchange), dehydration, pain and discomfort, unintended weight loss -Required isolation and was at risk for: loneliness, anxiety, and sadness due to isolation precautions. Record review of quarterly MDS dated [DATE] indicated Resident #5 was able to make self-understood and had the ability to understand others. The MDS indicated Resident #5 was cognitively intact with a BIMS score of 15 and was independent with most ADLs. During an observation on 3/30/25 at 6:07pm, Resident #5 had appropriate PPE box outside room to indicate contact and/or droplet isolation precautions. 6. Record review of undated admission record printed on 3/30/25 indicated Resident #6 was a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with diagnoses including Acute hypercapnic respiratory failure (also known as type 2 respiratory failure, occurs when the lungs struggle to remove carbon dioxide from the body, leading to a buildup in the blood), hypertension (or high blood pressure, a condition where the force of blood against artery walls is consistently too high, potentially damaging the heart, brain, and other organs) and chronic obstructive pulmonary disease (is a group of lung diseases that cause progressive airflow obstruction and breathing difficulties). Record review of Resident #6's order summary report dated 3/30/25 indicated an order for contact/droplet isolation precautions; all services are to be in room every shift until 3/31/25. Start date: 3/25/25 - End date: 3/31/25. Record review of a care plan for Resident #6 initiated on 3/21/25 and revised on 3/25/25 indicated the following: Focus: -Resident #6 had a dx of a viral respiratory infection (COVID 19, RSV, Influenza) and is a risk for: Respiratory complications (including impaired oxygen exchange), dehydration, pain and discomfort, unintended weight loss -Required isolation and was at risk for: loneliness, anxiety, and sadness due to isolation precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of quarterly MDS dated [DATE] indicated Resident #6 was able to make self-understood and had the ability to understand others. The MDS indicated Resident #6 was cognitively intact with a BIMS score of 15 and required partial/moderate assistance with most ADLs. During an observation on 3/30/25 at 6:13pm, Resident #6 did not have appropriate PPE box outside room. Record review resident roster dated 3/28/25 indicated the following: -Resident #1 resided on Hall 200 -Resident #2 resided on Hall 200 -Resident #3 resided on Hall 200 -Resident #4 resided on Hall 200 -Resident #5 resided on Hall 300 -Resident #6 resided on Hall 300 During an observation and record review on 3/29/25 at 1:02pm at the nurse station of an undated copied handwritten paper, listed the names of 45 Covid+ residents and 14 Covid+ staff for the charge nurses to use as a guide on which residents on their halls was in isolation for Covid+ indicated the following: -Resident #1, listed as number 40; dated 3/21/25 -3/31 -Resident #2, name was not listed -Resident #3, listed as number 42; with an unspecified date 3/26 -Resident #4, listed as number 32; - out unspecified -Resident #5, listed as number 35; dated 3/31 -Resident #6, listed as number 45; no date listed Record review of March 2025 calendar with handwritten title Covid positive tests Resident #'s provided by the Administrator on 3/29/25 indicated the following: -on 3/15/25 - 19 unknown residents tested positive -on 3/17/25 - 3 unknown residents tested positive -on 3/19/25 - 7 unknown residents tested positive -on 3/20/25 - 4 unknown residents tested positive (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-on 3/21/25 - 6 unknown residents tested positive -on 3/24/25 - 1 unknown resident tested positive -on 3/26/25 - 1 unknown resident tested positive Record review of a undated document titled respiratory pathogens and vaccination summary data indicated the facility reported the following information to the CDC's NHSN: -Week of data collection (Monday - Sunday): 3/10/25 - 3/16/25; Date Created and Date completed was on 3/22/25 at 9:40pm; .3. Resident Cases (Positive tests), 3a. COVID -19: Residents with a positive test = 16 -Week of data collection (Monday - Sunday): 3/17/25 - 3/23/25; Date Created and Date completed was on 3/22/25 at 9:43pm; .3. Resident Cases (Positive tests), 3a. COVID -19: Residents with a positive test = 26 -Week of data collection (Monday - Sunday): 3/24/25 - 3/30/25; Dated Created and Date completed was on 3/31/25 at 5:03pm; .3. Resident Cases (Positive tests), 3a. COVID -19: Residents with a positive test = 2 Record review of emailed typed Resident Covid+ list received on 4/4/25 at 2:44pm from The Administrator indicated the following: -Resident #1 tested positive on 3/21/25 and scheduled to be out of isolation on 4/1/25. -Resident #2 tested positive on 3/24/25 and scheduled to be out of isolation on 4/4/25. -Resident #3 tested positive on 3/25/25 and scheduled to be out of isolation on 4/5/25. -Resident #4 was not listed. -Resident #5 