

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs, for 3 of 23 (Residents #13, #11, and #1) residents reviewed for care plans. 1. The facility failed to implement Resident #13's physician recommendation for placement on the secure unit. 2. The facility failed to ensure Resident #11 was care planned for his splint. 3. The facility failed to ensure Resident #1 was care planned for activities. These failures could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. Findings included: 1. Record review of Resident #13's face sheet, dated 07/09/26, reflected Resident #13 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included encephalopathy (group of conditions that caused brain dysfunction) and dementia (a condition that affects memory and the ability to perform daily activities) without behavioral disturbance, psychotic disturbance (a collection of symptoms that affect the mind with loss of contact with reality), mood disturbance and anxiety (persistent feelings of fear or worry). Record review of Resident #13's quarterly MDS assessment, dated 05/08/26, reflected Resident #13 made herself understood, and understood others. Resident #13's BIMS score was 3, which reflected her cognition was severely impaired. Record review of Resident #13's comprehensive care plan, initiated 05/17/26, reflected Resident #13 was at risk for wandering/elopement related to cognitive impairment, and at risk for injury related to dementia, and poor safety awareness. Resident #13 did have exit wandering behaviors however; Resident #13 was able to push door open but had difficulty to physically leave facility without assistance. Resident #13 often attempts to leave through double doors and requires wheelchair for assistance. The care plan interventions included attempt to determine any pattern or cause of wandering. Record review of Resident #13's elopement/wandering risk assessment dated [DATE] reflected Resident #13 was at low risk. (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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #13's progress note dated 06/09/26 written by LVN F at 3:45 p.m. reflected an alarm was heard from Hall 100, resident had opened door at end of hall, had made it about halfway through and the CNA pulled resident in wheelchair back inside. Resident #13 redirected, alarm turned off and Administrator notified. Record review of Resident #13's incident report dated 06/09/26 written by LVN D at 6:15 p.m. reflected Resident #13 was heard being told to go to the room to wait for assistance to the bathroom. LVN D went to Resident #13's room to see where Resident #13 was and saw that she was not in there due to hearing the alarm on Hall 100 going off. LVN D opened the door and found Resident #13 standing up behind the wheelchair in the grass with socks on. Record review of Resident #13's progress note dated 06/09/26 written by LVN D at 6:41 p.m. reflected she notified Resident #13's physician and made him aware and he suggested Resident #13 to be transferred to a lock down unit. During an interview on 07/07/26 at 10:50 a.m., LVN D stated she reported the recommendation to the DON when she called to notify her about finding Resident #13 approximately 10 feet from the exit door. During an interview on 07/08/26 at 10:09 a.m., the DON stated she was not aware of the first incident when Resident #13 opened the door and made it halfway through when the CNA was able to pull her back inside. The DON was aware of the physician's recommendation for the secure unit but did not follow up with the Social Worker on her progress of placement. The DON stated Resident #13 would constantly search for the bathroom. The DON stated they had not put any interventions in place related to Resident #13 seeking the bathroom. The DON stated the incident was discussed the next morning (06/09/26) in morning meeting. The DON stated during morning meetings she usually reviewed the progress notes, but she did not the following day. The DON stated the Social Worker had made several referrals to facilities that had secure units but Resident #13 was denied. The DON stated she did not follow up to see if any more referrals were made. During an interview on 07/08/26 at 10:44 a.m., the Social Worker stated the incident was discussed in the morning meeting on 06/10/26 including finding a secure unit for Resident #13. The Social Worker stated she was instructed to hold off by the Administrator because she needed to speak with Resident #13's family member further. During an interview with Resident#13's family member on 07/08/26 at 10:56 a.m., family member said she was not aware of the physician recommendation for the secure unit. During an interview on 07/08/26 at 11:11 a.m., the Administrator stated she was not aware of the first incident on 06/09/26 when Resident #13 attempted to elope. The Administrator stated the first incident was not discussed during the morning meeting. The Administrator stated she expected the staff to let her know about all incidents. The Administrator stated she never told the Social Worker to hold off on finding a secure unit. The Administrator stated she was aware Resident #13 had wandering behaviors when seeking the restroom. The Administrator stated she was aware that there (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were no interventions put in place to prevent wandering. During an interview on 07/09/26 at 10:31 a.m., Resident #13's physician stated he expected the nurse that received the order for Resident #13 to be transferred to a lock down unit to put the order in electronic records and discuss it with the DON. 2. Record review of a Resident #11's face sheet, dated 03/26/26, indicated a [AGE] year-old male who was re-admitted to the facility on [DATE] with diagnoses which included dementia (loss memory), right hand contractures (a permanent tightening or shortening of muscles, tendons, skin, or other connective tissues that prevents the normal movement of a joint), muscle weakness, and depressive disorder (persistently depressed mood). Record review of Resident #11's quarterly MDS, dated [DATE], indicated Resident #11 sometimes made himself understood and rarely understood others. Resident #11 had difficulty with recall, and his BIMS score was 02, which indicated severe cognitive impairment. The MDS indicated Resident #11 required extensive assistance with bed mobility, dressing, personal hygiene, and bathing. Record review of Resident #11's comprehensive care plan, revised date of 05/12/26, revealed no care plan for his splint. Record review of Resident #11's physician order dated 06/25/26, indicated: Right resting hand splint to be worn as tolerated during waking hours every day shift related to muscle wasting. During an observation and interview on 07/07/26 at 9:38 a.m., Resident #11 was sitting up in his chair without anything on his right hand. Resident #11 did not answer when asked about his splint. During an interview on 07/07/26 at 4:14 p.m., CNA B said Resident #11 had a splint but was missing on Friday (07/3/26). She said she reported the splint missing to LVN A. She said prior to the splint being missing Resident #11 was wearing it. During an interview on 07/09/26 at 11:09 a.m., LVN A said she was Resident #11's charge nurse. LVN A said unknown staff reported his splint missing. She said she had talked with therapy, Occupational Therapist Q and he said they were going to order him a new splint. She said prior to Resident #11's splint being misplaced he was wearing his splint. During an interview on 07/09/26 at 11:24 a.m., the Rehab Director said Resident #11 should have a splint to his right hand. He said he was aware the splint was missing and they were going to order a new splint. He said Resident #11 was receiving therapy and was wearing his splint prior to it being misplaced. During an interview on 07/09/26 at 4:50 p.m., the MDS Coordinator said she was responsible for the care plans. She said acute care plans were a team effort. She said acute care plans should be done as soon as possible. She looked at Resident #11's care plan and verified his splint had not been care planned. She said a care plan was done to paint a picture of the resident and his/her care. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/09/26 at 5:34 p.m., the DON said care plans were a team effort. She said the MDS nurse was the overseer. She said if Resident #11 had an order for a splint to be worn then it should have been care planned. She said she was not aware his splint had not been care planned. During an interview on 07/09/26 at 6:09 p.m., the Administrator said she expected Resident #11 to have a care plan for his right-hand splint. She said the IDT worked together on care plans and the MDS Coordinator was the overseer. She said she expected care plans to be updated anytime there was a change in condition. She said care plans were done so staff would be aware of the resident's preference. 3. Record review of Resident #1's face sheet dated 07/09/2026 indicated he was a [AGE] year-old male who re-admitted to the facility on [DATE] with diagnoses which included kidney failure (when the kidney function is less than 15% and can no longer filter waste products from the blood), heart failure (serious condition where the heart muscle does not pump blood efficiently), chronic obstructive pulmonary disease (a progressive lung condition that restricts airflow and makes it hard to breathe), and high blood pressure. Record review of Resident #1's admission MDS assessment dated [DATE] indicated his activity preferences were very important to him. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated he could make himself understood and he understood others. The MDS also indicated he had a BIMS score of 15 which meant he was cognitively intact. The MDS indicated he required moderate assistance with transfers, bed mobility, and bathing, and he could eat independently. Record review of Resident #1's comprehensive care plan dated 4/12/2026 indicated he did not have a care plan for activities. During an observation and interview on 07/07/2026 at 9:09 AM Resident #1 was up in his wheelchair sitting in his room. Resident #1 said he did not have an activity calendar for the month of July to know what was going on, or an activity director. The activity calendar on his personal fridge was dated June 2026. During an interview on 07/09/2026 at 5:40 PM The MDS Nurse said The Activity Director was responsible for inputting the care plans for activities for residents. The MDS Nurse said the failure placed a risk for staff not knowing what activities Resident #1 liked and what kept him active mentally and physically. During an interview on 07/09/2026 at 6:29 PM The DON said all residents should have a care plan in place. The DON said the AD was responsible for ensuring the resident had the care plan in place, and the failure placed a risk for staff not being aware of what Resident #1 liked and enjoyed and how he completed activities. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/09/2026 at 7:03 PM The Administrator said Resident #1 should have had a care plan for activities. The Administrator said the AD was responsible for completing the care plan for activities. The Administrator said the facility did not have an AD but anyone in the IDT team (DON, ADON, MDS Nurse) could have completed a care plan for Resident #1. The Administrator said the failure placed a risk for staff not knowing Resident #1's needs or preferences and the needs or preferences would not be met. Record review of the facility policy Comprehensive Care Plans, dated 2/10/2021, indicated Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on interview and record review, the facility failed to ensure the activities program was directed by a qualified professional who was a qualified therapeutic recreation specialist or an activities professional who completed a training course approved by the State for 1 of 1 facility reviewed for Activity Director qualifications. The facility failed to hire a qualified Activity Director. This failure could place residents at risk of not receiving a program of activities that meets their assessed activity needs. Findings include: Interview on an undisclosed date and time, anonymous resident revealed that he did not receive an activity calendar. Interview on 07/06/2026 at 2:45 p.m., the materials director revealed that she had her Activities Director qualification, but she would not be providing it for the facility. The Material Director stated that she put her resignation in a week ago and would not be taking on the new role to cover for the Activity Director who had left the facility. Interview with a confidential group at an undisclosed date and time revealed that the group of residents were aware of there no longer being an activity director in the facility. The group stated that they had not received the activity calendar for July 2026. The group also stated that they had to have the Administrator sit in at their monthly resident council meeting due to lack of Activity Director. Interview on 07/09/2026 at 3:30 p.m., the DON stated she was aware that there was no activity director. The DON stated to her knowledge the residents were still having activities. The DON stated that resident council was affected by not having someone keep minutes and with help assembling the meeting. DON stated that the residents missed resident rights being discussed. Interview on 07/09/2026 at 4:35 p.m., the Administrator stated that she was aware that the facility did not have an activity director. Administrator stated that activity director was responsible for activities in the facility and resident council. The Residents were at risk of missing activities and not knowing their rights. The Administrator stated that she was in the process of hiring another Activity Director and it had only been a few weeks without an activity director. The Administrator stated that prior to the previous Activity Director leaving she created an activity calendar for July and had only been gone a few weeks but did not state exact amount of time the facility was without an activity director. Record review of the personnel file revealed no documentation of Activity director at this time with a certification, completion of an approved Activity Director training course, qualifying licensure, or other documentation demonstrating the facility met the needs and qualifications of activities director. It is unknown when a qualified activity director last worked at the facility. Record review of Recreation Services policy dated 01/2015 revealed each facility will have a director responsible for the provision of recreation services. Director requirements recreation services director will be qualified according to state requirements.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment was as free of accident hazards as is possible and each resident receives adequate supervision to prevent accidents for 3 of 22 residents (Resident #2, Resident #7, and Resident #13) reviewed for accidents and hazards. 1. The facility did not have a process to reassess elopement risk and safety for Resident #13 after elopement. 