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	05/12/2025

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 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on observation, interview and record review, the facility to ensure that the residents had the right to self determination and that the facility promoted and facilitated resident self-determination for 1 (Resident #9) of 23 resident who were reviewed for resident rights. The facility failed to ensure Resident #9's right to make choices about aspects of his life that were significant to the resident by not ensuring his right to have access to a working debit card attached to his personal funds for his own daily use. The facility failed to prevent the Administrator from purchasing a pre-need funeral plan in the amount of $13, 034.41 when Resident #9 had expressed to his family member he did not want a pre-need funeral plan. An IJ was identified on 05/09/25 at 06:24 PM. While the IJ was removed on 05/12/25 at 11:54 AM, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents with the ability to make choices at risk of having their rights violated, diminished quality of life and unmet needs. Findings included: Record review of Resident #9's face sheet dated 05/09/25 indicated he was an [AGE] year-old male who readmitted to the facility on [DATE] with the diagnoses dementia, anxiety, hear failure, high blood pressure, and lack of coordination. Record review of Resident #9's quarterly MDS dated [DATE] indicated he made himself understood and understood others. The MDS also indicated he had a BIMS score of 8 which meant he had moderate cognitive impairment. Record review of Resident #9's care plan revised on 04/07/25 indicated he had impaired cognition and was at risk for further decline with a goal of his needs being met timely, dignity maintained, and current level of functioning maintained. (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 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #9's trust funded prepaid funeral benefits dated 04/08/25 indicated he used a cashier's check in the amount of $13, 034.31 to purchase a prepaid funeral. During an interview on 05/08/25 at 06:00 PM Resident #9's family member said she did not have any control over his money. She said when she received the bank statements she would bring them to the facility. The family member said she had attempted to purchase a prepaid funeral plan for Resident #9 at one point, but he did not want her to do so. She said she was aware of people on the outside of the facility coming to pick him up and use his money but it was nothing she could do. During an interview on 05/09/25 at 08:00 AM CNA U said she told the administrator repeatedly Resident #63 was using Resident #9 for his money. She said the ADM told her it was none of the facility's business. CNA U said the ADM told her She had this under control and that the ADM was going to go have him spend all of his money today. CNA U said the ADM said, she was going to go make him go make him spend all his money so that's how they were going to solve this. CNA U said the ADM said she was taking him did a funeral arrangements. During an interview on 05/09/25 at 2:21 p.m., Resident #9 said he kept his own debit card and he gave Resident #63 his debit card to use 1 time. He told Resident #63 he could have between $20-$30. He said Resident #63 did pay him back for the money. The surveyor asked if he knew Resident #63 was giving others his debit card, including staff, and Resident #9 said he was unaware and he did not authorize Resident #63 to give his debit card to anyone else. Resident #9 and the surveyor reviewed some of his bank statements. After reviewing the bank statements dated 1/16/25-2/14/25, he and the surveyor saw some charges on 02/07/25 that reflected Resident #9 made an ATM withdrawal 3 times for $203, and $103, totaling $918in a day. Resident #9 put his head down and said in a shaky voice he did not know about those charges. Resident #9 became saddened and teary-eyed after discussing the charges on his bank account. The surveyor went to get ADON AA, and she witnessed Resident #9 say he had not given staff permission to use his card, and he authorized Resident #63 to use his card, but not for those amounts. During an interview on 05/09/25 at 4:41 p.m., the ADM stated she had taken Resident #9 to the bank on 02/24/25 to get his statements so she could see if any money was withdrawn from the account when Resident #63 gave Resident #9's bank card to CNA E and CNA N. She said Resident #9 kept his bank card for his own use. The ADM stated the bank was not going to give him another card because of the fraudulent activity. The ADM stated, I agreed with the lady at the bank. The ADM stated on a Monday (02/24/25) there was a risk call made that included herself, the DON, the Regional Consultant Nurse and the Regional Operations to discuss the incident about CNA E, CNA N, Residents #63 and #9 and another incident with CNA N. The ADM stated during the call on 02/24/25. The ADM said during the investigation she and the DON found out by CNA N that CNA E was given Resident #9's card by Resident #63 and was told to withdraw $200. The ADM stated during the call she told the regional people CNA E attempted to withdraw the money but was unsuccessful. The ADM stated she told them she suspended CNA E and was told by the Regional Operations Manager she should have never suspended her, just written her up because there was no money taken. The ADM stated she was told by Resident #9's family member who was not his POA or guardian to take Resident #9 to a funeral home to take out a pre-burial policy because Resident #9 would not let the family member take him. The ADM stated she took out $13,034.31 and $500 to start a trust fund at the facility. The ADM stated she, and Laundry V took him to the funeral home to take out the policy because he would not let his sister get one. (continued on next page)

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F 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 05/09/25 at 5:45 p.m., the BOM stated the ADM told her when she took Resident #9 to the bank after the incident with CNA E, CNA N and Resident #63 the card was put on hold. The BOM stated the ADM did not elaborate if the bank put the card on hold or if she initiated it. The BOM stated she was told by the ADM she did get bank statements that day (02/24/25). The BOM stated Resident #9's family member had brought statements in (on an unknown date) before the incident between CNA E, CNA N, and Resident #63 because she wanted to know what all the withdrawals were for. The BOM stated she told her she would look into it and that was when the BOM spoke with the ADM about the withdrawals of the bank acct. The BOM stated the ADM told her she would look into it. The BOM stated the issue was brought up several times in morning meetings and the ADM stated she was looking into it. The BOM stated it got to a point the ADM stated, We're done talking about that. During an observation on 05/09/25 at 6:15 p.m. the surveyor observed Resident #9 with the BOM attempting to purchase an item out the vending machine using his bank card, but the transaction was denied. This was determined to be an Immediate Jeopardy (IJ) on 05/09/2025 at 06:24 PM. The Administrator was provided with the IJ template on 05/09/2025. The following Plan of Removals was accepted on 05/12/2025 at 02:57 PM. The plan of removal was accepted on 5/12/2025 at 2:57 p.m., and included: A. On 5/9/2025 the ADON completed an assessment on Resident #9 to determine if the resident was having any emotional distress related to this incident. The resident stated he was fine and was attending church services. The assessment was conducted privately prior to church services. B. On 5/9/2025 the DON completed a Comprehensive Trauma screen on the resident, and on 5/9/2025 The V.A. Social Worker was contacted by the facility regarding the need of the resident needing a Psychology evaluation related to this incident. C. On 5/9/2025 the Regional Nurse Consultant provided 1:1 in-service with the DON on the facility's Resident Rights policy that includes: (continued on next page)

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F 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Prior to or upon admission, the social service designee, or another designated staff member, will inform the resident and/or the resident's representative of the resident's rights and responsibilities, Information about residents' rights and responsibilities will be given to the resident both orally and in writing, Information about resident rights will be given to the resident in a language that the resident understands to the extent possible, considering impediments which may be created by the resident's health and mental status. If a resident's knowledge of English or the predominant language of the facility is inadequate for comprehension, a means to communicate the information concerning rights and responsibilities in a language familiar to the resident will be made available and implemented. The facility will have written translations of its statements of rights and responsibilities in commonly encountered foreign languages, if/as applicable. Large print texts of the facility's statement of resident rights and responsibilities should be available. The facility will promptly inform residents of any changes to State or Federal laws relating to resident rights or facility rules. Receipt of any such changes must be acknowledged in writing. A posting of names, addresses, and phone numbers of all pertinent state client advocacy groups will be available in the facility. The facility prominently displays written information regarding how to apply for and use Medicare and Medicaid benefits. All residents will be treated equally regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression. The right to be fully informed of and participate in or refuse treatment, noting that before initiating or increasing a psychotropic medication, the resident must be notified of and have the right to participate in their treatment, including the right to accept or decline medication. The financial rights to make decisions pertaining to their personal finances. The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents. D. On 5/9/2025 the DON started in-service education with all staff on the facility's Resident Right's policy. This was completed at 8:00pm and no staff will be allowed to work until they have completed their education. E. On 5/8/2025 the Administrator was suspended by the Regional Director of Operations pending investigation. F. On 5/8/2025 the Misappropriation was reported to HHSC by DON. G. On 5/12/2025 the resident will be taken to his bank by the Maintenance Director and Social Services to obtain a new debit card. The residents' family will be encouraged to go as well. The resident does have an active Trust fund in the facility and has access to immediate funds if he chooses. The Resident has made 10 trust fund withdrawals in April 2025, and 4 in May 2025. 1. Identification of Residents Affected or Likely to be Affected: A. On 5/9/2025 the nurse manager on duty completed alert resident questionnaires to determine if any other resident was not allowed to make choices about aspects of his/her life in the facility. The questionnaire included financial choices as well. No other residents were found to be affected by this practice. 2. Actions to Prevent Occurrence/Recurrence: (continued on next page)