tested positive on 3/20/25 and scheduled to be out of isolation on 3/31/25. -Resident #6 was not listed. During an interview on 3/29/25 at 12:53pm, LVN G said that she was working the 6 a.m. to 6 p.m. shift and serving as the charge nurse for Halls 100/200 due to significant staffing shortages. She indicated that she was unaware of any residents on her assigned halls who were positive for COVID-19 because she was the treatment nurse. ADON E, who was acting as the charge nurse for Halls 300/400, was seen instructing LVN G to look at the handwritten list of residents who tested positive for COVID-19. After reviewing this handwritten list, LVN G stated that she was not aware that Residents #1, 2, 3, or 4 had tested positive and that she did not notify the NA assigned to her halls. LVN G emphasized that if residents were confirmed to be COVID-positive, staff were required to don appropriate PPE before entering their rooms and to wash or sanitize their hands after exiting to mitigate the risk of virus transmission. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/29/25 at 2:35pm, NA C said she was the assigned NA for the 300 hall and was working the 2pm to 10pm shift. She said she did not have any COVID positive residents on her hall that day and that she had already visited with all her residents on her assigned hall for that day. NA C said if residents were COVID positive then they would have red floor tape indicating they were positives, and she did not have any room on the 300 hall with red floor tape. NA C said she had been trained related to COVID and was told to completely gown up and use proper PPE when entering a COVID room. Regarding what could result from her entering a COVID positive room without donning the proper PPE, she stated, she could transmit COVID to another resident. During an interview on 3/30/25 at 6:15pm, MA D said she was the MA for Halls 200 and 300. She reported working double shifts on weekends, specifically from 6 AM to 10 PM on both Saturday and Sunday. According to MA D, the nursing staff would inform her of any positive cases within her assigned halls. She said that there were no positive residents on either of her halls on March 29 or March 30, 2025, and that this had been the case for approximately one week. In the event of a positive case, she indicated that she would donn the necessary PPE to safeguard herself and prevent the virus from spreading to other residents. MA D mentioned that the PPE boxes placed on the doors of certain residents had not been removed, which explained their continued presence outside some rooms. She noted that Residents #1-6 resided on her halls. In her view, the swift outbreak among residents was attributable to the facility administration's management of the situation. She expressed confusion regarding the decision to relocate a negative resident who shared a room with a positive resident, thereby exposing the other residents to the potential infection, rather than keeping the residents isolated together. During an observation 3/30/25 from 6:05pm to 6:13pm NA F was observed passing dinner trays to Residents on Hall 300. NA F wore N95 mask and was observed going in and out of 7 rooms of both positive and non-positive resident rooms. -NA F did not wash or sanitize her hands and did not donn appropriate personal protective equipment (PPE) when she entered and exited Resident #5 room. During an interview on 3/30/25 at 6:23pm, NA F said she worked PRN and was scheduled to work the 2p-10p shift on hall 300. NA F said there was only one positive room on Hall 300; since she was already wearing a N95 she only had to put on gloves and a gown. During an interview on 3/29/25 at 11:00am, Tthe Administrator stated that she was obligated to submit weekly reports on COVID-19 positive cases to the CDC's NHSN. She mentioned that she was ill from March 12, 2025, to March 17, 2025, which prevented her from completing her weekly reports. She clarified that she was the sole staff member authorized to access the CDC's NHSN. Upon her return to work on March 17, 2025, she finalized the overdue weekly reports from the week of March 10, 2025, on March 22, 2025. The Administrator identified the primary issue as the 3-5-day incubation period for symptoms to manifest after exposure, during which residents continued to participate in group activities without displaying any signs of illness. She noted that a therapist tested positive on March 14, 2025, prompting testing for the residents she was supervising. She observed that the COVID-19 virus spread rapidly for approximately two weeks before beginning to decline. (continued on next page)

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	03/30/2025