2. The facility failed to ensure Resident #7 did not have insect spray in her room. 3. The facility failed to ensure Resident #2 did not have the purple top microdot disinfectant wipes in her bathroom. These failures could place residents at risk of accidents that could result in serious injury, harm, or impairment. Findings included: 1. Record review of Resident #13's face sheet, dated 07/09/26, reflected Resident #13 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included encephalopathy (group of conditions that caused brain dysfunction) and dementia (a condition that affects memory and the ability to perform daily activities) without behavioral disturbance, psychotic disturbance (a collection of symptoms that affect the mind with loss of contact with reality), mood disturbance and anxiety (persistent feelings of fear or worry). Record review of Resident #13's quarterly MDS assessment, dated 05/08/26, reflected Resident #13 made herself understood, and understood others. Resident #13's BIMS score was 3, which reflected her cognition was severely impaired. Record review of Resident #13's comprehensive care plan, initiated 05/17/26, reflected Resident #13 was at risk for wandering/elopement related to cognitive impairment, and at risk for injury related to dementia, and poor safety awareness. Resident #13 did have exit wandering behaviors however; Resident #13 was able to push door open but had difficulty to physically leave facility without assistance. Resident #13 often attempts to leave through double doors and requires wheelchair for assistance. The care plan interventions included attempt to determine any pattern or cause of wandering. Record review of Resident #13's order summary report, dated 07/09/26, reflected monitor placement of wander guard bracelet every shift with start date 07/03/26. Record review of Resident #13's elopement/wandering risk assessment, dated 05/17/26 reflected Resident #13 was at low risk for elopement. Record risk of Resident #13's elopement/wandering risk assessment, dated 07/08/26 reflected Resident #13 was at risk for elopement. During an interview on 07/08/26 at 10:09 a.m., the DON stated she was not aware of the elopement attempts on 06/09/26 first incident when Resident #13 opened the door and made it halfway through (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when the CNA was able to pull her back inside. The DON stated the incident was discussed 06/10/26 the next morning in morning meeting, but she did not follow up to ensure the elopement/wandering risk was updated. The DON stated the Social Worker was responsible for completing a wandering/elopement assessment the following day. During an interview on 07/08/26 at 10:44 a.m., the Social Worker stated she had never been asked to complete an elopement assessment for Resident #13. The Social Worker stated she did not know was responsible for completing the assessment after Resident #13 attempted to elope. During an interview on 07/08/26 at 11:11 a.m., the Administrator stated she was not aware of the first incident on 06/09/26 when Resident #13 attempted to elope. The Administrator stated the first incident was not discussed during the morning meeting. The Administrator stated she expected the staff to let her know about all incidents. The Administrator stated she was aware Resident #13 had wandering behaviors when seeking the restroom. The Administrator stated she was aware that there were no interventions put in place to prevent wandering. The Administrator stated the nurse that was aware of the incident was responsible for reassessing Resident #13 for elopement. The Administrator stated it was important for Resident #13 to be assessed for safety. During an interview on 07/09/26 at 11:30 a.m., RN P stated she spoke with the DON and was instructed to reassess Resident #13 for elopement/wandering. RN P stated she got distracted and forgot to complete the assessment. RN P stated it was important to ensure the assessment was completed for resident safety. 2. Record review of Resident #7's face sheet, dated 07/09/26, reflected Resident #7 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #7's quarterly MDS assessment, dated 05/15/26, reflected Resident #7 made herself understood, and understood others. Resident #7's BIMS score was 15, which reflected her cognition was intact. Record review of Resident #7's comprehensive care plan, revised on 01/22/26, reflected Resident #7 had an ADL Self Care Performance Deficit and was at risk for not having her needs met in a timely manner. The care plan interventions included: ensure/provide a safe environment. During an interview and observation on 07/06/26 at 12:16 p.m., Resident #7 had a bottle labeled Hot Shot Flying Insect spray sitting on her dresser. Resident #7 stated she had her family member to bring it because she had gnats. Resident #7 stated she was unsure if the facility knew she had it. During an interview on 07/09/26 at 10:37 a.m., CNA G stated all staff were responsible for ensuring items were stored properly and securely. CNA G stated she had seen the insect spray and tried to remove it but Resident #7 would not let her. CNA G stated she did not report it to the charge nurse, DON or Administrator. CNA G stated the insect spray should not be in the facility for residents' safety. During an interview on 07/09/26 at 10:54 a.m., RN K stated all staff were responsible for ensuring (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	items were stored properly and securely. RN K stated she was not aware of the insect spray being on Resident #7's dresser. RN K stated the insect spray should not be in the building. RN K stated it was important to ensure items were not left in the residents' room for residents' safety. During an interview on 07/09/26 at 6:12 p.m., the DON stated insect spray should not be in the building because the chemical was not approved for the facility. The DON stated all staff were responsible for ensuring items were stored properly and securely. The DON stated she monitored compliance by daily rounds. The DON stated it was important to ensure insect spray was not left in resident's room for residents' safety. During an interview on 07/09/26 at 6:47 p.m., the Administrator stated insect spray was not allowed in the facility. The Administrator stated she was not aware this item was stored at the resident's bedside. The Administrator stated she made daily rounds and had found things at bedside that should not have been left at the bedside. be left. The Administrator stated she educated the family members and residents. The Administrator stated it was important to ensure items were not left at the bedside for residents' safety. 3. Record review of Resident #2's face sheet dated 07/06/2026 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus (chronic metabolic disease characterized by high blood sugar levels), anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure), and major depressive disorder (serious mental health condition characterized by persistent sadness, hopelessness, and loss of interest in activities). Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated she understood others and made herself understood. The MDS also indicated she had a BIMS score of 15 which meant she was cognitively intact. The MDS also indicated she was also incontinent of urine and required maximal assistance with toileting, dressing, and bed mobility, independent with eating, and she required total assistance with transfers. During an observation and interview on 07/06/2026 at 1:39 PM Resident #2 was lying in her bed and she had a container of purple top microdot disinfectant wipes in her bathroom on the back of the toilet. Resident #2 said a staff member must have left them because she did not place them there. Resident #2 said she did not ever use the bathroom. During an interview on 07/09/2026 at 6:17 PM The DON said the purple top microdot disinfectant wipes should not be available to residents or left in their rooms. The DON said the purple top microdot wipes should be in a locked cart or in medication room locked to ensure staff were wiping down their carts. The DON said the purple top disinfectant wipes should not be in resident rooms at all and all staff were responsible for ensuring the wipes were not left in resident rooms. The DON said she completed rounds every morning and she monitored for things left out. The DON said the failure placed a risk for safety for other residents who wander to get their hands on the wipes. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/09/2026 at 6:52 PM The Administrator said the purple tops disinfectant wipes should not be in the resident rooms. The Administrator said all staff were responsible for ensuring the purple top wipes were not left in the residents' rooms. The Administrator said the failure placed a risk for residents getting a hold of the wipes and harming themselves. Record review of the Safety Data Sheet .dated 08/21/24 reflected. Classification of Substance or Mixture. Physical Hazards. Flammable Aerosol.keep out of reach of children. Record review of the Incident/Accident Policy .revised 11/17 reflected. It is the policy of this facility to report and investigate all incidents and accidents that occur in the facility or on facility property in a timely manner. Incident: an unusual or unexpected event that is not consistent with the routine operation of the facility or the routine care of the resident.1. Immediately assess the condition of the person(s) involved in the incident/accident. The policy provided by the facility gave no relevant reference regarding hazardous material.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 3 of 6 medication carts (Hall 100, 300 and 400) reviewed for pharmacy services. 1.The facility failed to ensure over the counter medication was not expired on hall 100 cart. 2.The facility failed to ensure Resident #17's Novolog R (a short-acting human insulin used to control blood sugar in adults and children with diabetes) insulin was not expired on Hall 300 nurse's cart. 3. The facility failed to ensure Resident #30's Calcitonin Salmon nasal solution (a synthetic hormone used to treat postmenopausal osteoporosis in women) was not expired and Resident #4's Budesonide suspension (used to treat an itchy or runny nose, sneezing, or other symptoms caused by hay fever) was dated when opened on hall 400's nurse's cart. These failures could place the residents at risk of not having medications available for use, or receiving therapeutic doses of their medication Findings included1.During an observation on 07/07/26 at 12:09 p.m., Hall 100 medication aide's cart revealed eye drops undated, Geri-Tussin expired 5/26 and Calcium 600 with vitamin D expired 5/26/26.2. During an observation on 07/07/26 at 12:29 p.m., Hall 300 nurse's cart revealed Resident #17's Novolog R with a date of 05/30/26. 3.During an observation on 07/07/26 at 12:49 p.m., Hall 400 nurse's cart revealed Resident # 30's Calcitonin Salmon nasal solution expired 07/05/26, and Resident #4's Budesonide suspension was open and not dated.During an interview on 07/07/26 at 12:55 a.m., LVN D said all medications should be dated when opened. She said the nurse who opened these medications should have put a date on each of them. LVN D said all nurses should be held accountable for ensuring medications were dated; she said including herself. She said if medications were given past the manufacturer or expiration date, then they may not be as effective.During an interview on 07/07/26 at 1:30 p.m., MA E said expired medications or medications with unopened dates should not be on the cart. She said they did not have a system in place to check the carts.During an interview on 07/09/26 at 3:29 p.m., the facility's physician said he expected staff to pass medications as ordered and not to give expired medications.During an interview on 07/09/26 at 5:15 p.m., LVN A said she does look at the insulin medications because they were only good for 28 days. She said she was unaware of a system they had in place to check medication carts but if she worked on the weekend she would check the carts for expired meds. She said if she looked at a medication and could not read the date written on the insulin or any other medication, she would discard the medication and get another one. She said all multipacket medications should be dated. She said all medication should match what the physician had ordered. She said if a resident received an expired medication or the wrong dose of medication it could cause an adverse reaction.During an interview on 07/09/26 at 5:34 p.m., The DON said she expected the nurses to read the MAR and give medication as ordered. She said she expected all medication to be on the cart as ordered. She said the insulin, albuterol solutions and inhalers should be dated when opened and discarded when expired. The DON said the medication aide or nurse who opened the insulin and/or inhalers were responsible for dating them. She said she was the overseer of nursing. The DON said by not dating the insulin or inhalers when opened the staff would be unaware of when they expired. She said since these medications had a certain number of days before they would expire and if not given during those time frames, it could cause the medications not to be as effective. During an interview on 07/09/26 at 6:09 p.m., the Administrator said she expected the nurses and medication aides to give medication as ordered. She said the nurses were responsible for ensuring they removed expired medications from (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the carts and did not give any expired medications. She said the DON was responsible for monitoring and overseeing by rounding. The Administrator said if expired meds were given, they may not be as effective. Record review of the facility policy medication storage dated 01/20/2021 indicated Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored, dated and labeled according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, included the appropriate accessory and cautionary instructions, for 2 of 23 (Resident # 47 and Resident #2) residents medication reviewed for medications storage. 1. The facility failed to ensure Resident #47 did not have Nystatin powder in her bedside dresser. 2. The facility failed to ensure Resident #2 did not have sore throat spray on her personal refrigerator and nystop (nystatin external powder) (fungal powder used for yeast rashes) on her dresser beside her personal refrigerator. These failures could place residents at risk of not receiving the therapeutic benefit of medications, adverse reactions to medications, or expired medications. Findings included: 1. Record review of Resident #47's face sheet, dated 07/09/26, reflected Resident #47 was a [AGE] year-old female, admitted to the facility on [DATE] and re-admitted [DATE] with a diagnosis which included dementia (memory loss), depression (sadness), and muscle weakness. Record review of Resident #47's quarterly MDS assessment, dated 06/09/26, reflected Resident #47 made herself understood, and was understood by others. Resident #47's BIMS score was 15, which reflected her cognition was intact. The MDS indicated she received ointment/medication during the 7-day look back period. Record review of Resident #47's comprehensive care plan, revised 03/02/26, indicated, Resident #47 was at risk for increase in falls/injury due to use of personal safety device related to motorized wheelchair. Resident #47 had an actual wound (laceration) to her left shin. The intervention was for staff to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or firm surface. Record review of Resident #47's physician order, dated 01/08/26 indicated, Nystatin External Powder 100000 units per gram, apply to red areas topically every 12 hours as needed for yeast rash. During an interview on 07/07/26 at 11:41 a.m., LVN F said she said she did not see any medication left in Resident #47's room but said medication was not supposed to be left in any rooms because of the risk of other residents getting the medication. She said the nurse who took the medication in the room should have taken it out. During an interview on 07/08/26 at 9:56 a.m., CNA H said she said she saw the medication on Resident #47's bedside over the weekend (unsure of which date) and told LVN A. She said she had seen other medication such as creams in other residents' rooms. She said the nurses were aware. During an interview on 07/09/26 at 3:29 p.m., the facility's physician said he expected staff to pass (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications as ordered and not to give expired medications. During an interview on 07/09/26 at 5:15 p.m., LVN A said no medication should be left at bedside for safety reasons. During an interview on 07/09/26 at 5:34 p.m., the DON said the nurses were responsible for ensuring they removed any products (chemicals or medication) brought into the room with them and then stored them in a medication cart or in a medication room. She said Nystatin should not be left in the room because it contained chemicals and a resident could ingest it. She said she was the overseer of nursing. During an interview on 07/09/26 at 6:09 p.m., the Administrator said the nurses were responsible for ensuring they removed Nystatin before exiting a resident's room. She said she expected the nurses and medication aides to give medication as ordered. She said the DON was responsible for monitoring and overseeing by rounding. The Administrator said no medication should not be left in a resident's room for risk of swallowing. 