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F 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A. Starting 5/7/25 the Social Worker/designee will complete alert resident interviews 3 x week for 3 weeks, then weekly x 6 weeks to validate that all residents are allowed to make choices about aspects of his/her life in the facility, including financial choices. This will be reviewed after each interview is completed by the DON and Social Services so any issues, if applicable, can be addressed immediately. 3. On 5/9/25the facility's DON notified the Medical Director regarding the Immediate Jeopardy the facility received related to Self-determination and Resident Rights. 4. On 5/9/25 the facility conducted an Ad Hoc (created or done as necessary) QAPI meeting to discuss Resident Self-Determination and Resident Rights and sustaining compliance. The surveyor confirmed the following actions had been implemented sufficiently to remove the immediacy by: Record review of Resident #9's emotional assessment revealed it was completed by the DON on 5/09/2025 and indicated there were no issues. Record review of Resident #9's Comprehensive Trauma assessment revealed it was completed by the DON on 5/09/2025 and indicated there was no trauma present. Record review of a referral for Resident #9 dated 5/09/2025 to the VA Social Worker for psychological services. Record review of the Administrator's suspension form dated 5/08/2025 indicated she was suspended pending investigation. Record review of the DON's in-service on the facility's Resident Rights policy dated 5/09/2025 provided by the Regional Nurse Consultant included upon admission the resident or their representative would be informed of the resident's rights orally and written. The in-service included all residents will be treated equally regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression. The policy included financial rights to make decisions pertaining to their personal finances. Record review of the staff in-service of the Resident Right's policy provided by the DON on 5/09/2025 and would be on-going with all staff across all shifts and disciplines in-serviced prior to being allowed to work. During an observation on 5/12/2025 at 09:45 AM revealed Resident #9 was driven to his financial institution where he was able to obtain a new debit card to his personal account. During an interview on 5/12/2025 at 11:54 AM Resident #9 said he had obtained a working debit card to his personal account. Record review of the questionnaires of 4 alert residents completed by the nurse manager. The questionnaires included the right to make choices about aspects of their life including finances. The questionnaires indicated there were no other residents with concerns regarding their rights including financial rights. (continued on next page)

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F 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the Ad Hoc QAPI meeting completed on 05/09/25 indicated the DON, MD, BOM, MDS nurse, Activity Director, Treatment Nurse, Social Worker, ADON AA, and ADON XX were present. During an interview on 5/10/2025 at 06:11 PM the Medical Director indicated he was made aware by the DON of the facility's immediate jeopardy regarding Self-determination and Resident Rights. During interviews conducted on 5/10/2025 at 4:22 PM-5/10/2025 at 06:04 PM with the Administrator, DON, ADON AA, ADON XX, MDS Nurse, CNA F, CNA G, CNA L, CNA N, CNA O, MA T, MA T,CNA B, CNA D, CNA E, RN H, MA K, LVN M, CNA P, CNA Q, CNA R, CNA S, CNA U, Van Driver V, MA W, CNA X, MA Y, CNA Z, MA BB, LVN CC, LVN DD, CNA EE, LVN FF, MA GG, RN HH, Dishwasher KK, Dietary Aide LL, [NAME] MM, LVN OO, LVN PP, CNA QQ, CNA RR, CNA SS, LVN TT, MA UU, CNA VV, and RNC WW indicated they had been in-serviced on Self-determination and Resident Rights. The staff indicated a resident had the right to have access to their personal finances. The Administrator was informed the Immediate Jeopardy was removed on 05/12/2025 at 11:54 AM. The facility remained out of compliance at a severity level of potential for more than minimal harm that was not Immediate Jeopardy and a scope of isolated due to the facility's need to monitor the implementation of the plan of removal.

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on interview, and record review, the facility failed to ensure the right to be free from misappropriation of resident property for 2 of 23 residents reviewed for misappropriation of resident property. (Resident # 9 and Resident #63) The facility failed to protect Resident #9 from misappropriation of his personal funds when CNA D and CNA E attempted an ATM transaction for $200.00 on 2/21/2025 with unauthorized use of Resident #9's debit card. The facility failed to protect Resident #9 from misappropriation when Resident #63 used Resident #9's debit card and gave it to CNA E and CNA D to withdraw money that was not authorized by Resident #9 to allow CNA E and CNA D to use his debit card. The facility failed to prevent unauthorized transactions on Resident #9's debit card account on 1/27/25, 2/6/25, 2/7/25, and 2/10/25. An IJ was identified on 05/09/25. The IJ template was provided to the facility on [DATE] at 06:29 PM. While the IJ was removed on 05/10/25, the facility remained out of compliance at a scope isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk for decreased quality of life, misappropriation of property, and financial distress. Findings included: Record review of Resident #9's face sheet dated 05/09/25 indicated he was an [AGE] year-old male who readmitted to the facility on [DATE] with the diagnoses dementia and anxiety. Record review of Resident #9's quarterly MDS dated [DATE] indicated he made himself understood and understood others. The MDS also indicated he had a BIMS score of 8 which meant he had moderate cognitive impairment. Record review of Resident #9's care plan revised on 04/07/25 indicated he had impaired cognition and was at risk for further decline with a goal of his needs being met timely, dignity maintained, and current level of functioning maintained. The care plan interventions included keep routine consistent and try to keep caregivers consistent, and monitor/document/report to physician any changes in cognitive function. Record review of the facility associate discplinary memorandum dated 02/24/25 indicated CNA D was suspended pending investigation. Record review of Resident #9's checking account statement dated 01/16/25-02/14/25 indicated there were transactions at the ATM: (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	1)01/27/25 in the amount of $103.00, $2.00 and $103.00, $2.00 and $203.00, $2.00 and $203.00 2)2/06/2025 in the amount of $103.00, $2.00, $203.00, $2.00 3)2/7/25 in the amount of $103.00; $2.00; $203.00; $2.00 4)2/10/2025 in the amount of $103.00; $2.00, $203.00, $2.00 5) 2/10/2025 Temu charge in the amount of $20.25 and $277.89 During an interview on 05/5/25 at 02:22 PM CNA D stated a lot of staff would go to the store for Resident #63 and purchased things knowing the card did not belong to Resident #63. CNA D stated she never returned back to the facility to work because it's a lot of messy stuff going on and people taking advantage of that man card. During an interview on 05/08/25 at 4:40 p.m., CNA E stated her, and CNA D were leaving for break when Resident #63 asked her if she could go and withdraw $200 from the ATM. CNA E stated Resident #63 handed her a card and gave her the pin number to the card. CNA E stated she did not know at the time the card belonged to Resident #9 until she tried to withdraw the money and suspicious fraud popped up on the screen. CNA E stated she called to the facility and spoke with CNA N and had her to put Resident #63 on the phone. CNA E stated when Resident #63 got on the phone she stated she told him that was not his card and Resident #63 stated yes, I know, go ahead, and bring it back. We have to call his family member to fix the card because the same thing happened yesterday. CNA E stated she brought the card back and gave it to Resident #63 and told him to give it back to Resident #9. CNA E stated she did not report the incident to the Administrator until Monday (02/24/25) when an incident happened between CNA N and another resident. CNA E stated she was suspended that 02/24/25. CNA E stated there had been several occasions she witnessed Resident #63 going to get money from Resident #9 and handing it to Laundry V, CNA N, and Housekeeping C. CNA E stated CNA N's family member charge Resident #9 $1,000 to go to Walmart and CNA N' family member charged him $600 to take him to (city) Texas. CNA E stated Resident #29 family member has charged him $1,000 to go to the bank. CNA E stated Resident #29 and Resident #37 also takes money from Resident #9. CNA E stated she did not report any of these incidents to the ADM because was already aware. CNA E stated she also heard the ADM was taking money from Resident #9. During an interview on 05/06/25 at 1:41 p.m., MA UU stated she has heard about Resident #63 taking money from Resident #9. MA UU stated she had also heard Resident #29's family member coming to take Resident #9 to the bank. MA UU stated she reported what she had heard to the ADM. MA UU stated she could not recall the exact date. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 05/08/25 05:13 PM The Administrator said she was not aware of any staff members taking Resident #9's money. She said she asked Resident #9 about his money, and he told her he was giving out money to residents if they needed it. The Administrator said she called Resident #9's family member and told them about him giving away his money to residents in the facility. She said the VA came to the facility to assess Resident #9 and what he was doing with his money and the VA said he had the right to give his money away because his BIMS was high. The Administrator said Resident #9 gave Resident #63 his card to use. She said she knew CNA D and CNA E went to the gas station to get some chicken for a red soda. The Administrator said she said she was not aware of the $200 the CNAs attempted to get. She said CNA D and CNA E both were suspended on 02/24/25. She said it was not acceptable for staff to get Resident #9's card. She said she never got any money from that Resident #9. The Administrator said misappropriation was the state guideline but Resident #9 gave Resident #63 his card to use so that made it not misappropriation. She said CNA D and CNA E did not get money. The Administrator said the police said it was not misappropriation if Resident #9 gave it to Resident #63. During an interview on 05/09/25 at 1:41 p.m., Laundry aide V said she did not take any money from Resident #9, and he did not offer her any money. She said she was aware of Resident #63 getting money from Resident #9. She said the Administrator was aware that Resident #63 had taken Resident #9's money, but nothing was done about it. She said she took the Administrator and Resident #9 to the bank several times and once to the funeral home. She said she stayed on the bus, so she was unaware of what occurred while at the bank or the funeral home. During an observation and interview on 05/09/25 at 2:21 PM, Resident #9 said he gave Resident #63 his debit card to use 1 time. He told Resident #63 he could have between 20-30 dollars. He said Resident #63 did pay him back for the money. The surveyor asked if he knew Resident #63 was giving others his debit card, including staff, and Resident #9 said he was unaware and he did not authorize Resident #63 to give his debit card to anyone else. Resident #9 and the surveyor reviewed some of his bank statements. After reviewing the bank statements, he and the surveyor saw some charges on 02/07/25, showing Resident #9 made an ATM withdrawal 3 times for 203 dollars, and 103 dollars, totaling 918 dollars in a day. Resident #9 put his head down and said he did not know about those charges in a shaky voice. Resident #9 became saddened and teary-eyed after discussing the charges on his bank account. The surveyor went to get ADON AA, and she witnessed Resident #9 say he had not given staff permission to use his card, and he authorized Resident #63 to use his card, but not for those amounts. During a telephone interview on 05/09/25 at 2:58 p.m., CNA D stated her, and CNA E was going to lunch and CNA E told her to stop at the store so she could withdraw some money for Resident #63. CNA D stated, I had no dealing with card, I was just the driver. (continued on next page)