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/30/25 at 6:45pm, ADON E identified herself as the infection preventionist. She stated that it was the responsibility of the charge nurses to inform the NAs about which residents were COVID-positive. During her absence from March 20, 2025, to March 26, 2025, due to the virus, the facility implemented the use of red floor tape outside the rooms of COVID-positive residents. This measure served as an additional indicator for NAs to identify COVID-positive residents in case they had not received prior notification from the charge nurses. ADON E explained that residents who tested positive for COVID-19 were required to isolate for a period of 10 days, with the 11th day marking their exit from isolation. Throughout the 10-day isolation period, both asymptomatic and symptomatic residents were expected to remain in their rooms, while staff were mandated to wear appropriate PPE each time, they entered the room of a COVID-positive resident still within the isolation timeframe. Furthermore, ADON E noted that if a resident tested positive and had a roommate who tested negative, the positive resident would typically be relocated, and the housekeeping staff would conduct a deep cleaning of the positive resident's area. The facility would then monitor the negative roommate for any signs or symptoms of the virus. She stated that she was unaware that Resident #6 did not have a PPE box positioned outside her room. She mentioned that it was mandatory for all COVID-positive residents to have PPE available outside their rooms for staff to use before entering. During an interview on 3/30/25 at 7:06pm, the DON stated that NAs were expected to receive reports from their charge nurses regarding which residents tested positive for Covid-19. She mentioned that the charge nurses possessed a handwritten list she had compiled, which detailed the residents who were Covid-positive, along with the dates they tested positive and the dates they were cleared from isolation. The DON explained that this list was created rapidly due to the high number of residents testing positive daily. At one point, they introduced red floor tape outside the rooms of residents with short-term memory issues, intending for the tape to serve as a visual reminder for them to remain in isolation. However, corporate informed her that this practice infringed upon residents' rights, necessitating the removal of the red tape. The DON explained that residents who tested positive for COVID-19 were required to isolate for a period of 10 days, with the 11th day marking their exit from isolation. Throughout the 10-day isolation period, both asymptomatic and symptomatic residents were expected to remain in their rooms, while staff were mandated to wear appropriate PPE each time, they entered the room of a COVID-positive resident still within the isolation timeframe to prevent the spread of the virus to the other residents and themselves. The DON stated that she was unaware that Resident #6 did not have a PPE box positioned outside her room. She mentioned that it was mandatory for all COVID-positive residents to have PPE available outside their rooms for staff to use before entering. During a telephone interview on 3/31/25 at 10:30am, the Administrator called and said they had just retested Resident #6 and she was not positive. The Administrator said she was told by staff that it was a chance Resident #6 was never a true COVID + and should not had been on the COVID+ list. Record review of Complaint Investigation worksheet, Intake 573448 revealed an allegation of infection control. The complaint was reported to HHSC CII on 3/27/25. Intake 573448 read in part: .many residents had obtained covid. The complainant stated that was mainly due to the staff not taking precautions. The complainant stated that staff [did not] sanitize or clean the facility . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a revised policy titled Infection Prevention and Control Program dated 11/6/24 indicated, This facility has established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections as per accepted national standards and guidelines. Record review of a revised policy titled Responding to Suspected Novel Coronavirus Illness dated 1/24/25 indicated, The facility is committed to prompt action upon identifying potential respiratory illness related to novel coronavirus, including COVID-19 and other respiratory infections like influenza.d. Patients with mild to moderate illness who are not moderately to severely immunocompromised: I. At least 10 days have passed since symptoms first appeared and II. At least 24 hours have passed since last fever without the use of fever-reducing medications and III. Symptoms (cough, shortness of breath) have improved. C. Patients who were asymptomatic throughout their infection and are not moderately to severely immunocompromised: I. At least 10 days have passed since the date of their first positive viral test . Record review of a revised policy titled Facility Coronavirus Testing dated 1/24/25 indicated, The facility will implement testing of facility residents and HCP, including individuals providing services under arrangement and volunteers, for COVID -19, as well as other respiratory illnesses .