2. Record review of Resident #2's face sheet dated 07/06/2026 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus (chronic metabolic disease characterized by high blood sugar levels), anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure), and major depressive disorder (serious mental health condition characterized by persistent sadness, hopelessness, and loss of interest in activities). Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated she understood others and made herself understood. The MDS also indicated she had a BIMS score of 15 which meant she was cognitively intact. The MDS also indicated she was also incontinent of urine and required maximal assistance with toileting, dressing, and bed mobility, independent with eating, and she required total assistance with transfers. Record review of Resident #2's comprehensive care plan dated 11/02/2023 indicated she had a rash with interventions to give anti-pruritic medication as ordered by the doctor and monitor and document side effects. Record review of Resident #2's order summary report dated 07/06/2026 indicated she had an order for: nystatin external powder 100000 unit/gram (nystatin(topical)) apply to skin folds topically as needed for yeast rash with a start date of 10/11/2025 and no end date. During an observation and interview on 07/06/2026 at 1:36 PM Resident #2 was lying in her bed and she had a bottle of nystop fungal powder on her dresser beside her personal refrigerator and a bottle of sore throat spray on top of her personal refrigerator. Resident #2 said the nurse (she couldn't remember her name) applied the powder on her all the time and she used the sore throat spray as she needed it. Resident #2 said she was not aware the nystop was left in the room, but she did know the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sore throat spray was on top of her personal refrigerator. Resident #2 said she had other residents wander in her room at times and understood why she should not have medications in her room. During an interview on 07/09/2026 at 6:39 PM The DON said the expectation was for the meds to not be left at bedside and never use other resident medications. The DON said there were residents who wanted to keep medications and self-medication, there were steps to take, but she did not encourage self-medication. The DON said the failure placed a risk for medications at bedside being taken by other residents, Resident #2 not using appropriately, and other resident getting the medications and using it inappropriately or drinking. During an interview on 07/09/2026 at 7:10 PM The Administrator said the medications should not be left in any resident rooms. The Administrator said all medications should be locked in the medication carts or the medication room. The Administrator said the CNAs and nurses were responsible as the department managers. The Administrator said the failure placed a risk for residents getting into the medications and getting sick. Record review of the facility policy medication storage dated 01/20/2021 indicated Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored, dated and labeled according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, and interviews, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 2 of 2 residents (Residents #27 and #38) and one lunch meal reviewed for food and nutrition services. The facility failed to ensure dietary staff provided food that was palatable and had an appetizing temperature on 07/06/26 and 07/07/26. This failure could place residents at risk of decreased food intake, hunger, and unwanted weight loss. Findings included: During an interview on 07/06/26 at 1:00 p.m., Resident #38 stated the food could be more seasoned and served hotter. During an interview on 07/06/26 at 1:08 p.m., Resident #27 stated the food was served cold and could be more seasoned. Resident #27 stated he ate in his room during meal service. During an observation and interview on 07/07/26 at 1:42 p.m., the lunch tray was sampled by the Administrator and 5 surveyors. The sample tray consisted of pork loin which was lukewarm and dry; the broccoli was lukewarm and bland; and rice that had the texture of sticky rice. The Administrator stated the pork loin could have been warmer and more tender; the broccoli could have been warmer and more salt added; and the rice tasted sticky but should have the texture of steamed rice and could have been warmer. During an interview on 07/09/26 at 10:37 a.m., CNA G stated residents had complained to her about food. CNA G stated the residents had described the food as slopped. CNA G stated when the residents complained she would go ask the dietary staff for an alternative. CNA G stated she had reported the complaints to the charge nurse, DON and Administrator. CNA G stated residents not eating their food could potentially cause weight loss. During an interview on 07/09/26 at 10:54 a.m., RN K stated she had not had any residents complain about food being cold or bland. RN K stated she would offer an alternative and report to the Dietary Manager, DON and Administrator. RN A stated residents not eating their food could potentially cause weight loss and malnutrition. During a telephone interview on 07/09/26 at 2:35 p.m., the Dietician stated she had not heard any residents complain about food being cold or bland. The Dietician stated she got a test tray in June 2026 and it passed. The Dietician stated a substitute was always available. The Dietary Manager stated it was important to ensure food was palatable and had an appetizing temperature to prevent malnutrition. During an interview on 07/09/26 at 2:59 p.m., the Dietary Manager stated she had complaints about the food being cold but not bland. The Dietary Manager stated she told the residents before if there were any issues to come directly to her and she would try her best to fix it. The Dietary Manager stated she did follow up on those complaints and the residents seemed to be pleased. The Dietary Manager stated she monitored meal service including food quality daily by interviewing residents and tray sampling. The Dietary Manager stated there were no issues found with food quality during her tray sampling. The Dietary Manager stated it was important to ensure food was palatable and had an appetizing temperature to prevent weight loss. During an interview on 07/09/26 at 6:12 p.m., the DON stated she expected food to be palatable and at an appetizing temperature. The DON stated she has had staff and residents complained to her about the food being cold and not seasoned. The DON stated she could not state any residents specific. The DON stated she had reported all complaints to the Administrator. The DON stated she had not had a test tray. The DON stated it was important to ensure food was palatable and had an appetizing temperature to prevent weight loss. During an interview on 07/09/26 at 6:47 p.m., the Administrator stated she expected food to be at the appropriate temperature and seasoned for palatability. The Administrator stated she has had complaints about the food being cold and bland. The Administrator stated she monitored by test trays and rounds during meal service. The Administrator stated she in-serviced the dietary staff verbally when complaints came to her. The (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administrator stated it was important to ensure food was palatable and had an appetizing temperature to prevent weight loss, malnutrition and overall quality of life. The Administrator stated the facility did not have a policy for palatable food.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety for 1 of 1 kitchen reviewed. The facility did not ensure:1. Food items were labeled and dated.2. The ice scoop holder was clean.3. The microwave was clean and free of food debris.4. The deep fryer was clean and had clear grease.5. The exterior of the blender was clean.6. Can opener blade was clean.7. Hair restraints were worn.8. [NAME] L had a clean spoon before stirring the pureed chicken. These failures could place residents at risk for foodborne illness. Findings included: During an initial tour observation and interview with the Dietary Manager on 07/06/26 beginning at 10:31 a.m. until 10:56 a.m. the following was revealed: 1. [NAME] M and the Dietary's Manager's hairnets were not covering their entire head. The Dietary Manager hair net only covered half of her head and [NAME] M had loose hair sticking out. 2. A bag of garlic bread undated and unsealed was found in the walk-in cooler. 3. A bag of puffy pastries undated and unsealed was found in the walk-in cooler. 4. A box that included 14 unsalted margarines undated was found in walk-in cooler. 5. The ice machine scoop holder had several brown and white pieces floating in the bottom. 6. Can opener blade had a black substance buildup. 7. Inside the microwave was a brown buildup. 8. The exterior of the blender had a tan buildup. 9. The deep fryer had golden food crumbs of various sizes observed on the inside surfaces. During an observation and interview on 07/07/26 at 11:50 a.m., [NAME] L removed the spoon from the prep sink and mixed the pureed chicken before washing. The Dietary Manager stated she should have washed the spoon first before stirring the pureed chicken. The Dietary Manager had [NAME] L discard the chicken. The Dietary Manager stated this failure put residents at risk for foodborne illness. An attempted telephone interview on 07/09/26 at 12:05 p.m., with Dietary Aide B was unsuccessful, unable to leave voicemail. During a telephone interview on 07/09/26 at 2:35 p.m., the Dietician stated she expected food to be dated and sealed. The Dietician stated she expected hairnets to be covering the entire head. The Dietician stated the ice scoop, and grease should be changed once a week. The Dietician stated the fryer should be cleaned after every use. The Dietician stated the can opener blade, blender, and microwave should be cleaned after every use. The Dietician stated she monitored by monthly observations and had not had any issues since April 2026. The Dietician stated she did have an issue in May 2026 during breakfast where a staff did not wash the spoon prior to using it and a verbal in-service was done to discuss the proper way to prevent cross contamination. The Dietician could not recall the staff member. The Dietician stated these failures could potentially put residents at risk for foodborne illness and cross contamination. During an interview on 07/09/26 at 2:53 p.m., [NAME] L stated all staff were responsible for dating food products and ensuring food was sealed. [NAME] L stated the can opener blade, microwave, and exterior of the blender should be cleaned after every use by the cook. [NAME] L stated the cooks were responsible for cleaning the fryer and changing the grease once a week. [NAME] L stated she should have washed the spoon first before stirring the pureed chicken. [NAME] L stated these failures could possibly cause food borne illness and cross contamination. During an interview on 07/09/26 at 2:59 p.m., the Dietary Manager stated cleanliness was important in the kitchen, so staff were not spreading germs or contaminating anything. The Dietary Manager stated she was responsible for making sure the kitchen was cleaned appropriately. The Dietary Manager stated food should be labeled and sealed by all staff. The Dietary Manager stated the aides were responsible for cleaning the ice scoop holder daily. The Dietary Manager stated the cooks were responsible for cleaning the can opener blade, microwave, blender and the fryer daily. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Dietary Manager stated hair nets should be worn while in the kitchen and covering the entire head without loose hair sticking out. The Dietary Manager stated she was responsible for monitoring and overseeing by daily walk throughs and when there was an isolated issue that staff were verbally in serviced and if a widespread issue a paper in service was completed. The Dietary Manager stated these failures could potentially put residents at risk for cross contamination and food borne illness. During an interview on 07/09/26 at 6:47 p.m., the Administrator stated she expected food to be dated/sealed, hair nets covering the entire head without loose hair sticking out. The Administrator stated all staff should be ensuring the ice scoop holder, blender, microwave and the fryer cleaned daily. The Administrator stated the grease should be changed at least weekly. The Administrator stated [NAME] L should have washed the spoon first prior to stirring the pureed chicken. The Administrator stated these failures could potentially put residents at risk for cross contamination, and food borne illness. Record review of the facility's policy titled, Equipment Cleaning Procedures revised 05/2018 reflected . It is the policy of this facility that all dietary equipment and the environment are cleaned and sanitized in a manner that meets local (if applicable), state, and federal regulations. Routine cleaning will be practiced on a regular basis in order to keep all dietary equipment and the environment safe, sanitary, and in compliance with state and federal regulations. Cleaning Frequency.: Daily: Equipment and items that are used in food preparation should be cleaned and sanitized after each use. Kitchen and storeroom floors should be swept and mopped daily. Weekly: If the fryer is used frequently (five or more times a week), clean weekly. Record review of the facility's policy titled, Personal Hygiene revised 09/12/23 reflected . Dietary employees will maintain proper food safety practices through proper personal hygiene. Proper hand-washing techniques and exclusion of infectious individuals from handling food are critical for prevention of foodborne illness. 9. Dietary employees shall wear proper hair restraints. at all times while working in the kitchen. Staff that work serving in the dining room do not need to wear hair restraints. Any staff and/or vendors entering the kitchen must comply with hair restraints and hand-washing policies. Record review of the facility's policy titled, Frozen and Refrigerated Foods Storage revised 11/16/17 reflected . 9. Items stored in the refrigerator must be dated upon receipt, unless they contain a manufacturer use by, sell by, best by date, or a date delivered. Most pick stickers do have the delivery date on the sticker. They must also be dated with an expiration date unless they have one from the manufacturer. Record review of FDA 2-402.11, dated 2022, revealed FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE_SERVICE and SINGLE-USE ARTICLES.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington Greenville, TX 75402	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 6 residents (Resident #1, Resident #2, and Resident #55) room reviewed for infection control practices and enhanced barrier precautions. 1. The facility failed to ensure OT Q used the proper PPE while providing care to Resident #1 on 07/08/2026. 2. The facility failed to ensure CNA C wiped correctly and performed hand hygiene while providing incontinent care for Resident #2 on 07/06/26. 