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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 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 05/09/25 at 4:41 p.m., the ADM stated she had taken Resident #9 to the bank to get his statements so she could see if any money was withdrawn from the account when Resident #63 gave Resident #9 bank card to CNA E and CNA N. The ADM stated the bank was not going to give him another card because of the fraudulent activity. The ADM stated, I agreed with the lady at the bank. The ADM stated on Monday (02/24/25) there was a risk call made that included she, DON, Regional Consultant Nurse and the Regional Operations to discuss the incident about CNA E, CNA D, Residents #63 and #9 and another incident with CNA D. The ADM stated she stated during the call during the investigation her and the DON found out by CNA D that CNA E was given Resident #9 card by Resident #63 and was told to withdraw $200. The ADM stated during the call she told the regional people CNA E attempted to withdraw the money but was unsuccessful. The ADM stated she told them she suspended CNA E and was told by the Regional Operations Manager she should have never suspended her just written her up because there was no money taken. The ADM stated she was told by Resident #9 family member to take Resident #9 to a funeral home to take out a pre-burial policy because Resident #9 would not let his family member take him. The ADM stated she took out $13,034.41 And $500 to start him a trust fund at the facility. The ADM stated her, and Laundry V took him to the funeral home to take out the policy. During an interview on 05/09/25 at 5:45 p.m., the BOM stated the ADM told her when she took Resident #9 to the bank after the incident with CNA E, CNA D and Resident #63 the card was put on hold. The BOM stated the ADM did not elaborate if the bank put the card on hold or if she initiated it. The BOM stated she was told by the ADM she did get bank statements that day. The BOM stated Resident #9 family member had brought statements in before the incident between CNA E, CNA D, and Resident #63 because she wanted to know what all the withdrawals was for. The BOM stated she told her she would look into and that was when the BOM spoke with the ADM about the withdrawals of the bank account. The BOM stated the ADM told her She would look into it. The BOM stated the issue was brought up several times in morning meetings and the ADM stated she was looking into it. The BOM stated it got to a point the ADM stated, were done talking about that. Record review of the facility policy Policy and Procedures: Abuse, Neglect and Exploitation dated 10/24/22 indicated: Policy: It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property This was determined to be an Immediate Jeopardy (IJ) on 05/09/2025 at 06:24 PM. Administrator was provided with the IJ template on 05/09/2025. The following Plan of Removals was accepted on 05/12/2025 at 02:57 PM. The plan of removal was accepted on 5/12/2025 at 2:57 p.m., and included: Immediate Action Taken: V. On 5/9/2025 DON completed an assessment on Resident # 9 to determine if resident was having any emotional distress related to this incident. The resident stated he was fine and was attending church services. The assessment was conducted privately prior to church services. (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	05/12/2025

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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 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	W. On 5/9/2025 the DON completed a Comprehensive Trauma screen on the resident, and resident will be referred to Psychology services for further evaluation. On 5/9/2025 The V.A. Social Worker was contacted by the facility regarding the need of the resident needing a Psychology evaluation related to this incident. X. On 5/9/2025 the Regional Director of Operations provided 1:1 in-service with the Regional Nurse Consultant on the facility's abuse, Neglect, and Misappropriations policy. Y. On 5/9/2025 The Regional Nurse Consultant provided 1:1 education to the facility DON on the Abuse, Neglect, and Misappropriations policy. This was completed on 5/9/25. Z. On 5/9/2025 DON started in-service education with all staff on the facility's Abuse, Neglect, Misappropriations policy, including post-test. This was completed at 8:00pm on 5/9/2025, and no staff will be allowed to work until they have completed their education. AA. On 5/8/2025 the Administrator was suspended by the Regional Director of Operations pending investigation. BB. On 5/12/2025 the resident will be taken to his bank by the Maintenance Director and Social Services to obtain a new debit card. Residents' family will be encouraged to go as well. Resident does have an active Trust fund in the facility and has access to immediate funds if he chooses. Residents have made 10 trust fund withdrawals in April 2025, and 4 in May 2025. CC. On 5/8/2025 the Misappropriation incident was reported to HHSC by DON. DD. On 5/8/2025 the Misappropriation incident was also reported to the local law enforcement agency. EE. On 5/9/2025 this incident was reported to HHSC by DON regarding resident # 63 not being authorized to use resident #9 debit card. FF. Resident # 63 was discharged from the facility on 5/7/2025 and does not have access to resident # 9 debit card. GG. On 5/8/2025 the facility started an investigation into the incident, the investigation was completed on 5/10/2025 at 12:00 pm. HH. On 5/9/2025 C.N.A. E was suspended by the DON related to this incident. II. C.N.A. D was suspended on 2/24/2025 and never returned to work. 2. Identification of Residents Affected or Likely to be Affected: A. Starting 5/7/25 the Social Worker/designee will complete alert resident interviews 3 x week for 3 weeks, then weekly x 6 weeks to validate that all residents are allowed to make choices about aspects of his/her life in the facility, including financial choices. This will be reviewed after each interview is completed by the DON and Social Services so any issues, if applicable, can be addressed immediately. (continued on next page)

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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 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	B. The Regional Nurse Consultant will oversee this process weekly x 6 weeks. 7. On 5/9/25the facility's DON notified the Medical Director regarding the Immediate Jeopardy the facility received related to failure to implement the abuse policy 8. On 5/9/25 the facility conducted an Ad Hoc QAPI meeting to discuss Misappropriation, and implementation of the abuse policy and sustaining compliance. The surveyor confirmed the following actions had been implemented sufficiently to remove the immediacy by: Record review of Resident #9's emotional assessment was completed by the DON on 5/09/2025. Record review of Resident #9's Comprehensive Trauma assessment was completed by the DON on 5/09/2025. Record review of a referral dated 5/09/2025 to the VA Social Worker for psychological services. Record review of the Administrator's suspension form dated 5/08/2025 indicated she was suspended pending investigation. Record review of the DON's in-service on the facilities Resident Rights policy dated 5/09/2025. Record review of the Regional Nurse Consultant's 1:1 in-service with the DON on the Abuse, Neglect, and Misappropriation policy. Record review of the Regional Director of Operation's 1:1 in-service with the Regional Nurse Consultant on the Abuse, Neglect, and Misappropriation policy. Record review of the in-service on the facility's Abuse, Neglect, Misappropriation policy dated 5/09/2025 conducted by the DON. The in-service also included a post test. During an observation on 5/12/2025 Resident #9 was driven to his financial institution where he was able to obtain a new debit card to his personal account. During an interview on 5/12/2025 at 11:54 AM Resident #9 said he had obtained a working debit card to his personal account. Record review of the reportable incident on 5/08/2025 to HHSC with intake #1008525 regarding Resident #9's misappropriation. Record review of the policy report # dated 5/08/2025 indicated the local authority was notified of the unauthorized use of Resident #9's debit card. Record review of the reportable incident on 5/09/2025 to HHSC with intake #1008767 indicated the reporting of Resident #63's unauthorized use of Resident #9's debit card. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #63's electronic record indicated he had discharged from the facility on 5/07/2025. Record review of the facility's investigation regarding the incident #--- with the completion date of 5/10/2025. Record review of CNA E's personnel record indicated she had been suspended pending investigation. Record review of CNA D's personnel record indicated she was suspended on 2/24/2025 and never returned to work. During an interview on 5/10/2025 the Medical Director indicated he was made aware by the DON of the facility's immediate jeopardy regarding failure to implement the abuse policy regarding misappropriation. During interviews conducted on 5/10/2025 - 5/12/2025 the Administrator, DON, ADON AA, ADON XX, MDS Nurse, CNA F, CNA G, CNA L, CNA N, CNA O, MA T, MA T,CNA B, CNA D, CNA E, RN H, MA K, LVN M, CNA P, CNA Q, CNA R, CNA S, CNA U, Van Driver V, MA W, CNA X, MA Y, CNA Z, MA BB, LVN CC, LVN DD, CNA EE, LVN FF, MA GG, RN HH, Dishwasher KK, Dietary Aide LL, [NAME] MM, LVN OO, LVN PP, CNA QQ, CNA RR, CNA SS, LVN TT, MA UU, CNA VV, and RNC WW indicated they had been in-serviced on the facilities abuse and neglect policy. The staff indicated a resident had the right to be free from abuse including misappropriation of property, and allegations should be reported immediately to the abuse coordinator. The Administrator was informed the Immediate Jeopardy was removed on 05/12/2025 at 11:54 AM. The facility remained out of compliance at a severity level of potential for more than minimal harm that was not Immediate Jeopardy and a scope of isolated due to the facility's need to monitor the implementation of the plan of removal.