3. The facility did not ensure The Floor Tech used the proper PPE before entering Resident #55's room on 07/06/26. These failures could place residents at the facility at risk for cross-contamination and the spread of infection. Findings included: 1) Record review of Resident #1's face sheet dated 07/09/2026 indicated he was a [AGE] year-old male who re-admitted to the facility on [DATE]. His diagnoses included kidney failure (when the kidney function is less than 15% and can no longer filter waste products from the blood), heart failure (serious condition where the heart muscle does not pump blood efficiently), chronic obstructive pulmonary disease (a progressive lung condition that restricts airflow and makes it hard to breathe), and high blood pressure. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated he could make himself understood and he understood others. The MDS also indicated he had a BIMS score of 15 which meant he was cognitively intact. The MDS also indicated Resident #1 had an indwelling catheter for urinating and he required maximal assistance with toileting. The MDS indicated he required moderate assistance with transfers, bed mobility, and bathing, and he could eat independently. Record review of Resident #1's comprehensive care plan revised 7/7/2026 indicated he had a urinary catheter, and he required enhanced barrier precautions and staff must use gown and gloves during high-contact resident care activities that could possibly result in transfer of MDROs to hands and clothing of staff. (e.g., residents with wounds or indwelling medical devices). The care plan also indicated he was at risk for urinary tract infections and injury with interventions to provide catheter care per the facility policy. During an observation on 07/08/2026 at 8:50 AM OT Q was fastening the brief for Resident #1 when surveyor walked in. When surveyor walked in Resident #1's room OT Q did not have a gown but had gloves on. Resident #1 had an enhanced barrier precaution sign on his door and PPE hanging on his door. During an interview on 07/08/2026 at 9:25 AM OT Q said he probably should have had on his gown and gloves but was not really providing catheter care. He said he was placing a new brief on, but the failure placed a risk for infection or cross-contamination. During an interview on 07/09/2026 at 6:33 PM The DON said her expectation was for the staff to use the enhanced barrier precautions any time care was being provided to Resident #1. The DON said the failure placed a risk for infection being spread. During an interview on 07/09/2026 at 7:06 PM The Administrator said her expectation was for the staff to wear the proper PPE which was gown and gloves while providing care for Resident #1. The Administrator said that was the reason Resident #1 had signs and boxes of PPE. The Administrator said the failure placed a risk for spread of disease. 2) Record review of Resident #2's face sheet dated 07/06/2026 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE]. Her diagnoses included type 2 diabetes mellitus (chronic metabolic disease characterized by high blood sugar levels), anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure), and major depressive disorder (serious mental health condition characterized by persistent sadness, hopelessness, and loss of interest in activities). (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington Greenville, TX 75402	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated she understood others and made herself understood. The MDS also indicated she had a BIMS score of 15 which meant she was cognitively intact. The MDS also indicated she was also incontinent of urine and required maximal assistance with toileting, dressing, and bed mobility, independent with eating, and she required total assistance with transfers. Record review of Resident #2's comprehensive care plan last revised 07/01/2026 indicated she had an ADL self-care performance deficit and was dependent on staff for toileting, transfers, and bathing. During an observation on 07/06/2026 at 2:00 PM Resident #2 was lying in bed when CNA C and LVN F came in to change her. CNA C and LVN F explained to Resident #2 what they were going to do. CNA C wiped Resident #2's perineal area from front to back and then assisted LVN F to turn her to her side and wiped the buttocks without changing her gloves. CNA C then wiped Resident #2's back side from back to front with the same wipe. CNA C then removed her gloves and did not perform hand hygiene prior to new gloves being applied and then applied a clean brief. CNA C then applied baby oil and changed her gloves but did not perform hand hygiene. Then she pulled up the covers and moved the bed next to the wall. She did hand hygiene when leaving the room. During an interview 07/08/2026 at 10:54 AM CNA C said she was supposed to change her gloves after providing incontinent care from the front to the back. CNA C said she wiped from down to up and should not have on the buttocks. CNA C said she was supposed to change her gloves and complete hand hygiene from dirty to clean to stop the spreading of infection. During an interview on 07/09/2026 at 6:37 PM The DON said she expected the staff to all understand and provide perineal care correctly and wipe from front to back especially on a woman. The DON said the CNAs should wash hands before and after care and she expected the CNAs to be using hand sanitizers between glove changes. The DON said the nurses and herself were responsible for ensuring the staff correctly perineal care. The DON said check offs for proper perineal care were completed periodically as well as upon hire and then when she had any issues she started to increase the frequency. During an interview on 07/09/2026 at 7:09 PM The Administrator said her expectation was for proper perineal care and proper hand hygiene to be completed by all staff. The Administrator said the nursing administration (DON, ADON) were responsible for ensuring the staff provided proper perineal care and hand hygiene. The Administrator said proficiency checks were completed upon hire, annually, and as needed. The Administrator said the failure placed a risk for spread of disease and create situations for urinary tract infections. 3) Record review of Resident #55's face sheet dated 07/09/2026 indicated he was a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included dementia (progressive decline in cognitive abilities, such as memory, thinking, and reasoning), anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure), high blood pressure, and benign prostatic hyperplasia (disease in which the prostate grows in size causing weak stream and frequent urination). Record review of Resident #55's quarterly MDS assessment dated [DATE] indicated he was able to understand others and made himself understood. The MDS also indicated he had a BIMS score of 10 which meant he had moderate cognitive impairment. The MDS also indicated he required touching assistance with toileting and showers, and he was independent with eating, bed mobility, and dressing. Record review of Resident #55's comprehensive care plan dated 06/29/2026 indicated he had a urinary tract infection that required the use of an antibiotic and the infection required the staff to use contact isolation precautions. During an observation and interview on 07/06/2026 at 11:40 AM Resident #55's door had a sign for contact precautions visible with the isolation PPE supplies on the door. When the Floor tech went into Resident #55's room and check the sanitizer dispenser, he took old one out of the room then went to the environmental door and changed it out without PPE on. The (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington Greenville, TX 75402	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Floor Tech said he was in his own little world and said he didn't touch anything but the hand dispenser. The Floor Tech said he should have put on PPE because he could have contracted something or spread it to someone else. The Floor Tech then went in the environmental room and washed his hands and returned to Resident #55's room and sanitized the door and environmental room door. During an interview on 07/09/2026 at 6:35 PM the DON said she expected the maintenance man and anyone else to wear the proper PPE for contact isolation. The DON said the failure placed a risk for infection. The DON said she was responsible for ensuring that everyone was aware and signage was there for a reason. During an interview on 07/09/2026 at 7:07 PM The Administrator said she expected The Floor Tech to wear the proper PPE before entering the contact isolation room. The Administrator said the failure placed a risk for spread of disease. Record review of the facility policy, dated 2/20/2020, Hand Hygiene indicated Policy: All staff will perform proper hand hygiene procedures to prevent the spread of.2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. When, during resident care, moving from a contaminated body site to a clean body site.6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Record review of the facility policy, dated 10/24/2022, Infection Prevention and Control Program indicated Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. c. All staff shall use personal protective equipment (PPE) according to established facility policy.6. Enhanced Barrier Precautions EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure Resident #39 had the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition for 1 of 5 residents (Resident #39) reviewed for resident rights. The facility failed to provide communication or translation assistance to effectively communicate with Resident #39. This failure could place residents at risk for declining and diminishing quality of life, and neglect. Findings included: Record review of face sheet dated 7/9/2026 revealed Resident #39 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnosis of dementia (loss of memory, thinking and reasoning skills). Record review of care plan date initiated 04/07/2025 revealed Activities: Resident #39 was dependent on staff for cognitive stimulation, activity attendance, and social interaction related to cognitive impairment and is at risk for isolation. Record review of Quarterly MDS dated [DATE] revealed Resident #39 had a BIMS of 05 which indicated severe cognitive impairment. MDS assessment revealed Resident #39 was of Spanish origin and Mexican. MDS assessment revealed Resident #39's preferred language was Spanish. Record review of order summary revealed Resident #39 had an order for 'Resident able to understand rights' started on 01/03/2025. Observation on 07/06/2026 at 10:25 a.m. revealed Resident #39 speaking to speech therapists in Spanish. No observation of any other employee speaking to him in Spanish or using translation assistance. Interview on 07/06/2026 at 10:30 a.m., the speech therapists revealed that Resident #39 could not see out of his right eye, write or read. The Speech Therapist revealed Resident #39 chooses to speak in Spanish most of the time. The Speech Therapist stated that she only knew some Spanish but was not fluent and resident frequently asked what did you say and repeat that please. The Speech Therapist stated that it was Resident #39's right to speak in his preferred language and to be spoken to in his preferred language. Interview on 07/06/2026 at 10:31 a.m. with Resident #39 was limited due to communication barrier. Translation app was used to assist with communication. Resident responded to questions asked by shaking his head indicating he was not sure what was being said by staff and stating Mande (asking for clarification). Resident #39 stated no one spoke Spanish at the facility and only some people understood him. Interview on 07/06/2026 at 2:45 p.m., the LVN D stated that she used google translate to assist in communication. LVN D stated that Resident #39 had difficulty seeing out of his right eye and Resident #39 spoke 'broken Spanish' and understood some English. LVN D stated that she called the resident family to assist in communication, but she felt bad calling late at night. Interview on 07/07/2026 at 11:30 a.m., Resident #39's family member stated that the facility called her to assist in translation. The family member stated that resident was primarily Spanish speaking and could understand very little English. The resident's choice of language was Spanish to understand his care. Interview on 07/07/2026 at 1:35 p.m. the NA G stated Resident #39 was primarily Spanish speaking although he could understand some English. NA G stated that she used translate on her phone to sometimes communicate, however, Resident #39 did not always understand it. NA G stated it would have been helpful to have a source to understand what he was saying and help the staff communicate with Resident #39. NA G stated she knew of only 2 staff members who knew Spanish but they were not at the facility 24 hours a day. Interview on 07/09/2026 at 3:40 p.m., the RN K stated to her knowledge that no one has used google translate. RN K stated that she knew some Spanish enough to communicate with him. RN K stated that Resident #39 speaks some English. Interview on 07/09/2026 at 3:54 p.m., DON stated she expected them to address Resident #39 in his preferred language. DON stated that Resident #39 was (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at risk of not having effective communication. Interview on 07/09/2026 at 4:30 p.m., Administrator stated that she expected the staff to address Resident #39 in his preferred language of Spanish. Administrator stated Resident #39 was at risk of his care and needs not being met due to his primary language being used to communicate with Resident #39. The Administrator stated that Resident #39 had the right to be spoken to in his preferred language. Record review of Resident Rights policy dated 2/20/2026 revealed residents had the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming, and personal and oral hygiene for 1 of 6 residents (Resident #5) reviewed for ADL care. The facility failed to ensure Resident #5 was showered on 06/30/26, 07/02/26, or 07/04/26. This failure could place residents at risk of not receiving care/services, decreased quality of life, and loss of dignity. Findings included: 1. Record review of Resident #5's face sheet, dated 07/09/26, indicated a [AGE] year-old female who was re-admitted to the facility on [DATE] with diagnoses which included Atrial fibrillation, also known as heart failure (a heart condition characterized by an irregular and often rapid heartbeat), Dementia (a general term for the loss of thinking, remembering, and reasoning abilities), and lack of coordination. Record review of Resident #5's quarterly MDS assessment, dated 06/26/26, indicated Resident #5 made herself understood and understood others. Her BIMS score was a 13, which indicated she was cognitively intact. The MDS indicated she required maximal assistance for bathing, bed mobility, dressing, and transferring. The MDS did not indicate she refused care. Record review of Resident #5's care plan revised 06/07/22 indicated Resident #5 had an ADL self-care performance deficit requiring total assistance with bathing. The interventions were for staff to provide shower, shave, oral care, hair care, and nail care per schedule and when needed. Record review of the shower sheets from 06/30/26 through 07/06/26 did not indicate Resident #5 received a shower. During an observation and interview on 07/06/26 at 11:19 a.m., Resident #5 was in bed. Her hair was oily and she said she was not getting her showers 3 times a week on Tuesday, Thursday and Saturday. She said she was lucky to get a shower 1 time a week. She said she had not had a shower since last Saturday (06/27/26). She said she was stinky. During an interview on 07/08/26 at 11:00 a.m., CNA G said Residents #5 do complain about not receiving their baths from the 2pm-10pm shifts. She said they were not always able to give the residents showers because of time and all the duties they had to complete. She said the DON was aware. During an interview on 07/08/26 at 3:00 p.m., CNA E who worked on 2pm-10pm shift said residents received baths when they had time. She said Resident #5 does refuse to take showers at times. She said she thought she gave Resident a shower last week but was unsure. During an interview on 07/09/26 at 9:50 a.m., CNA H said Resident #5 had complained to her that she was not receiving her showers from 2pm-10pm. She said she asked her to give her a shower about 2 weeks ago and she did. She said Resident #5 does not generally refuse care. During an interview on 07/09/26 at 10:50 a.m., CNA C said Resident #5 had complained to her that she was not receiving her showers from 2pm-10pm. She said Resident #5's shower days were Tuesday, Thursday and Saturday. She said she did ask her to give her a shower on 07/04/26 on the 6am-2pm shift but she did not have time. She said she did report to an unknown nurse about Resident #5 saying she was not receiving her showers. She said Resident #5 was aware and knew if she had a shower or not. During an interview on 07/09/26 at 5:34 p.m., the DON said she expected showers to be given according to the shower schedule. She said the staff was aware of the shower days. She said she was aware they had shower issues, but it had gotten better. She said she was unaware of Resident #5 missed showers. She said if a resident refused his/her shower(s) then the charge nurse was supposed to document it in his/her chart and notify her. She said showers should be given for cleanliness and prevention of skin breakdown. During an interview on 07/09/26 at 6:09 p.m., the Administrator said she expected the residents to receive their baths and expected the staff to document if they did not receive them. The Administrator said the charge nurse was responsible for (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensuring the showers were completed. She said showers were given for sanitary and infection reasons. Record review of the facility policy titled, Activities of Daily Living Care Guidelines, dated 02/11/21, indicated Anticipated Outcome: Residents will receive essential services for activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene. Process: Residents participate in and receive the following person-centered care: Bathing: includes grooming activities such as shaving, and brushing teeth and hair.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington Greenville, TX 75402	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 3 (Resident #12) residents reviewed for quality of care. The facility failed to perform wound care for 3 days 7/4, 7/5, and 7/6 for Resident #12 with a toe wound with cellulitis. This failure could place residents at risk for not receiving appropriate care and treatment, a decreased quality of life, and pressure ulcers. Finding including: Record review of face sheet dated 07/09/2026 revealed Resident #12 was a [AGE] year-old female admitted to the facility on [DATE] with the diagnosis of type 2 diabetes mellitus with hyperglycemia (metabolic disorder that affects how the pancreas controls blood sugar with high blood sugar). Record review of care plan revealed Resident #12 was care planned for risk of complications of impaired circulation related to elevated cholesterol with the intervention to inspect the foot, ankle, and calf skin for changes in the skin. Record review of annual MDS dated [DATE] revealed Resident #12 had a BIMS of 15 indicating no cognitive impairment. MDS assessment indicated Resident #12 was at risk of developing pressure ulcers. Record review of order summary report dated 07/09/2026 revealed Resident #12 had an order for wound care to the right great toe: Order started 07/04/2026 Cleanse right great toe with normal saline, pat dry, and apply calcium alginate, cover with band aid daily every day shift. Record review of progress note dated 06/30/2026 revealed Resident #12 reported a toe wound to the right big toe by the NA G to the nurse on duty. Progress note revealed the toe had a blister, was inflamed and warm to touch. Record review of skin assessment issue dated 07/04/2026 revealed a new documented skin issue identified by the DON acquired in house. Measurements revealed a length (cm): 0.2 Width (cm): 0.2 Depth (cm): 0.1 Undermining (tissue at the edge of the injury had separated from the deeper tissue underneath): No. Tunneling(wound created hidden passageways under the skin) =: No. Record review of the treatment record revealed blanks in the record for 7/4 and 7/5 indicating wound care was not documented for Resident #12 indicating it was not completed. Observation on 07/06/2026 at 11:00 a.m. revealed Resident #12's right great toe was red, open and had a sore without a bandage on it. Interview on 07/06/2026 at 11:05 a.m., Resident #12 revealed the staff had not put a bandage on her toe while in the facility. Resident #12 stated she had had a sore on her toe since 6/30/2026. Resident #12 stated she had cellulitis (infection of the skin) of the right toe. Resident #12 stated that no wound care had been done on her toe. Observation on 07/07/2026 at 9:00 a.m., revealed Resident #12 had not had wound care done because there was no bandage on the toe. Interview on 07/09/2026 at 1:45 p.m., LVN D stated she was unaware of the order for wound care on Resident #12. LVN D stated that Resident #12 had cellulitis and was at risk of wound worsening and sepsis (infection). LVN D stated that she did not complete wound care on 7/4, 7/5, and 7/6 of July 2026. LVN D stated she was responsible for Resident #12 wound care. Interview on 07/09/2026 at 3:00 p.m., ADON stated she was responsible for overseeing wound care for Resident #12. ADON stated that she expected wound care to be completed according to physician order daily. ADON stated that she was unaware Resident #12 was not receiving scheduled daily wound care. Interview on 07/09/2026 at 3:35 p.m., the DON stated she was not aware that the wound care was not getting completed. Resident #12 had cellulitis to the toe. The DON stated there is 24-hour care and she expected nurses to complete the task if they check off documentation that the nurse had completed the task of wound care. The DON stated that if it was on point of care t should have been completed according to the wound care orders. Resident #12 was at risk of sepsis and worsening wounds. Interview on 07/09/2026 at 4:40 p.m., the Administrator stated (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington Greenville, TX 75402	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she expected wound care orders to be followed. Administrator stated that Resident #12 was at risk of wound worsening. Administrator stated that the nurses were responsible for doing the wound care and ADON was responsible for overseeing the nurse to ensure wound care is completed. Record review of wound care management policy review date on 2/10/2021 revealed wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who was incontinent of bladder received appropriate treatment and services 1 of 3 (Resident #1) residents reviewed for indwelling catheter. 1. The facility failed to ensure Resident #1's indwelling catheter (tube inserted into bladder) was secured on 07/06/26, 07/07/2026, and 07/08/26. These failures could affect residents with an indwelling urinary catheter and place them at risk of urethral tears, discomfort, infection, and lack of dignity. Findings included: Record review of Resident #1's face sheet dated 07/09/2026 indicated he was a [AGE] year-old male who re-admitted to the facility on [DATE] with diagnoses which included kidney failure (when the kidney function is less than 15% and can no longer filter waste products from the blood), heart failure (serious condition where the heart muscle does not pump blood efficiently), chronic obstructive pulmonary disease (a progressive lung condition that restricts airflow and makes it hard to breathe), and high blood pressure. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated he could make himself understood and he understood others. The MDS also indicated he had a BIMS score of 15 which meant he was cognitively intact. The MDS also indicated Resident #1 had an indwelling catheter for urinating and he required maximal assistance with toileting. The MDS indicated he required moderate assistance with transfers, bed mobility, and bathing, and he could eat independently. Record review of Resident #1's comprehensive care plan revised 7/7/2026 indicated he had a urinary catheter, and he was at risk for urinary tract infections and injury with interventions to provide catheter care per the facility policy. During an observation on 07/06/2026 at 11:38 AM Resident #1 was rolling himself in his wheelchair in the hallway. He had shorts on and a catheter drainage bag on left side of chair with no strap or securement device on his leg. During an observation and interview on 07/07/2026 at 9:09 AM Resident #1 was up in his wheelchair in his room. Resident #1 said he had not had a catheter strap in place for about 2 weeks. Resident #1 had on shorts and surveyor could see that he did not have a catheter securement device or strap in place. During an observation and interview on 07/08/2026 at 8:50 AM OT Q was in Resident #1's room completing care and fastening the brief for Resident #1 when surveyor walked in. Resident #1 had a worn catheter securement device hanging on catheter drainage line and OT Q said the catheter securement device should have been attached to resident's leg. OT Q said the failure of the catheter lock for catheter not attached correctly caused it to be hanging and could have pulled the catheter. OT Q said he was going to tell the nurse. LVN A came into Resident #1's room with OT Q and she replaced the securement device. LVN A said the catheter securement device should always be in place to prevent pain and discomfort. During an interview on 07/09/2026 at 6:32 PM the DON said her expectation was for Resident #1 was to always have a catheter strap or securement device in place. The DON said the charge nurses and CNAs were responsible and the CNAs should have notified the charge nurse if not in the room. The DON said the failure placed a risk for resident pulling the catheter out or injury. During an interview on 07/09/2026 at 7:05 PM The Administrator said her expectation was for Resident #1 to always have a catheter strap or secure device. The Administrator said the nurses were responsible for ensuring the strap or securement device was in place and CNAs were responsible to notify the nurses if they were aware. The Administrator said the failure placed a risk for the catheter shifting and tangling causing pain or injury. Record review of the facility policy Indwelling Foley Catheters Guidelines dated 05/23/2014 indicated Anticipated Outcome The facility shall identify and assess patients with an indwelling (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheter or at risk for catheterization, provide appropriate treatment and services. Properly secure indwelling catheters after insertion to prevent movement and urethral traction.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 2 of 6 residents (Residents #4 and Resident #8) reviewed for respiratory care.1.The facility failed to ensure Resident #4's oxygen was set at 3 liters per nasal cannula on 07/07/26 and 07/08/26 and HHN (handheld nebulizer) was bagged on 07/06/26, 07/07/26, and 07/08/26.2.The facility failed to ensure Resident #8's oxygen was set at 2 liters per nasal cannula on 07/07/26.These failures could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care.Findings included:Record review of Resident #4's face sheet, dated 07/09/26, revealed a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease also known as COPD (is a progressive, incurable lung disease that restricts airflow and causes breathing difficulty), hypoxia (a condition in which your body or specific tissues do not receive enough oxygen to function properly), dementia (a loss of mental functioning such as, thinking, memory, mood and behavior), and diabetes (high blood sugars).Record review of Resident #4's quarterly MDS assessment, dated 05/25/26, indicated Resident #4 understood and was understood by others. Resident #4's BIMS score was 05, which indicated her cognition was severely impaired. The MDS indicated Resident #4 required assistance with toileting, bed mobility, dressing, personal hygiene, transfers, and eating. The MDS indicated she received oxygen during the 7-day look-back period. The MDS did not indicate she received nebulizer treatments during the 7-day look back period.Record review of Resident #4 's comprehensive care plan, revised on 03/01/23, indicated Resident #4 had impaired respiratory status and was at risk for shortness of breath, respiratory distress, increased anxiety, and hypoxia. The intervention was to provide oxygen therapy as ordered.Record review of Resident #4 's comprehensive care plan, revised on 05/19/26, did not indicate any nebulizer treatments.Record review of Resident #4's physician order dated 04/28/26 indicated oxygen at 3 liter per nasal cannula every shift related COPD.Record review of Resident #4's physician order dated 05/19/26 indicated Budesonide give 1 vial inhale orally every shift for COPD.Record review of Resident #4's medication administration record dated 07/01/26 through 07/06/26 indicated she received a breathing treatment of Budesonide Inhalation Suspension 0.5 milligram/2 milliliter (Budesonide (Inhalation)1 vial inhale orally every shift for COPD.During an observation and interview on 07/07/26 at 8:43 a.m., Resident #4 oxygen was noted at 2/5 liters and had a hand-held nebulizer with tubing on her nightstand, not bagged. Resident #4 said she had a breathing treatment last night. During an observation and interview on 07/07/2026 at 9:11a.m., MA E was in Resident #4's room giving medication and said the HHN was not in a bag but should be for infection reasons.During an observation and interview on 07/08/26 at 11:36 a.m., LVN A said she was the nurse for Resident #4. LVN A verified Resident #4 had a nebulizer tubing not bagged, and oxygen was set at 2 liters per nasal cannula. She said nebulizer tubing should be bagged when not in use for infection reasons. She said oxygen should be set as ordered to prevent respiratory issues.2.Record review of Resident #8's face sheet, dated 07/09/26, indicated a [AGE] year-old female who was re-admitted to the facility on [DATE] with diagnoses which included dependence on supplemental oxygen (occurs when your body requires a continuous or intermittent supply of extra oxygen to maintain healthy blood oxygen levels), congestive heart failure (occurs when the heart muscle doesn't pump blood as well as it should), and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anxiety (a feeling of fear, dread, and uneasiness).Record review of Resident #8's physician orders dated 04/04/25 indicated oxygen at 2 liters per minute via nasal cannula continuously for diagnosis of COPD.Record review of Resident #8's care plan revised date of 04/28/25, indicated she required oxygen for congestive heart failure. The intervention was for staff to apply oxygen as ordered.Record review of Resident #8's quarterly MDS assessment, dated 06/16/26, indicated Resident #8 made herself understood and was understood by others. The MDS indicated her BIMS score was a 04 which meant she was severely cognitively impaired. The MDS indicated Resident #8 required assistance with dressing, personal hygiene, toileting, bathing, bed mobility, transfers, and for eating. The MDS during the 7-day look-back period indicated Resident #8 was receiving oxygen.During an observation on 07/06/26 at 10:12 a.m., Resident #8 was in bed with oxygen applied at 2.5 liters. No distress noted.During an observation and interview on 07/07/26 at 3:07 p.m., Resident #8 was in her bed with oxygen at 2.5 liters via nasal cannula. No distress noted. Resident #8 said her oxygen should be set at 2 liters. During an interview on 07/08/26 at 11:33 a.m., LVN A said she was Resident #8's nurse. She looked and verified Resident #8's oxygen was set at 2.5 liters. LVN A went to look at Resident #8's order and said she should be at 2 liters. She said she would turn her oxygen to 2 liter as ordered. She said the nurses were responsible to look at all oxygen every shift. She said failure to have oxygen as ordered could lead to respiratory issues such as shortness of breath. During an interview on 07/09/26 at 5:34 p.m., the DON said the nurses were responsible for ensuring oxygen was on as ordered and HHN tubing was bagged. She said she and the ADON did random rounds. She said it was important to store tubing in a bag when not in use to prevent infection and apply oxygen as ordered to prevent increased confusion or respiratory issues such as poor oxygen exchange. During an interview on 07/09/26 at 6:09 p.m., the Administrator said if a resident had an order for oxygen, it should be applied. She said HHN tubing should be bagged. She said the nurses were responsible for ensuring the oxygen was set at the ordered rate, and tubing was bagged when not in use. She said nurse management were the overseers. She said failure to apply oxygen at the correct rate could affect their health and unbagged tubing could lead to infection control issues. Record review of the facility's policy titled Oxygen Administration, revised date of 01/05/20, indicated, Policy: To describe methods for delivering oxygen to improve tissue oxygenation. Procedure:1. Verify Physician Order.