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on observation, interview and record review, the facility failed to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility failed to follow their policy on abuse for 1 of 23 residents (Resident #9) reviewed for abuse. The facility failed to implement their abuse policy and failed to protect Resident #9 from misappropriation of his personal funds when CNA D and CNA E attempted an ATM transaction on 02/21/25 using Resident #9's debit card associated with his personal bank account. The facility failed to implement their policy when they failed to conduct an investigation of misappropriation of Resident #9's monies and unauthorized transactions. An IJ was identified on 05/09/25. The IJ template was provided to the facility on [DATE] at 06:29 PM. While the IJ was removed on 05/12/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could cause residents to have misappropriation of their property and financial distress. Findings included: Record review of the facility policy Policy and Procedures: Abuse, Neglect and Exploitation dated 10/24/22 indicated: Policy: It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property Record review of Resident #9's face sheet dated 05/09/25 indicated he was an [AGE] year-old male who readmitted to the facility on [DATE] with the diagnoses dementia, anxiety, hear failure, high blood pressure, and lack of coordination. Record review of Resident #9's quarterly MDS dated [DATE] indicated he made himself understood and understood others. The MDS also indicated he had a BIMS score of 8 which meant he had moderate cognitive impairment. Record review of Resident #9's care plan revised on 04/07/25 indicated he had impaired cognition and was at risk for further decline with a goal of his needs being met timely, dignity maintained, and current level of functioning maintained. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 05/08/25 at 4:40 p.m., CNA E stated she and CNA D were leaving for break on 02/23/25 when Resident #63 asked her if she could go and withdraw $200 from the ATM. CNA E stated Resident #63 handed her a card and gave her the pin number to the card. CNA E stated she did not know at the time the card belonged to Resident #9 until she tried to withdraw the money and suspicious fraud popped up on the screen. CNA E stated she called the facility and spoke with CNA N and had her to put Resident #63 on the phone. CNA E stated when Resident #63 got on the phone she stated she told him that was not his card and Resident #63 stated Yes, I know, go ahead, and bring it back. We have to call Resident #9's family member to fix the card because the same thing happened yesterday. CNA E stated she brought the card back and gave it to Resident #63 and told him to give it back to Resident #9. She said she gave it back to Resident #63 instead of Resident #9 because that was who she got the card from. CNA E stated she did not report the incident to the Administrator until Monday 02/24/25 when an incident happened between CNA N and another resident. CNA E stated she was suspended that 02/24/25. CNA E stated there had been several occasions she witnessed Resident #63 going to get money from Resident #9 and handing it to Laundry V, CNA N, and Housekeeping C. CNA E stated CNA N's aunt charged Resident #9 $1,000 to take him to Walmart and CNA N's cousin charged Resident #9 $600 to take him to another city. CNA E stated Resident #29's family member has charged Resident #9 $1,000 to go to the bank. CNA E stated Resident #29 and Resident #37 also took money from Resident #9. CNA E stated she did not report any of those incidents to the ADM because the ADM was already aware. CNA E stated she also heard the ADM was taking money from Resident #9. During an interview on 05/06/25 at 1:41 p.m., MA UU stated she heard about Resident #63 taking money from Resident #9. MA UU stated she had also heard Resident #29's family member taking Resident #9 to the bank. MA UU stated she reported what she had heard to the ADM. MA UU stated she could not recall the exact date. During an interview on 05/08/25 05:13 PM the Administrator said she was not aware of any staff members taking Resident #9's money. She said she asked Resident #9 about his money on several occasions, and he told her he was giving out money to residents if they needed it. The Administrator said she called Resident #9's family member and told them about him giving away his money to residents in the facility. She said the VA came to the facility to assess Resident #9 and what he was doing with his money and the VA said he had the right to give his money away because his BIMS was high. The Administrator said Resident #9 gave Resident #63 his card to use. She said she knew CNA D and CNA E went to the gas station to get some chicken and for a red soda. The Administrator said she was not aware of the $200 the CNAs attempted to get. She said CNA D and CNA E both were suspended on 02/24/25. She said it was not acceptable for staff to get Resident #9's card. She said she never got any money from Resident #9. The Administrator said misappropriation was the state guideline but Resident #9 gave Resident #63 his card to use so that made it not misappropriation. She said CNA D and CNA E did not get money. The Administrator said the police said it was not misappropriation if Resident #9 gave it to Resident #63. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation and interview on 05/09/25 at 2:21 PM, Resident #9 said he gave Resident #63 his debit card to use 1 time on an unrecalled date. He told Resident #63 he could have between $20-$30. He said Resident #63 did pay him back for the money. The surveyor asked if he knew Resident #63 was giving others his debit card, including staff, and Resident #9 said he was unaware and he did not authorize Resident #63 to give his debit card to anyone else. Resident #9 and the surveyor reviewed some of his bank statements. After reviewing the bank statements dated 1/16/25-2/14/25, he and the surveyor saw some charges on 02/07/25 that reflected Resident #9 made an ATM withdrawal 3 times for $203, and $103, totaling $918in a day. Resident #9 put his head down and said he did not know about those charges in a shaky voice. Resident #9 became saddened and teary-eyed after discussing the charges on his bank account. The surveyor went to get ADON AA, and she witnessed Resident #9 say he had not given staff permission to use his card, and he authorized Resident #63 to use his card, but not for those amounts and he had not been to an ATM. During a telephone interview on 05/09/25 at 2:58 p.m., CNA D stated she, and CNA E were going to lunch on 02/23/25 and CNA E told her to stop at the store so she could withdraw some money for Resident #63. CNA D stated, I had no dealing with card, I was just the driver. During an interview on 05/09/25 at 4:41 p.m., the ADM stated she had taken Resident #9 to the bank to get his statements so she could see if any money was withdrawn from the account when Resident #63 gave Resident #9 bank card to CNA E and CNA N. The ADM stated the bank was not going to give him another card because of the fraudulent activity. The ADM stated, I agreed with the lady at the bank. The ADM stated on Monday (02/24/25) there was a risk call made that included herself, the DON, the Regional Consultant Nurse and the Regional Operations to discuss the incident about CNA E, CNA D, Residents #63 and #9 and another incident with CNA D. The ADM stated she stated during the call during the investigation her and the DON found out by CNA D that CNA E was given Resident #9 card by Resident #63 and was told to withdraw $200. The ADM stated during the call she told the regional people CNA E attempted to withdraw the money but was unsuccessful. The ADM stated she told them she suspended CNA E and was told by the Regional Operations Manger she should have never suspended her just written her up because there was no money taken. The ADM stated she was told by Resident #9 sister to take Resident #9 to a funeral home to take out a pre-burial policy because Resident #9 would not let the sister take him. The ADM stated she took out #13, 034.41 and $500 to start him a trust fund at the facility. The ADM stated she and Laundry V took him to the funeral home to take out the policy. During an interview on 05/09/25 at 5:45 p.m., the BOM stated the ADM told her when she took Resident #9 to the bank after the incident with CNA E, CNA N and Resident #63 the card was put on hold. The BOM stated the ADM did not elaborate if the bank put the card on hold or if she initiated it. The BOM stated she was told by the ADM she did get bank statements that day (02/24/25). The BOM stated Resident #9's family member had brought statements in (on an unknown date) before the incident between CNA E, CNA N, and Resident #63 because she wanted to know what all the withdrawals were for. The BOM stated she told her she would look into it and that was when the BOM spoke with the ADM about the withdrawals of the bank acct. The BOM stated the ADM told her she would look into it. The BOM stated the issue was brought up several times in morning meetings and the ADM stated she was looking into it. The BOM stated it got to a point the ADM stated, We're done talking about that. This was determined to be an Immediate Jeopardy (IJ) on 05/09/2025 at 06:24 PM. The Administrator was provided with the IJ template on 05/09/2025. The following Plan of Removals was accepted on 05/12/2025 at 02:57 PM. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The plan of removal was accepted on 5/12/2025 at 2:57 p.m., and included: Immediate Action Taken: H. On 5/9/2025 the DON completed an assessment on Resident #9 to determine if resident was having any emotional distress related to this incident. The resident stated he was fine and was attending church services. The assessment was conducted privately prior to church services. I. On 5/9/2025 the DON completed a Comprehensive Trauma screen on the resident, and resident will be referred to psychology services for further evaluation. On 5/9/2025 The V.A. Social Worker was contacted by the facility regarding the need of the resident needing a psychology evaluation related to this incident. J. On 5/9/2025 the Regional Director of Operations provided 1:1 in-service with the Regional Nurse Consultant on the facility's abuse, Neglect, and Misappropriations policy. K. On 5/9/2025 the Regional Nurse Consultant provided 1:1 education to the facility DON on the Abuse, Neglect, and Misappropriations policy. This was completed on 5/9/25. L. On 5/9/2025 the DON started in-service education with all staff on the facility's Abuse, Neglect, Misappropriations policy, including post-test. This was completed at 8:00pm on 5/9/2025, and no staff will be allowed to work until they have completed their education. M. On 5/8/2025 the Administrator was suspended by the Regional Director of Operations pending investigation. N. On 5/12/2025 the resident will be taken to his bank by the Maintenance Director and Social Services to obtain a new debit card. Residents' family will be encouraged to go as well. Resident does have an active Trust fund in the facility and has access to immediate funds if he chooses. Residents have made 10 trust fund withdrawals in April 2025, and 4 in May 2025. O. On 5/8/2025 the Misappropriation incident was reported to HHSC by the DON. P. On 5/8/2025 the Misappropriation incident was also reported to the local law enforcement agency. Q. On 5/9/2025 the incident was reported to HHSC by the DON regarding Resident #63 not being authorized to use Resident #9's debit card. R. Resident #63 was discharged from the facility on 5/7/2025 and did not have access to resident # 9's debit card. S. On 5/8/2025 the facility started an investigation into the incident; the investigation was completed on 5/10/2025 at 12:00 pm. T. On 5/9/2025 C.N.A. E was suspended by the DON related to the incident. U. C.N.A. D was suspended on 2/24/2025 and never returned to work. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	2. Identification of Residents Affected or Likely to be Affected: A. Starting 5/7/25 the Social Worker/designee will complete alert resident interviews 3 x week for 3 weeks, then weekly x 6 weeks to validate that all residents are allowed to make choices about aspects of his/her life in the facility, including financial choices. This will be reviewed after each interview is completed by the DON and Social Services so any issues, if applicable, can be addressed immediately. B. The Regional Nurse Consultant will oversee this process weekly x 6 weeks. 5. On 5/9/25 the facility's DON notified the Medical Director regarding the Immediate Jeopardy the facility received related to failure to implement the abuse policy 6. On 5/9/25 the facility conducted an Ad Hoc QAPI meeting to discuss Misappropriation, and implementation of the abuse policy and sustaining compliance. The surveyor confirmed the following actions had been implemented sufficiently to remove the immediacy by: Record review of Resident #9's emotional assessment was completed by the DON on 5/09/2025 with no issues noted. Record review of Resident #9's Comprehensive Trauma assessment was completed by the DON on 5/09/2025 with no trauma found. Record review of a referral for Resident #9 dated 5/09/2025 to the VA Social Worker for psychological services. Record review of the Administrator's suspension form dated 5/08/2025 indicated she was suspended pending investigation. Record review of the DON's in-service on the facilities Resident Rights policy dated 5/09/2025. Record review of the Regional Nurse Consultant's 1:1 in-service with the DON on the Abuse, Neglect, and Misappropriation policy which indicated it was the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property Record review of the Regional Director of Operation's 1:1 in-service with the Regional Nurse Consultant on the Abuse, Neglect, and Misappropriation policy indicated it was the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property Record review of the in-service provided to all disciplines across all shifts on the facility's Abuse, Neglect, Misappropriation policy dated 5/09/2025 conducted by the DON. The in-service also included a post test. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation on 5/12/2025 at 09:45 AM Resident #9 was driven to his financial institution where he was able to obtain a new debit card to his personal account. During an interview on 5/12/2025 at 11:54 AM Resident #9 said he had obtained a working debit card to his personal account. Record review of the reportable incident on 5/08/2025 to HHSC regarding Resident #9's misappropriation. Record review of the police report #25-313884 dated 5/08/2025 indicated the local authority was notified of the unauthorized use of Resident #9's debit card. Record review of the reportable incident on 5/09/2025 to HHSC indicated the reporting of Resident #63's unauthorized use of Resident #9's debit card. Record review of Resident #63's electronic record indicated he had discharged from the facility on 5/07/2025. Record review of the facility's investigation regarding the incident #1008525 determined to be reported on 05/08/25 and the investigation was ongoing. Record review of CNA E's personnel record indicated she had been suspended on 02/24/25 pending investigation. Record review of CNA D's personnel record indicated she was suspended on 2/24/2025 and never returned to work. During an interview on 5/10/2025 at 06:11 PM the Medical Director indicated he was made aware by the DON of the facility's immediate jeopardy regarding failure to implement the abuse policy regarding misappropriation. During interviews conducted on 5/10/2025 at 04:22 PM - 5/10/2025 06:04 PM the Administrator, DON, ADON AA, ADON XX, MDS Nurse, CNA F, CNA G, CNA L, CNA N, CNA O, MA T, MA T,CNA B, CNA D, CNA E, RN H, MA K, LVN M, CNA P, CNA Q, CNA R, CNA S, CNA U, Van Driver V, MA W, CNA X, MA Y, CNA Z, MA BB, LVN CC, LVN DD, CNA EE, LVN FF, MA GG, RN HH, Dishwasher KK, Dietary Aide LL, [NAME] MM, LVN OO, LVN PP, CNA QQ, CNA RR, CNA SS, LVN TT, MA UU, CNA VV, and RNC WW indicated they had been in-serviced on the facilities abuse and neglect policy. The staff indicated a resident had the right to be free from abuse including misappropriation of property, and allegations should be reported immediately to the abuse coordinator. The Administrator was informed the Immediate Jeopardy was removed on 05/12/2025 at 11:54 AM. The facility remained out of compliance at a severity level of potential for more than minimal harm that was not Immediate Jeopardy and a scope of isolated due to the facility's need to monitor the implementation of the plan of removal.

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** 45810 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 and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24-hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials (which included the State Survey Agency and Adult Protective Services where state law provides for jurisdiction in long-term care facilities) in accordance with State Law through established procedures for 3 of 23 residents (Resident #'s 9, Resident #126, and Resident #54) reviewed for abuse and neglect. The facility failed to report timely to HHSC when CNA D and CNA E attempted an ATM transaction on 02/21/25 using Resident #9's debit card associated with his personal bank account. The facility failed to ensure that CNA E, LVN FF, and LVN YY reported the resident-to-resident altercation between Residents #126 and Resident #54 to the Administrator, who was the abuse coordinator, immediately on 02/22/25, which resulted in the Administrator not learning of the altercation until 02/25/25. The non-compliance was identified as PNC. The IJ began on 02/21/25 and ended on 02/25/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for further potential neglect due to unreported and uninvestigated allegations of abuse and neglect. Findings included: 1)Record review of Resident #9's face sheet dated 05/09/25 indicated he was an [AGE] year-old male who readmitted to the facility on [DATE] with the diagnoses dementia, anxiety, hear failure, high blood pressure, and lack of coordination. Record review of Resident #9's quarterly MDS dated [DATE] indicated he made himself understood and understood others. The MDS also indicated he had a BIMS score of 8 which meant he had moderate cognitive impairment. Record review of Resident #9's care plan revised on 04/07/25 indicated he had impaired cognition and was at risk for further decline with a goal of his needs being met timely, dignity maintained, and current level of functioning maintained. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 05/08/25 at 4:40 p.m., CNA E stated she and CNA D were leaving for break on 02/23/25 when Resident #63 asked her if she could go and withdraw $200 from the ATM. CNA E stated Resident #63 handed her a card and gave her the pin number to the card. CNA E stated she did not know at the time the card belonged to Resident #9 until she tried to withdraw the money and suspicious fraud popped up on the screen. CNA E stated she called the facility and spoke with CNA N and had her to put Resident #63 on the phone. CNA E stated when Resident #63 got on the phone she stated she told him that was not his card and Resident #63 stated Yes, I know, go ahead, and bring it back. We have to call Resident #9's family member to fix the card because the same thing happened yesterday. CNA E stated she brought the card back and gave it to Resident #63 and told him to give it back to Resident #9. She said she gave it back to Resident #63 instead of Resident #9 because that was who she got the card from. CNA E stated she did not report the incident to the Administrator until Monday 02/24/25 when an incident happened between CNA N and another resident. CNA E stated she was suspended that 02/24/25. CNA E stated there had been several occasions she witnessed Resident #63 going to get money from Resident #9 and handing it to Laundry V, CNA N, and Housekeeping C. CNA E stated CNA N's aunt charged Resident #9 $1,000 to take him to Walmart and CNA N's cousin charged Resident #9 $600 to take him to another city. CNA E stated Resident #29's family member has charged Resident #9 $1,000 to go to the bank. CNA E stated Resident #29 and Resident #37 also took money from Resident #9. CNA E stated she did not report any of those incidents to the ADM because the ADM was already aware. CNA E stated she also heard the ADM was taking money from Resident #9. During an interview on 05/06/25 at 1:41 p.m., MA UU stated she heard about Resident #63 taking money from Resident #9. MA UU stated she had also heard Resident #29's family member taking Resident #9 to the bank. MA UU stated she reported what she had heard to the ADM. MA UU stated she could not recall the exact date. During an interview on 05/08/25 05:13 PM the Administrator said she was not aware of any staff members taking Resident #9's money. She said she asked Resident #9 about his money on several occasions, and he told her he was giving out money to residents if they needed it. The Administrator said she called Resident #9's family member and told them about him giving away his money to residents in the facility. She said the VA came to the facility to assess Resident #9 and what he was doing with his money and the VA said he had the right to give his money away because his BIMS was high. The Administrator said Resident #9 gave Resident #63 his card to use. She said she knew CNA D and CNA E went to the gas station to get some chicken and for a red soda. The Administrator said she was not aware of the $200 the CNAs attempted to get. She said CNA D and CNA E both were suspended on 02/24/25. She said it was not acceptable for staff to get Resident #9's card. She said she never got any money from Resident #9. The Administrator said misappropriation was the state guideline but Resident #9 gave Resident #63 his card to use so that made it not misappropriation. She said CNA D and CNA E did not get money. The Administrator said the police said it was not misappropriation if Resident #9 gave it to Resident #63. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation and interview on 05/09/25 at 2:21 PM, Resident #9 said he gave Resident #63 his debit card to use 1 time on an unrecalled date. He told Resident #63 he could have between $20-$30. He said Resident #63 did pay him back for the money. The surveyor asked if he knew Resident #63 was giving others his debit card, including staff, and Resident #9 said he was unaware and he did not authorize Resident #63 to give his debit card to anyone else. Resident #9 and the surveyor reviewed some of his bank statements. After reviewing the bank statements dated 1/16/25-2/14/25, he and the surveyor saw some charges on 02/07/25 that reflected Resident #9 made an ATM withdrawal 3 times for $203, and $103, totaling $918in a day. Resident #9 put his head down and said he did not know about those charges in a shaky voice. Resident #9 became saddened and teary-eyed after discussing the charges on his bank account. The surveyor went to get ADON AA, and she witnessed Resident #9 say he had not given staff permission to use his card, and he authorized Resident #63 to use his card, but not for those amounts and he had not been to an ATM. During a telephone interview on 05/09/25 at 2:58 p.m., CNA D stated she, and CNA E were going to lunch on 02/23/25 and CNA E told her to stop at the store so she could withdraw some money for Resident #63. CNA D stated, I had no dealing with card, I was just the driver. During an interview on 05/09/25 at 4:41 p.m., the ADM stated she had taken Resident #9 to the bank to get his statements so she could see if any money was withdrawn from the account when Resident #63 gave Resident #9 bank card to CNA E and CNA N. The ADM stated the bank was not going to give him another card because of the fraudulent activity. The ADM stated, I agreed with the lady at the bank. The ADM stated on Monday (02/24/25) there was a risk call made that included herself, the DON, the Regional Consultant Nurse and the Regional Operations to discuss the incident about CNA E, CNA D, Residents #63 and #9 and another incident with CNA D. The ADM stated she stated during the call during the investigation her and the DON found out by CNA D that CNA E was given Resident #9 card by Resident #63 and was told to withdraw $200. The ADM stated during the call she told the regional people CNA E attempted to withdraw the money but was unsuccessful. The ADM stated she told them she suspended CNA E and was told by the Regional Operations Manger she should have never suspended her just written her up because there was no money taken. The ADM stated she was told by Resident #9 sister to take Resident #9 to a funeral home to take out a pre-burial policy because Resident #9 would not let the sister take him. The ADM stated she took out #13, 034.41 and $500 to start him a trust fund at the facility. The ADM stated she and Laundry V took him to the funeral home to take out the policy. During an interview on 05/09/25 at 5:45 p.m., the BOM stated the ADM told her when she took Resident #9 to the bank after the incident with CNA E, CNA N and Resident #63 the card was put on hold. The BOM stated the ADM did not elaborate if the bank put the card on hold or if she initiated it. The BOM stated she was told by the ADM she did get bank statements that day (02/24/25). The BOM stated Resident #9's family member had brought statements in (on an unknown date) before the incident between CNA E, CNA N, and Resident #63 because she wanted to know what all the withdrawals were for. The BOM stated she told her she would look into it and that was when the BOM spoke with the ADM about the withdrawals of the bank acct. The BOM stated the ADM told her she would look into it. The BOM stated the issue was brought up several times in morning meetings and the ADM stated she was looking into it. The BOM stated it got to a point the ADM stated, We're done talking about that. Record review of the facility patient questionnaires for 4 other residents dated 02/24/25 completed by the Social Worker indicated no other residents had any concerns with abuse. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the facility in-service for Allegations of Abuse and the abuse coordinator dated 02/24/25 indicated staff members across all shifts had been in-serviced over the abuse and neglect policy, contacting the Administrator immediately, to speak directly with the Administrator to report allegations, not to text allegations, and to call the DON as the second choice if the Administrator was not available. Record review of the facility associate disciplinary memorandum dated 02/24/25 indicated CNA D was suspended pending investigation. Record review of the facility associate disciplinary memorandum dated 02/24/25 indicated CNA E was suspended pending investigation. Record review of the time sheet for CNA D dated 02/20/25-02/27/25 indicated the last time CNA D clocked in the facility on 02/24/25 at 06:14 AM and clocked out of the facility on 02/24/25 at 09:48 AM and her status was now terminated. Record review of the time sheet for CNA E dated 02/20/25-02/27/25 indicated the last time CNA D clocked in the facility on 02/24/25 at 06:14 AM and clocked out of the facility on 02/24/25 at 10:01 AM and returned to work on 02/26/25 at 01:27 PM. 2.Record review of Resident #126's face sheet, dated 05/12/25, indicated a [AGE] year-old male who was readmitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease, also known as COPD (a long-term lung disease that makes breathing difficult), stroke and dementia (diseases that affect memory, thinking, and the ability to perform daily activities). Record review of Resident #126's quarterly MDS assessment, dated 01/26/25, indicated Resident #126 usually understood and was usually understood by others. Resident #126's BIMS score was 03, which meant he was severely cognitively impaired. The MDS indicated Resident #126 required total assistance with toileting, bed mobility, dressing, transfers, personal hygiene, and eating. The MDS did not indicate any behaviors. A record review of Resident #126's care plan, revised on 03/30/25, indicated Resident #126 had an alteration in musculoskeletal status related to contracture of bilateral (both) upper extremities. The intervention was for staff to anticipate and meet his needs. Record review of Resident #126's nurses' notes dated 02/25/25, written by ADON XX revealed she was notified by CNA VV about an incident that occurred in the television room on 02/22/25 after lunch. CNA VV said she was informed by Resident #37 that Resident #54 hit Resident #126 in the head three times. ADON XX assessed Resident #126 from head to toe with no skin issues noted. ADON XX then notified the abuse coordinator and the DON. Resident #126 was unable to give any details related to the incident due to his cognitive impairment. Record review of Resident #126's skin assessment dated [DATE] did not indicate any skin issues. 3. Record review of Resident #54's face sheet, dated 05/07/25, indicated a [AGE] year-old male who was readmitted to the facility on [DATE] with diagnoses which included depression (sadness), anxiety (characterized by excessive and persistent worry, fear, and nervousness) and dementia (diseases that affect memory, thinking, and the ability to perform daily activities). (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #54's quarterly MDS assessment, dated 03/28/25, indicated Resident #54 understood and was understood by others. Resident 54 BIMS score was 05, which meant his cognition was severely impaired. The MDS indicated Resident #54 required help with toileting, bed mobility, dressing, transfers, personal hygiene, and was independent with eating. The MDS indicated Resident #54 has verbal and physical behavior. Record review of Resident #54's care plan, revised on 10/14/24, indicated Resident #54 had a Behavioral Problem as evidenced by aggressive behaviors. The interventions were for staff to assist the resident to a calm, quiet area if he starts to become agitated. Record review of Resident #54's skin assessment dated [DATE] did not indicate any skin issues. During a phone interview on 05/09/25 at 8:50 a.m., CNA E said she was walking down the hall towards the lounge area when she saw Resident #54 hit Resident #126 in the head three times. She said she removed Resident #126 to safety and then reported to LVN FF and LVN YY. She said Resident #54 had a history of hitting others. She said Resident #54 said Resident #126 was talking about him. She said Resident #126 does not talk. During a phone interview on 05/09/25 at 9:47 a.m., LVN YY said he was Resident #126 and Resident #54's nurse. He said he vaguely remembered them. He said he did not recall a resident-to-resident altercation. He said he was newly hired at the facility and did not know all the steps he needed to take to complete an incident or skin assessment. He said as he continued to work at the facility, he became aware of filling out an incident report, skin assessment, and reporting to the Administrator. He said if a resident-to-resident altercation occurred, he should have reported it to the Administrator. During an interview on 05/09/25 at 11:45 a.m., LVN FF said she was a nurse on duty when Resident #126 and Resident #54 had the altercation on 02/22/25. She said CNA E told her she was walking down the hall toward the lounge area when she saw Resident #54 hit Resident #126 on the top of his head. She said as she was about to assess the situation, the charge nurse (LVN YY) for Resident #126 and Resident #54 came out from the medication room, and she reported the incident to him. She said she was not aware LVN YY did not report the incident to the Administrator or DON until a few days later, when she was questioned by the Administrator. She said she knew the incident should have been reported to the Administrator as soon as it happened but thought LVN YY reported since he was their charge nurse. During an interview on 05/09/25 at 4:47 p.m., the DON said she expected staff to report any abuse to the Administrator when they were made aware. She said they were not aware of Resident #54 hitting Resident #126 in the head until CNA VV heard it from Resident #37 on 02/25/25. She said that upon their investigation, CNA E said she saw Resident #54 hit Resident #126 in the head three times and separated them. She said CNA E reported the altercation to her charge nurse, LVN YY. She said they spoke with LVN YY, but he did not remember why he did not report it to the Administrator. She said then she spoke to LVN FF, who said she was on duty when the incident occurred between Resident #54 and Resident #126. LVN FF said CNA E reported it to her, and then she reported to their nurse, LVN YY. She said LVN FF thought LVN YY had reported the incident to the Administrator and did the assessment and incident report. She said both residents were assessed on 02/25/25 with no injuries noted. She said they did an in-service on reporting abuse. The DON said it was important to report and investigate abuse/neglect to prevent further abuse/neglect from occurring. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a phone interview on 05/09/25 at 6:03 p.m., the Administrator said she was unaware of Resident #126 and Resident #54's altercation that occurred on 02/22/25 until 02/25/25. She said once she became aware, the nurses assessed both residents, and the investigation process began. She said she then reported to HHSC. She said the resident-to-resident altercation should have been reported to her, and her responsibility was to protect the residents and report to HHSC within 2 hours of the incident. She said the staff was aware that she was the abuse coordinator and should have reported the allegation of abuse to her. She said they did an in-service with staff on reporting. The Administrator said when allegations were not reported promptly, abuse could continue to occur, and residents could be in danger if the abuse/neglect was continuing. Record review of the facility's in-service on reporting dated 02/25/25, revealed an in-service on resident-to-resident altercations.1.Immediately separate residents, 2. Place aggressor on 1:1 supervision and document, 3. Contact Administrator immediately, 4. License nurses will complete a head-to-toe assessment on both residents and document, 5. Notify family and doctor, 6.License nurse will complete an incident report, 7.Refer resident to psych services for clearance, 8.Update care plan for behaviors, 9.Educate staff on abuse/neglect and resident to resident altercations. Record review of the facility's in-service on abuse dated 02/25/25, revealed an in-service on reporting to the abuse coordinator. 