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was not 5 percent or greater. The facility had a medication error rate of 7.14 %, based on 3 errors out of 28 opportunities, which involved 2 of 5 residents (Residents #59, and Resident #4) reviewed for medication administration. 1. The facility failed to ensure LVN D did not administer insulin to Resident #49 on [DATE] that had expired on [DATE]. 2. The facility failed to ensure MA E administered Potassium (an essential mineral that is needed by all tissues in the body. It is sometimes referred to as an electrolyte), and Slow Magnesium (a dietary supplement formulated with magnesium chloride and calcium to support muscle, nerve, and cardiovascular health) as ordered by the physician for Resident #4 on [DATE]. These failures could place residents at risk of not receiving the intended therapeutic benefit of their medications or receiving them as prescribed by the physician's orders. Findings included: 1. Record review of Resident #59's face sheet, dated [DATE], reflected Resident #59 was a [AGE] year-old male, admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included Type 2 diabetes mellitus (lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels), stroke, and high blood pressure. Record review of Resident #59's quarterly MDS assessment, dated [DATE], indicated Resident #59 made himself understood and understood others. Resident #59's BIMS score was 15, which indicated his cognition was intact. The MDS indicated he received insulin over the 7-day look-back period. Record review of Resident #59's physician order dated [DATE], reflected an order for: Novolin R Solution (Insulin Regular Human) Inject as per sliding scale: if 0 - 200 = 0 units; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units Greater than 450 notify the physician, subcutaneously before meals and at bedtime related to diabetes. Record review of Resident #59's comprehensive care plan dated [DATE] indicated Resident #59 had diabetes mellitus. The care plan interventions were for staff to monitor blood sugar as ordered by the physician. Administer sliding scale insulin if ordered. For any blood sugars not within the acceptable parameters as dictated by the physician, document and notify the physician. During an observation and interview on [DATE] at 11:04 a.m., LVN D took Resident #59's blood sugar with a reading of 208. LVN D prepared Resident #59's Novolog and administered 2 units to Resident #59's left arm. LVN D reviewed the insulin vial and said she could not read the date on the bottle but looked like it was [DATE]. She said if so, the insulin had expired. She said giving expired medication may not be effective. 2. Record review of Resident #4's face sheet, dated [DATE], revealed a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses to include Congestive heart failure also known as CHF (is a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), Chronic Obstructive Pulmonary Disease also known as COPD (is a progressive, incurable lung disease that restricts airflow and causes breathing difficulty), hypoxia (a condition in which your body or specific tissues do not receive enough oxygen to function properly), dementia (a loss of mental functioning such as, thinking, memory, mood and behavior), and diabetes (high blood sugars). Record review of Resident #4's quarterly MDS assessment, dated [DATE], indicated Resident #4 understood and was understood by others. Resident #4's BIMS score was 05, which indicated her cognition was severely impaired. The MDS indicated Resident #4 required assistance with toileting, bed mobility, dressing, personal hygiene, transfers, and eating. The MDS did not indicate she received Potassium or Slow Magnesium. Record review of Resident #4's comprehensive care plan, revised on [DATE] did not indicate a care plan for potassium or Slow Magnesium. Record (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident #4's physician order dated [DATE], indicated Resident #4 had an order for the following: Potassium Chloride extended-release oral tablet extended release 20 MEQ (Potassium Chloride) Give 1 tablet by mouth in the morning for CHF.Slow-Mag Oral Tablet Delayed Release 71.5-119 MG (Magnesium Chloride-Calcium Carbonate) Give 1 tablet by mouth every 12 hours for Supplement.During an observation on [DATE] at 9:59 a.m., MA E checked the Medication Administration Record for Resident #4 and then gave 1 tablet of Slow Magnesium which contained Calcuim-212mg, Magnesium128mg and Chloride 373mg.During an observation on [DATE] at 9:59 a.m., MA E checked the MAR for Resident #4 and did not give Potassium as ordered.During an interview on [DATE] at 12:58 p.m., MA E said she gave Resident #4, 1 tablet of Slow Magnesium which contained Calcuim-212mg, Magnesium128mg and Chloride 373mg. She said since the order read to give 1 tablet of Slow-Mag Oral Tablet Delayed Release 71.5-119 MG, she said she gave the wrong dose. She said since it was a supplement she was not sure how it could affect the resident. MA E said she thought she gave Resident #4 her Potassium 20 MEQ, but she looked on the cart and Resident #4 did not have any Potassium on the cart. She said the DON pulled it from the emergency kit.During an interview on [DATE] at 2:09 p.m., the DON said she did not pull Potassium out of the emergency kit for Resident #4.During an interview on [DATE] at 5:34 p.m., the DON said she expected nurses not to give expired insulin, and/or medication aides to give the wrong medication or not to give medication as ordered. The DON said she expected the medication aides and nurses to read the MAR and give medication as ordered. The DON said she was aware of Resident #4 missing some medications but not Potassium. She said she had reached out to the physician about the Slow Magnesium, and he had given new orders. The DON said if residents did not receive the ordered dose, or expired medication they may not be receiving the therapeutic dose.During an interview on [DATE] at 6:09 p.m., the Administrator said she expected medications to be administered by the physician's orders and for there not to be any mistakes. The Administrator said the DON and ADON were responsible for monitoring to ensure medication errors did not occur. The Administrator said expired medication could affect residents depending on the medication and why ordered.Record review of the facility policy titled, Physician Orders, dated [DATE], indicated, Policy: The policy provides guidance on receiving and following physician orders.Record review of the facility's policy titled, Medication -Treatment Administration and Documentation Guidelines, revised [DATE], indicated, Anticipated Outcome: To provide a process for accurate, timely administration and documentation of medication and treatments. Fundamental Information Medication are administered according to manufacturer's guidelines unless otherwise indicated by physician order. Process: 1. Verify labels accurately reflect the physician orders on the Electronic Medication Administration Record (EMAR) and Electronic Treatment Administration Record (ETAR) prior to administering patient medications and treatments. 2. Verify administration accuracy by checking the medication with the EMAR three (3) times. 4. Administer the medication according to the physician order.Record review of the facility's policy titled, Medication Labeling and Storage, revised February 2023, indicated, Policy: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Policy Interpretation and Implementation: Medication Storage1.Medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Medication Labeling: 5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that residents were free of significant medication errors for 1 of 1 resident (Resident #59) reviewed for insulin administration. The facility did not ensure LVN D did not administered Resident #59 expired Novolog (insulin medication) on 07/07/26. This failure could place residents at risk of medical complications and prevent them from receiving the therapeutic effects of their medications. Findings included: Record review of Resident #59's face sheet, dated 07/09/26, reflected Resident #59 was a [AGE] year-old male, admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included Type 2 diabetes mellitus (lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels), stroke, and high blood pressure. Record review of Resident #59's quarterly MDS assessment, dated 06/16/26, indicated Resident #59 made himself understood and understood others. Resident #59's BIMS score was 15, which indicated his cognition was intact. The MDS indicated he received insulin over the 7-day look-back period. Record review of Resident #59's physician order dated 11/13/25, reflected an order for: Novolin R Solution (Insulin Regular Human) Inject as per sliding scale: if 0 - 200 = 0 units; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units Greater than 450 notify the physician, subcutaneously before meals and at bedtime related to diabetes. Record review of Resident #59's comprehensive care plan dated 06/11/26 indicated Resident #59 had diabetes mellitus. The care plan interventions were for staff to monitor blood sugar as ordered by the physician. Administer sliding scale insulin if ordered. For any blood sugars not within the acceptable parameters as dictated by the physician, document and notify the physician. During an observation and interview on 07/07/26 at 11:04 a.m., LVN D took Resident #59's blood sugar with a reading of 208. LVN D prepared Resident #59's Novolog and administered 2 units to Resident #59's left arm. LVN D reviewed the insulin vial and said she could not read the date on the bottle but looked like it was 05/05/26. She said if so, the insulin had expired. She said giving expired medication may not be effective. She disposed of the Novolog insulin and got him a new vial. During an interview on 07/09/26 at 3:29 p.m., the facility's physician said he expected staff to pass meds as ordered and not to give expired medications. During an interview on 07/09/26 at 5:34 p.m., the DON said she expected nurses not to give expired insulin. The DON said she expected the nurses to look at insulin before given and if expired to discard it and get a new vial. She said she was the oversee of nursing. She said they did not have a system in place for checking medication carts. The DON said if Resident #59 received expired insulin, it might not be effective. During an interview on 07/09/26 at 6:09 p.m., the Administrator said she expected insulin to be dated and discarded when it expired. She said she did not expect nurses to give expired insulin. The Administrator said the DON and ADON were responsible for monitoring to ensure no expired medication was not on the cart. The Administrator said risk of expired medication could make the medication not effective or cause a resident to become sick. Record review of the facility's policy titled, Medication -Treatment Administration and Documentation Guidelines, revised 04/06/23, indicated, Anticipated Outcome: To provide a process for accurate, timely administration and documentation of medication and treatments. Fundamental Information Medication are administered according to manufacturer's guidelines unless otherwise indicated by physician order. Process: 1. Verify labels accurately reflect the physician orders on the Electronic Medication Administration Record (EMAR) and Electronic Treatment Administration Record (ETAR) prior to administering patient medications and treatments. 2. Verify administration accuracy by checking the medication with the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EMAR three (3) times. 4. Administer the medication according to the physician order. Record review of the facility's policy titled, Medication Labeling and Storage, revised February 2023, indicated, Policy: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Policy Interpretation and Implementation: Medication Storage1. Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Medication Labeling: 5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on interview and record review the facility failed to provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service for 1 out of 7 (Dietary Aide B) dietary staff. The facility did not ensure Dietary Aide B had a current food handler permit. This failure could place residents who consumed food prepared from the kitchen at-risk of foodborne illness or nutritional deficiencies. Findings include: Review of the food handler's certificates of completion provided by the facility on 07/06/2026 at 2:00 p.m., revealed the following: Dietary Aide B had a food handler certificate that expired on 07/15/25. During an interview on 07/07/26 at 4:15 p.m., Dietary Aide B stated she was not aware her food handler permit was expired. Dietary Aide B stated it was important to have a food handler certificate to know how to handle food and prevent cross contamination or infection. During an interview on 07/09/26 at 2:59 p.m., the Dietary Manager stated she was responsible for ensuring staff completed their food handler certificate training every 2 years. The Dietary Manager stated she reviewed the certificates weekly but overlooked the actual day it expired. The Dietary Manager stated this failure could potentially put residents at risk for food borne illness and cross contamination. During an interview on 07/09/26 at 6:47 p.m., the Administrator stated she expected the Dietary Manager to ensure the dietary staff had their food handler certificates before they expired. The Administrator stated this failure could potentially put residents at risk for food borne illness and cross contamination. Record review of the facility's policy titled Certified Food Protection Professional and Food Safety Training revised 11/14/17 reflected. 6. The food establishment shall maintain on premises a certificate of completion of the food handles training course for each employee.