1 contact the Administrator, 2. Notify Immediately and do not wait, 3. Do not text, you must call the Administrator, if no answer then keep calling, 4.The DON is second choice to call if administrator is out or does not return your call after several attempts. Record review of the Texas Unified Licensure Information Portal, also noted as TULIP (an online system for submitting long-term care licensure applications), indicated the facility reported the intake regarding the resident-to-resident altercation involving Resident #126 and Resident #54 on 02/25/25. During interviews conducted on 5/10/2025 at 04:22PM - 5/10/2025 at 06:04 PM the Administrator, DON, ADON AA, ADON XX, MDS Nurse, CNA F, CNA G, CNA L, CNA N, CNA O, MA T, MA T,CNA B, CNA D, CNA E, RN H, MA K, LVN M, CNA P, CNA Q, CNA R, CNA S, CNA U, Van Driver V, MA W, CNA X, MA Y, CNA Z, MA BB, LVN CC, LVN DD, CNA EE, LVN FF, MA GG, RN HH, Dishwasher KK, Dietary Aide LL, [NAME] MM, LVN OO, LVN PP, CNA QQ, CNA RR, CNA SS, LVN TT, MA UU, CNA VV, and RNC WW indicated they had been in-serviced on the facilities abuse and neglect policy. The staff indicated a resident had the right to be free from abuse including misappropriation of property, and allegations should be reported immediately to the abuse coordinator. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the facility policy titled Abuse, Neglect, Exploitation, revised 10/24/22, indicated, policy: it is the policy of this facility to provide protection for the health, wealth, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury. II.Employee Training: A. New employees will be educated on abuse, neglect, exploitation, and misappropriation of resident property during initial orientation. B. Existing staff will receive annual education through planned In-services and as needed. C. Training topics will include: 1. Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation. 2. Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property. 3. Recognizing signs of abuse, neglect, exploitation, and misappropriation of resident property, such as physical or psychoactive indicators. 4. Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources IV. Identification of Abuse, Neglect, and Exploitation A. The facility assists staff to understand the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff-to-resident abuse and certain resident-to-resident altercations Reporting: A. The facility reports abuse and abuse allegations that include: I. Reporting allegations involving staff-to-resident abuse, resident-to-resident altercations, injuries of unknown source, misappropriation of resident property/exploitation, and mistreatment. 2. Reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies (e.g., law enforcement when applicable) within specified timelines: A. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or B. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The non-compliance was identified as PNC. The IJ began on 02/21/25 and ended on 02/25/25. The facility had corrected the noncompliance before the survey began.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on interview and record review the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including misappropriation of resident property were thoroughly investigated for 1 of 23 residents (Resident #9) reviewed for abuse. 1.The facility failed to thoroughly investigate and failed to protect Resident #9 from misappropriation of his personal funds when CNA D and CNA E attempted an ATM transaction on 02/21/25 using Resident #9's debit card associated with his personal bank account. 2.The facility failed to thoroughly investigate and failed to protect Resident #9 from misappropriation of his personal funds when staff reported allegations of misappropriation. These failures could place residents at risk for abuse, neglect, exploitation, mistreatment, and further injuries of unknown source. Findings included: Record review of Resident #9's face sheet dated 05/09/25 indicated he was an [AGE] year-old male who readmitted to the facility on [DATE] with the diagnoses dementia, anxiety, hear failure, high blood pressure, and lack of coordination. Record review of Resident #9's quarterly MDS dated [DATE] indicated he made himself understood and understood others. The MDS also indicated he had a BIMS score of 8 which meant he had moderate cognitive impairment. Record review of Resident #9's care plan revised on 04/07/25 indicated he had impaired cognition and was at risk for further decline with a goal of his needs being met timely, dignity maintained, and current level of functioning maintained. (continued on next page)

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	675020	A. Building B. Wing	05/12/2025

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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 05/08/25 at 4:40 p.m., CNA E stated she and CNA D were leaving for break on 02/23/25 when Resident #63 asked her if she could go and withdraw $200 from the ATM. CNA E stated Resident #63 handed her a card and gave her the pin number to the card. CNA E stated she did not know at the time the card belonged to Resident #9 until she tried to withdraw the money and suspicious fraud popped up on the screen. CNA E stated she called the facility and spoke with CNA N and had her to put Resident #63 on the phone. CNA E stated when Resident #63 got on the phone she stated she told him that was not his card and Resident #63 stated Yes, I know, go ahead, and bring it back. We have to call Resident #9's family member to fix the card because the same thing happened yesterday. CNA E stated she brought the card back and gave it to Resident #63 and told him to give it back to Resident #9. She said she gave it back to Resident #63 instead of Resident #9 because that was who she got the card from. CNA E stated she did not report the incident to the Administrator until Monday 02/24/25 when an incident happened between CNA N and another resident. CNA E stated she was suspended that 02/24/25. CNA E stated there had been several occasions she witnessed Resident #63 going to get money from Resident #9 and handing it to Laundry V, CNA N, and Housekeeping C. CNA E stated CNA N's aunt charged Resident #9 $1,000 to take him to Walmart and CNA N's cousin charged Resident #9 $600 to take him to another city. CNA E stated Resident #29's family member has charged Resident #9 $1,000 to go to the bank. CNA E stated Resident #29 and Resident #37 also took money from Resident #9. CNA E stated she did not report any of those incidents to the ADM because the ADM was already aware. CNA E stated she also heard the ADM was taking money from Resident #9. During an interview on 05/06/25 at 1:41 p.m., MA UU stated she heard about Resident #63 taking money from Resident #9. MA UU stated she had also heard Resident #29's family member taking Resident #9 to the bank. MA UU stated she reported what she had heard to the ADM. MA UU stated she could not recall the exact date. During an interview on 05/08/25 05:13 PM the Administrator said she was not aware of any staff members taking Resident #9's money. She said she asked Resident #9 about his money on several occasions, and he told her he was giving out money to residents if they needed it. The Administrator said she called Resident #9's family member and told them about him giving away his money to residents in the facility. She said the VA came to the facility to assess Resident #9 and what he was doing with his money and the VA said he had the right to give his money away because his BIMS was high. The Administrator said Resident #9 gave Resident #63 his card to use. She said she knew CNA D and CNA E went to the gas station to get some chicken and for a red soda. The Administrator said she was not aware of the $200 the CNAs attempted to get. She said CNA D and CNA E both were suspended on 02/24/25. She said it was not acceptable for staff to get Resident #9's card. She said she never got any money from Resident #9. The Administrator said misappropriation was the state guideline but Resident #9 gave Resident #63 his card to use so that made it not misappropriation. She said CNA D and CNA E did not get money. The Administrator said the police said it was not misappropriation if Resident #9 gave it to Resident #63. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation and interview on 05/09/25 at 2:21 PM, Resident #9 said he gave Resident #63 his debit card to use 1 time on an unrecalled date. He told Resident #63 he could have between $20-$30. He said Resident #63 did pay him back for the money. The surveyor asked if he knew Resident #63 was giving others his debit card, including staff, and Resident #9 said he was unaware and he did not authorize Resident #63 to give his debit card to anyone else. Resident #9 and the surveyor reviewed some of his bank statements. After reviewing the bank statements dated 1/16/25-2/14/25, he and the surveyor saw some charges on 02/07/25 that reflected Resident #9 made an ATM withdrawal 3 times for $203, and $103, totaling $918in a day. Resident #9 put his head down and said he did not know about those charges in a shaky voice. Resident #9 became saddened and teary-eyed after discussing the charges on his bank account. The surveyor went to get ADON AA, and she witnessed Resident #9 say he had not given staff permission to use his card, and he authorized Resident #63 to use his card, but not for those amounts and he had not been to an ATM. During a telephone interview on 05/09/25 at 2:58 p.m., CNA D stated she, and CNA E were going to lunch on 02/23/25 and CNA E told her to stop at the store so she could withdraw some money for Resident #63. CNA D stated, I had no dealing with card, I was just the driver. During an interview on 05/09/25 at 4:41 p.m., the ADM stated she had taken Resident #9 to the bank to get his statements so she could see if any money was withdrawn from the account when Resident #63 gave Resident #9 bank card to CNA E and CNA N. The ADM stated the bank was not going to give him another card because of the fraudulent activity. The ADM stated, I agreed with the lady at the bank. The ADM stated on Monday (02/24/25) there was a risk call made that included herself, the DON, the Regional Consultant Nurse and the Regional Operations to discuss the incident about CNA E, CNA D, Residents #63 and #9 and another incident with CNA D. The ADM stated she stated during the call during the investigation her and the DON found out by CNA D that CNA E was given Resident #9 card by Resident #63 and was told to withdraw $200. The ADM stated during the call she told the regional people CNA E attempted to withdraw the money but was unsuccessful. The ADM stated she told them she suspended CNA E and was told by the Regional Operations Manger she should have never suspended her just written her up because there was no money taken. The ADM stated she was told by Resident #9 sister to take Resident #9 to a funeral home to take out a pre-burial policy because Resident #9 would not let the sister take him. The ADM stated she took out #13, 034.41 and $500 to start him a trust fund at the facility. The ADM stated she and Laundry V took him to the funeral home to take out the policy. During an interview on 05/09/25 at 5:45 p.m., the BOM stated the ADM told her when she took Resident #9 to the bank after the incident with CNA E, CNA N and Resident #63 the card was put on hold. The BOM stated the ADM did not elaborate if the bank put the card on hold or if she initiated it. The BOM stated she was told by the ADM she did get bank statements that day (02/24/25). The BOM stated Resident #9's family member had brought statements in (on an unknown date) before the incident between CNA E, CNA N, and Resident #63 because she wanted to know what all the withdrawals were for. The BOM stated she told her she would look into it and that was when the BOM spoke with the ADM about the withdrawals of the bank acct. The BOM stated the ADM told her she would look into it. The BOM stated the issue was brought up several times in morning meetings and the ADM stated she was looking into it. The BOM stated it got to a point the ADM stated, We're done talking about that. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the facility policy titled Abuse, Neglect, Exploitation, revised 10/24/22, indicated, policy: it is the policy of this facility to provide protection for the health, wealth, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury. Policy Explanation and Compliance Guidelines: The facility provides resident pro1ec1ion that include: a) Prevention/prohibit resident abuse, neglect, and exploitation and misappropriation of resident property; b) Investigation of all allegations listed above and c) Training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedure, and dementia management and resident abuse prevention; A. New employees will be educated on abuse, neglect, exploitation, and misappropriation of resident property during initial orientation. B. Existing staff will receive annual education through planned In-services and as needed. C. Training topics will include: 1. Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation. 2. Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property. 3. Recognizing signs of abuse, neglect, exploitation, and misappropriation of resident property, such as physical or psychoactive indicators. 4. Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources IV. Identification of Abuse, Neglect, and Exploitation A. The facility assists staff to understand the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff-to-resident abuse and certain resident-to-resident altercations Reporting: A. The facility reports abuse and abuse allegations that include: I. Reporting allegations involving staff-to-resident abuse, resident-to-resident altercations, injuries of unknown source, misappropriation of resident property/exploitation, and mistreatment. 2. Reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies (e.g. , law enforcement when applicable) within specified timelines: A. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or B. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review, the facility failed to ensure residents received therapeutic diets that were prescribed by the attending physician for 2 of 21 residents (Resident #10 and Resident #29) reviewed for therapeutic diets. 1. The facility failed to ensure Resident #10 received her fortified food, Ensure Clear, or water on 05/05/25 as indicated on her tray card. 2. The facility failed to ensure Resident #29 received fortified foods with his lunch meal on 05/05/25. The facility did not ensure Resident #29 was given his fortified food on 05/05/25 as indicated on his tray card. These failures could place residents at risk for poor intake, weight loss, unmet nutritional needs, and a loss of dignity. Findings Included: Record review of Resident #10's face sheet dated 05/10/25 indicated a [AGE] year-old female who was readmitted to the facility on [DATE] with diagnoses which included Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), heart failure, dysphagia (difficulty swallowing), and high blood pressure. Record review of Resident #10's quarterly MDS assessment dated [DATE] indicated Resident #10 understood and was understood by others. The MDS assessment indicated Resident #10 had a BIMS score of 06, indicating she was severely cognitively impaired. The MDS indicated she required assistance with ADLs and supervision with meals. The MDS assessment indicated Resident #10 had a therapeutic diet and weight loss. Record review of Resident #10's comprehensive care plan revised on 04/25/25, indicated Resident #10 had a mechanical soft diet and was at risk for nutritional & hydration. Resident #10 could not have dairy products. The care plan interventions were for staff to provide and serve diet as ordered and for the registered dietitian to evaluate and make diet/supplement change recommendations as needed. Record review of Resident #10's lunch meal ticket for 05/05/25 indicated . ***Fortified food (foods that have nutrients added to them, typically vitamins and minerals) all meals. The meal ticket included Mexican lasagna, Buttered dinner roll, buttered diced carrots, yellow cake with vanilla icing, 8 oz water, 8 oz iced tea, and add Ensure Clear to the tray. During an interview on 05/05/25 at 12:18 p.m., [NAME] MM said she added extra sour cream and cheese to the regular Mexican Lasagna, but did not add any fortified ingredients to the mechanically soft Mexican Lasagna. She said she did not serve any fortified food for the lunch meal today (05/05/25). (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 05/05/25 at 12:23 p.m., Resident #10 was sitting in the assisted dining room for the lunch meal. She received the mechanical soft Mexican lasagna, roll, diced carrots, tea, and cake. CNA S was sitting at the table assisting Resident #10 with her lunch meal. CNA S said she did not know what was fortified on Resident #10's tray. During an interview on 05/08/25 at 2:26 p.m., the DM said if the tray card read fortified food, then the resident should have been served fortified foods. He said he did not know what the fortified meal was on Monday (05/05/25), but they usually had mashed potatoes for residents who required fortified food. He said the cook was responsible for serving fortified food to each resident who required fortified food. He said the cook was supposed to read the meal ticket to ensure the resident received the correct diet or supplements. He said failure to serve the fortified food could lead to potential weight loss. During an interview on 05/09/25 at 4:47 p.m., the DON said the trays were supposed to be checked by the nurses in the dining room and then by the aides when they passed the trays. She said it was important for the staff to read the tickets and ensure the residents were receiving the correct diets. She said if Resident #10's tray card read fortified foods, then she should have received fortified foods on her lunch tray. She said failure to give the fortified foods could lead to weight loss. During an interview on 05/09/25 at 6:04 p.m., the Administrator said that when staff were serving the trays, they were responsible for ensuring the resident had the correct diet and all supplements that were ordered. She said it was important for residents to receive the correct diet/supplement to prevent weight loss. 46928 2.Record review of Resident #29's face sheet dated 05/08/25, indicated a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #29 had diagnoses of diabetes mellitus (disease that results in too much sugar in the blood), anorexia (eating disorder causing abnormally low body weight), anemia (condition in which the blood does not have enough healthy red blood cells to carry oxygen throughout the body), and cerebral infarction (stroke). Record review of Resident #29's quarterly MDS assessment dated [DATE], indicated he was understood and understood others. Resident #29 had a BIMS score of 15, which indicated his cognition was intact. Resident #29 was independent with all ADLs. Resident #29 had not had a weight loss/gain of 5% or more in the last month or 10% or more in the last 6 months. The MDS assessment did not indicate Resident #29 received a therapeutic diet. Record review of Resident #29's comprehensive care plan revised on 05/01/25, indicated he was on a Regular/CCHO/NAS and at nutritional and hydration risk related to anemia and anorexia. The care plan interventions included to provide and serve diet as ordered. Record review of Resident #29's order summary report dated 05/14/25, indicated he had an order for CCHO NAS diet regular texture with an order start date of 01/24/24. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #29's lunch meal ticket for 05/05/25 indicated . ***Fortified food all meals, fried eggs for Breakfast the meal ticket included Mexican lasagna, Buttered dinner roll, 1 cup of tossed salad with dressing, yellow cake with vanilla icing, 8 oz water, 8 oz iced tea, and 4 oz fortified mashed potatoes. During an observation on 05/05/25 at 12:19 PM, Resident #29 was sitting in the dining room for the lunch meal. He received the Mexican lasagna, roll, salad, tea, and cake. Resident #29 did not receive the 4 oz of fortified mash potatoes as indicated on his meal ticket. During an interview on 05/05/25 at 12:31 PM, [NAME] MM said she did not make any fortified mash potatoes. She said she did not realize Resident #29 required fortified foods. [NAME] MM said Resident #29 should have gotten a pudding. [NAME] MM said she was responsible for ensuring residents received the correct meal. [NAME] MM said failure to provide Resident #29 fortified meals could cause him to lose weight. During an interview on 05/05/25 at 1:51 PM, the Dietary Manager said the cook was responsible for ensuring the resident received what was ordered on the meal ticket. He said Resident #29 should have received the fortified mash potatoes. The Dietary Manager said failure to provide Resident #29 with the fortified foods placed him at risk for weight loss. During an interview on 05/09/25 at 2:00 PM, the DON said Resident #29's meal ticket had a typo. She said Resident #29 was supposed to receive fortified foods but not specifically mashed potatoes. She said the dietary staff was responsible for ensuring residents received fortified foods as ordered. She said failure to provide residents with fortified foods could cause them to have a weight loss. During an interview on 05/09/25 at 5:24 PM, the Administrator said she expected residents to receive fortified foods as ordered. She said the dietary staff was responsible for ensuring residents received fortified foods as ordered. She said failure to provide residents with fortified foods could cause them to have a weight loss. Record review of the facility's policy Therapeutic Diet Orders Process dated 08/25/22 indicated . The facility provides all residents will foods in the appropriate form and/or the appropriate nutritive content as prescribed by the physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences . 3. All diet orders are to be communicated to the dietary department in accordance with facility procedures. 4. The Dietary Manager or designee should check the resident orders to validate all diet, diet textures and changes in diet order and texture .