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the meals served met the nutritional needs of residents for 1 of 1 meal (the lunch meal) reviewed for meal service. The facility failed to ensure the Dietary Manager followed the recipe for preparing fortified pudding on 07/06/26. This failure could place residents at risk for weight loss, not having their nutritional needs met, and a decreased quality of life. Findings included: 1. Record review of Resident #58's face sheet, dated 07/09/26, indicated a [AGE] year-old male who was re-admitted to the facility on [DATE] with diagnoses which included protein-calorie malnutrition (is defined as a condition resulting from inadequate intake of protein and calories, often due to decreased oral intake), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), anxiety (a feeling of fear, dread, and uneasiness), and dysphagia (difficulty swallowing). Record review of Resident #58's quarterly MDS assessment, dated 04/30/26, indicated Resident #58 made himself understood and was understood by others. The MDS indicated his BIMS score was a 15 which indicated he was cognitive intact. The MDS indicated Resident #58 required assistance with dressing, personal hygiene, toileting, bathing, bed mobility, transfers, and independent with eating. The MDS during the 7-day look-back period did not indicate Resident #58 had weight loss. Record review of Resident #58's physician's order dated 09/30/24, indicated Regular diet Regular texture, Regular consistency. Add fortified foods to every meal related to protein calorie malnutrition. Record review of Resident #58's care plan revised on 05/06/25 indicated Resident #58 had potential nutritional problems related to malnutrition and impaired cognition. The intervention was for staff to serve diet as ordered. During an observation on 07/06/26 at 12:30 p.m., Resident #58 was in the dining room eating pudding. His tray card read fortified pudding. During an observation and interview on 07/07/26 at 2:14 p.m., the Dietary Manager said they made the fortified pudding with condensed milk for the pudding served on 07/06/26. She reviewed the recipe and said it called for regular milk. She said the fortified pudding was not made correctly because she used condensed milk. She said the recipe was not followed. She said the risk of not following the recipe could lead to weight loss. During an interview on 07/09/26 at 2:47 p.m., the dietician said the dietary staff should follow the recipe when making the fortified pudding. She said residents who usually receive fortified pudding were at risk for malnutrition and weight loss. During an interview on 07/09/26 at 5:34 p.m., the DON said she expected the dietary staff to follow the recipe. She said the Dietary Manager was the overseer of the kitchen. She said Resident #58 was ordered fortified pudding because he was at risk of weight loss. During an interview on 07/09/26 at 6:09 p.m., the Administrator said she expected the kitchen to follow the recipe when preparing food in the kitchen. She said the Dietary Manager was the overseer of the kitchen. She said residents often received fortified pudding for weight loss. Record review of the facility's policy titled, Diets, Nutrition and Hydration, revised March 2016, indicated, Fundamental Information: The facility will provide each resident with three meals daily. Each meal will be provided according to physician orders, Facility Diet Manual, and menu spread sheet.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to accommodate residents' food preferences for 1 of 6 residents (Resident #17) reviewed for nutrition. The facility failed to honor Resident #17's preference for no apples for the lunch meal on 07/06/2026. This failure could place residents at risk for a decrease in resident choices, diminished interest in meals, and weight loss. Finding including: Record review of the face sheet dated 07/09/2026 revealed Resident #17 was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included cerebral infarction due to embolism of right cerebellar artery (dead brain tissue caused by a blocked blood vessel). Observation on 07/06/2026 at 12:25 p.m., Resident #17 had apples on her tray. Interview on 07/06/2026 at 12:30 p.m., Resident #17 stated she does not like apples and wished to have a substitution for the apples on her meal. Resident #17 stated that she requested a substitution but had not received one. Interview on 07/06/2026 at 12:35 p.m., the Dietary Manager stated that she should have substituted the apples for Resident #17 but she did not because she forgot. The Dietary Manger stated that she was the dietary aid for the day and did not realize she did not supply Resident #17. Interview on 07/09/2026 at 2:45 p.m., the Registered Dietitian stated that she expected Dietary to substitute the apples for another fruit available. The Registered Dietitian stated that she expected the dietary to have available substitutes for Resident #17. Interview on 07/09/2026 at 3:00 p.m., the Dietary Manager revealed that she expected Resident #17 to receive her preference to prevent weight loss and quality of life. Resident #17 was at risk of not receiving the proper nutrition. Interview on 07/09/2026 at 4:09 p.m., the DON stated that she expected that Resident #17 receive her preference or substitution. Resident #17 was at risk of weight loss or malnutrition. The DON stated that the nurse checks the trays and she expected the ticket meal to be followed and match the tray accordingly. Interview on 07/09/2026 at 4:44 p.m., the Administrator stated that she expected Resident #17 to receive her preference or a substitution. Resident #17 was at risk of not eating her preferred foods. The Administrator stated that nurses were responsible for checking the trays and dietary was responsible for providing the substitution. Record review of Instructions for completing Meal Choice Form dated 2/16/2017 revealed a meal choice form would be completed for each resident and should be followed according to the meal ticket. Record review of Menu Planning Guidelines and Procedure dated 7/17/2024 revealed Additional alternative/substitute foods will be kept on hand for quick preparation and service in the event a resident refuses all foods served.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 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** Based on observation, interview and record review, the facility failed to ensure food was prepared in a form designed to meet individual needs for 1 of 3 residents (Resident #54) reviewed for therapeutic diets. The facility failed to ensure Resident #54 received a magic shake and fortified pudding as ordered by the physician 07/06/2026. This failure could place residents at risk for poor intake, weight loss, unmet nutritional needs, choking, and aspiration (when food or drinks enter the lungs). Finding included: Record review of the face sheet dated 07/09/2026 revealed Resident #54 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnosis of major depressive disorder (severe sadness). Record review of Resident #54's care plan revision date 07/15/2024 revealed he was care planned for ADLs self-care performance deficit and is at risk of not having their needs met in a timely manner with an intervention of eating: setup and clean-up assistance. Resident #54 was care planned for nutritional status for regular large portion diet and at nutritional risk related to adult failure to thrive. Care plan intervention listed as provide, serve diet as ordered and provide and serve supplements as ordered. Record review of Annual MDS dated [DATE] revealed Resident #54 had a BIMS of 03 indicating severe cognitive impairment. MDS indicated Resident #54 had an active diagnosis of Malnutrition or risk for Malnutrition. MDS assessment indicated Resident #54 eating functional ability was setup or clean-up assistance. Record review of order summary report dated 07/09/2026 revealed Resident #54 had an order for regular diet and texture, regular consistency, plate guard, add fortified foods at all meals started on 04/10/2026. Resident #54 had an order for magic cup with meals started on 02/12/2026. Record review of meal ticket for the lunch meal dated 07/06/2026 revealed Resident #54 was supposed to receive a magic cup-1cup, fortified pudding-4oz, and plate guard. Observation on 07/06/2026 at 12:20 p.m. revealed resident sitting in the assisted dining room without his magic shake and fortified pudding. Observation revealed resident did not receive his order and only ate about 50% of his plate. Interview on 07/06/2026 at 12:23 p.m., Resident #54 stated that he was supposed to get a magic shake and fortified pudding. Interview on 07/06/2026 at 12:35 p.m., NA G revealed on multiple occasions Resident #54 had not received his prescribed magic shake and fortified pudding. NA G stated that Resident #54 did not require assistance with meals but did have nutritional supplements for weight loss. Interview on 07/06/2026 at 3:35 p.m., LVN D stated that she was not aware Resident #54 did not receive his ordered magic shake and fortified pudding. LVN D stated that the magic shake and fortified pudding was prescribed for weight loss and to prevent weight loss. LVN D stated that Resident #54 was at further risk of weight loss because he did not receive his prescribed therapeutic diet. Interview on 07/09/2026 at 1:30 p.m., the Registered Dietitian stated Resident #54 magic shake and fortified pudding was ordered and it was there for a reason. The Registered Dietitian stated the magic shake and fortified pudding was for malnutrition and high risk of weight loss. The Registered Dietitian stated she expected the facility to provide the magic shake and fortified pudding according to the order. Interview on 07/09/2026 at 3:09 p.m., the Dietary Manager revealed she expected Resident #54 to receive the correct therapeutic diet. The Dietary Manager stated that it was on the ticket and he was supposed to receive the magic shake and fortified pudding. The Dietary Manager stated she was responsible for placing the shake and fortified pudding on the tray. The Dietary Manager stated Resident #54 was at risk of not receiving the proper nutrition and weight loss. Interview on 07/09/2026 at 4:14 p.m., the DON stated she was not aware that Resident #54 was not offered or provided his shake or pudding. The DON said Resident #54 was at (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risk of weight loss and poor appetite. Interview on 07/09/2026 at 4:46 p.m., the Administrator stated she expected Resident #54 to receive his therapeutic diet according to physician order. The Administrator stated the diet should have been provided by dietary. The Administrator stated that the nurses were responsible for checking the trays. Record review of Menu Planning Guidelines and Procedure dated 7/12/2024 revealed menus will be followed and served as written. If a menu change or substitution is necessary, the Menu Change or Substitution Policy will be followed. A substitution log should be completed by the DSM as needed and then presented to the consulting RD for review/signature. Record review of following physician orders revised on 9/28/2021 revealed for consulting physician/practitioner orders received via telephone, the nurse will: a. Document the order on the physician order form, notating the time, date, name and title of the person providing the order, and the signature and title of the person receiving the order. b. Follow facility procedures for verbal or telephone orders including noting the order, submitting to pharmacy, and transcribing to medication or treatment administration record. c. Carry out and implement physician orders Record review of Diet, Nutrition, and Hydration policy dated 3/2016 revealed Diet order: A diet order is a prescription written by the attending Physician, Practitioner or Registered Dietitian to change a resident's diet or establish a diet for a new admission. Diets may be liberalized to allow more freedom in meal selection. Therapeutic and calorie restricted diets are available for residents who are not candidates for liberalized diets. Diet textures and fluid consistencies are ordered or changed by the Speech Language Pathologist. House Supplements: The physician, practitioner or Dietitian may choose to order House supplements to provide residents with additional Calories and Protein. The term house supplement will cover all items listed in the supplement rotation guide, this allows for rotating of various supplements and foods, so that residents do not become dissatisfied with the same shake day after day. The physician order should state frequency of the supplement. All procedures for supplements should be followed. One serving will be provided per ordered supplement.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals for 1 resident reviewed (Resident #54) for special eating equipment and assistance when consuming meals. The facility failed to provide Resident #54's physician ordered plate guard on 07/06/2026. These failures could place residents at risk for weight loss, diminished independence, and self-esteem. Findings included: Record review of face sheet dated 07/09/2026 revealed Resident #54 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnosis of major depressive disorder (severe sadness). Record review of care plan for Resident #54 revision date 07/15/2024 revealed he was care planned for ADLs self-care performance deficit and was at risk of not having his needs met in a timely manner with an intervention of eating: setup and clean-up assistance. Resident #54 was care planned for nutritional status for regular large portion diet and was at nutritional risk related to adult failure to thrive. Care plan intervention listed as provide, serve diet as ordered and provide and serve supplements as ordered. Record review of Annual MDS dated [DATE] revealed Resident #54 had a BIMS of 03 indicating severe cognitive impairment. MDS indicated Resident #54 had an active diagnosis of Malnutrition or risk for Malnutrition (body is not getting the right balance of protein or calorie nutrients). MDS assessment indicated Resident #54 eating functional ability was setup or clean-up assistance. Record review of order summary report dated 07/09/2026 revealed Resident #54 had an order for regular diet and texture, regular consistency, plate guard, add fortified foods at all meals started on 04/10/2026. Record review of meal ticket for the lunch meal dated 07/06/2026 revealed Resident #54 was supposed to receive a plate guard. Observation on 07/06/2026 at 12:32 p.m., Resident #54 did not receive a plate guard until surveyor intervention. Observation revealed Resident #54 had food falling off his plate. Interview on 07/06/2026 at 12:35 p.m., Resident #54 stated that sometimes he did not receive the plate guard. Resident #54 stated that it helped him eat his food. Interview on 07/06/2026 at 12:40 p.m., NA G stated that she had told the Dietary staff that he needed a plate guard multiple times and frequently he does not receive the plate guard. NA G stated that Resident #54 needed the plate guard to assist him in eating due to weight loss. Interview on 07/06/2026 at 3:35 p.m., LVN D stated that she was not aware Resident #54 did not receive his ordered plate guard. LVN D stated that the plate guard was prescribed for assistance in eating and to prevent weight loss. LVN D stated that Resident #54 was at further risk of weight loss because he did not receive his prescribed therapeutic assistive device. Interview on 07/09/2026 at 1:35 p.m., the Registered Dietitian stated Resident #54 cannot feed himself appropriately without the plate guard. The Registered Dietitian stated that she expected the facility to provide a plate guard to Resident #54 every meal. The Registered Dietitian stated Resident #54 was at risk of malnutrition because Resident #54 was not able to adequately feed himself. Interview on 07/09/2026 at 3:09 p.m., the Dietary Manager revealed she expected Resident #54 to receive his plate guard. The Dietary Manager stated she expected Resident #54 meal ticket to be followed. The Dietary Manager stated cook and herself were responsible for the plate guard. The Dietary Manager stated that she was the Dietary Aide during the Lunch meal and the plate guard was not given on accident. The Dietary Manager stated that the plate guard was an assistive device used to assist Resident #54 in eating and Resident #54 was at risk of weight loss. Interview on 07/09/2026 at 3:40 p.m., the DON stated that the plate guard was to keep (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the food on the plate and assist Resident #54 in eating. The DON stated that it was the nurses responsibility to check the trays prior to Resident #54 receiving his food. The DON stated that she was in the dining room when Resident #54 did not receive the plate guard and she was unable to explain why he did not receive the plate guard. Record review of adaptive eating devices policy dated 7/22/2021 revealed the facility must provide special eating equipment and utensils for residents who need them. If the resident has been seen by an Occupational Therapist, they may have recommended specific equipment and purchased these items for the resident. Food and Nutrition services should also keep extra pieces of all equipment needed by residents so that it can be washed and sanitized each meal. The therapy department can help to determine what equipment is needed. At a minimum food and nutrition services should keep on hand, deep dish divided plates or plate guards, sippy cups and variety of adaptive		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medical record was complete and accurately documented for 1 of 4 residents (Resident #11) reviewed for resident records. The facility failed to provide documentation of Resident #11's Habilitation Coordination and Behavior Support services. This failure could place residents at risk for not receiving appropriate care due to incomplete/inaccurate information being documented. Findings included: Record review of Resident #11's face sheet, dated 07/09/26, reflected Resident #11 was a [AGE] year old male, admitted to the facility on [DATE] with diagnoses which included Bipolar (a mental health condition characterized by extreme, recurring shifts in mood, energy, and activity levels), seizures and rhabdomyolysis (a serious medical condition involving the rapid breakdown of damaged skeletal muscle). Record review of Resident #11's annual MDS dated [DATE] indicated he was considered by the state level II PASRR process to have intellectual disability. The MDS also indicated Resident #11 usually made himself understood and understood others and he had a BIMS score of 15 which meant he was cognitively intact. Record review of Resident #11's comprehensive care plan, revised 06/10/26, reflected Resident #11 had identified that he needed specialized services due to history of intellectual disabilities (ID), and epilepsy (DD). The care plan interventions included: an IDT (Interdisciplinary Team) meeting would be conducted with the designated Local Intellectual and Developmental Disability Authority (LIDDA) and Local Mental Health Authority (LMHA) representative annually and as needed for significant changes in status and specialized services determined to be necessary by the IDT will be initiated. Record review of the PCSP meeting dated 03/20/26 reflected that Habilitation Coordination and Behavior Support Coordinator was recommended for Resident #11. Record review of Resident #11's EMR dated 07/07/26 reflected no documentation of Habilitation Coordination or Behavior Support Coordinator notes. During an interview on 07/09/26 at 3:43 p.m., Resident #11 was unable to answer questions when asked about habilitation services he was receiving. During a telephone interview on 07/09/26 at 4:37 a.m., the Habilitation Supervisor said the Habilitation agent and Behavior Support agent came to the facility monthly to get a report from Resident #11 to ensure his needs were met. She said Resident #11 had a quarterly meeting on 06/24/26. She said the Habilitation agent saw Resident #11 for a face-to-face meeting on 03/20/26, 04/16/26 and 05/19/26. She said the Behavior Support agent last visited on 03/10/26. She said the Behavior Support agent was no longer employed and the position had not been filled. The Habilitation Supervisor said they did not leave any documentation for the monthly visits at the facility. The Habilitation Supervisor said she was not sure if the Habilitation agent or Behavior Support agent followed up with the nurses after each visit to see if there were any concerns with his care but assumed they did. During an interview on 07/09/26 at 5:28 p.m., The SW said she was responsible for ensuring visits were conducted by the Habilitation Coordinator and the Behavior Support Coordinator. The Social Worker said she was not aware when the last Behavior Coordinator came to visit but she believed the Habilitation Coordinator came about every 1-2 months. The Social Worker said staff did not coordinate with habilitation after their visits. The Social Worker said they did not have a system in place to ensure Resident #11 was receiving his PASRR services. The Social Worker said it was important for them to receive documentation after every visit to ensure the residents were receiving services. She said residents should receive PASRR services if they qualify because it was their right and it enhanced their quality of life. During an interview on 07/09/26 at 5:34 p.m., the DON said she did (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not know the PASRR services Resident #11 should have received. The DON said she had attended 1 PCSP meeting in the past but was not familiar with the process. She said she did not know the system on how or when they visited but she expected some type of documentation to be provided after every visit to show they were in the facility. She said the Social Worker was the overseer for PASRR. The DON said it was important to ensure residents were receiving PASRR services. During an interview on 07/09/26 at 6:09 p.m., the Administrator stated he did not know what services Resident #11 was receiving. She said the Social Worker was the oversee of PASRR. The Administrator said there was not a system in place to monitor the Social Worker oversight of the PASRR needs. The Administrator said it was important to receive documentation to ensure Resident #11 was receiving his services because it could benefit him. Record review of the facility's undated policy titled PASRR Rational, dated 01/25/26, indicated, Purpose: The aim of the PASRR program is to identify residents with Mental Illness (MI), Intellectual Disability (ID) or Developmental Disability (DD)/Related Conditions (RC) and to ensure they are properly placed, whether in community or in a Nursing Facility (NF) and to ensure they receive the services they require for their MI, or ID/DD. The IDT Meeting Process: The IDT will review and discuss the recommended Specialized Services on the PE and come to an agreement on which specialized services the resident needs. The IDT will identify the most appropriate entity to provide those services and will follow-up to ensure they are provided to the residents.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure the quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 2 of 3 (Resident #8 and Resident #9) residents receiving hospice services. 1.The facility failed to obtain Resident #8's most recent updated hospice IDG meeting notes, hospice medication list, and hospice plan of care.2. The facility failed to obtain Resident #9's most current Interdisciplinary Group Meeting.These failures could place residents who receive hospice services at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. Findings include: Record review of Resident #8's face sheet dated 07/09/26indicated she admitted to the facility on [DATE]. She had diagnoses of congestive heart failure also known as CHF (a chronic condition in which the heart cannot pump blood effectively to meet the body's needs), essential hypertension (condition where the force of blood against the artery walls is consistently too high), and anxiety (a feeling of worry, nervousness, or unease). Record review of Resident #8's quarterly MDS dated [DATE], reflected she made herself understood and understood others with a BIMS score of 4 which indicated severely impaired cognition. MDS indicated Resident #8 received hospice care. Record review of resident care plan initiated on 04/28/25 indicated resident has a terminal illness and was receiving hospice services or palliative care. Record review of Resident #8's physician order dated 01/22/25 revealed, admit to (unnamed) hospice with the diagnosis of CHF. Record review of Resident #8's physician order dated 05/25/25 revealed, Ativan oral tablet 0.5 milligrams (Lorazepam), give 0.5 tablet by mouth every 8 hours as needed for anxiety. Record review of Resident 8's hospice binder did not reveal the updated medication plan, plan of care, or IDG meetings. The binder indicated the medication list was last updated 05/19/26 and did not include the Ativan. The plan of care was last updated 05/19/26, and the IDG meetings were not in the binder. During an interview on 07/09/26 at 9:15 a.m. the Hospice Director said the IDG meetings were held every Thursday and Resident #8's most recent meeting was held on 07/01/26. She said updated information was usually provided to the facility within the next week. She said the business development was responsible for bringing the information to the facility and place the updated information in the hospice binder. She said it was important to have updated information so if the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility looked, they could see the information was updated and it helped ensure coordination of care. She said she expected the binder to be updated every 2 weeks after the IDG meetings. During an interview on 07/09/26 at 5:20 p.m., LVN A said the hospice binder should contain contact information, care plan, medications, emergency information, and face sheets. She said she thought the hospice nurse was responsible for updating the hospice binder. She said hospice staff came by 3 times a week but did not know how often the binder was updated. She said it was important for the information to be updated for continuity of care, and so everyone could be on the same page about Resident #8's care. During an interview on 07/09/26 at 5:40 p.m., the DON said the hospice plan of care, medications, and IDG meetings should be in the hospice binder. She said hospice kept their information in the binders, and hospice staff signed in when they visited the resident. She said she tried to check the binders monthly but was not doing an effect job since things were missing from the binder. She said it was important to have updated information in the binder to make sure everyone was on the same page. During an interview on 07/09/26 at 6:13 p.m., the Administrator said hospice progress notes, diagnosis, updates, changes to medications, consents, resident face sheet, and demographics should be in the hospice binder. She said it was the hospice staff's responsibility to update the information, and the facility nurses should ensure it was updated. She said she does not know how often the binders were updated but assumed as needed. She said the information was needed for caring for the residents. She said when hospices staff brought added information, they did not let anyone know specifically what was being updated. She said they usually just say they updated the binder. 2.Record review of the face sheet dated 07/09/2026 revealed Resident #9 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnosis of Huntington's disease (progressive break down of the nerve cells in the brain). Record review of the care plan dated 06/28/2026 revealed Resident #9 was care planned for terminal prognosis related to Huntington disease with hospice care with the intervention to coordinate with hospice to ensure the resident's spiritual, emotional, intellectual, physical, and social needs are met. Record review of the Quarterly MDS dated [DATE] revealed Resident #9 received hospice care. MDS assessment indicated Resident #9 had a BIMS score of 15 indicating Resident #9 had no cognitive impairment. Record review of Resident #9's hospice binder revealed no intradisciplinary group meeting documentation located in the hospice binder. During an interview on 07/08/2026 at 11:35 a.m., the RN K stated that she was unsure who reviewed the hospice binders. RN K stated that the binder was used to coordinate care between hospice and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility. RN K stated that it was not her responsibility to check the binders or place the required documentation in the binders. During an interview on 07/08/26 at 1:30 p.m., the Hospice RN stated that she was responsible for bringing the IDG meeting notes to the facility, however, she had not. Hospice RN stated that the IDG meeting was to ensure all parties of Resident #9 care were coordinated and all followed according to the plan of care. Hospice RN stated that Resident #9 was at risk of not receiving the care that was intended for him according to his care plan. Interview on 07/08/26 at 2:30 p.m., the DON stated that she was responsible for reviewing the hospice binders. The DON stated that when she reviewed the hospice binders, she was unsure what the required documents were. The DON stated that the binder was to ensure that each resident receiving hospice services was coordinating with hospice. Interview 07/09/26 at 4:48 p.m., the Administrator stated that she expected the binders to be updated according to the care plan and interdisciplinary group meeting. The binder was to ensure care was provided according to orders. The Administrator stated that she expected the DON to check and ensure the binders were up to date. Record review of the Coordination of Hospice Services policy dated 3/12/2022 revealed the facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care. Record review of the facility's policy titled Coordination of Hospice Services, dated 03/12/22, indicated Policy Explanation and Compliance Guidelines: 2. The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goals, and recognized standards of practice in consultation with the resident's attending physician/practitioner and resident's representative, to the extent possible.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public, for 1 of 6 resident's rooms (Resident #5) and 1 of 4 halls (300 hall) reviewed for physical environment. The facility failed to secure loose flooring under Resident #5's bed and wallpaper behind the headboard in Resident #5's room. The facility failed to secure loose baseboard in the hallway of hall 300. These failures could affect all residents, staff, and the public by placing them at risk of not having a safe, clean, sanitary, and comfortable environment. Findings included 1. Record review of Resident #5's face sheet, dated 07/09/26, indicated a [AGE] year-old female who was re-admitted to the facility on [DATE] with diagnoses which included Atrial fibrillation, also known as heart failure (a heart condition characterized by an irregular and often rapid heartbeat), Dementia (a general term for the loss of thinking, remembering, and reasoning abilities), and lack of coordination. Record review of Resident #5's quarterly MDS assessment, dated 06/26/26, indicated Resident #5 26 made herself understood and was understood by others. Her BIMS score was a 13, which indicated she was cognitively intact. The MDS indicated she required maximal assistance for bathing, bed mobility, dressing, and transferring. Record review of Resident #5's care plan revised 06/07/22 indicated Resident #5 had an ADL self-care performance deficit requiring total assistance with bathing. The interventions were for staff to provide shower, shave, oral care, hair care, and nail care per schedule and when needed. During an observation and interview on 07/06/26 at 11:14 p.m., Resident #5 was in bed. She said her floors had been coming apart for unknown period. She pointed at the wallpaper and said it had been coming down as well. She said she did not like the look of the wall or the floor tile. During an observation on 07/06/26 at 11:15 a.m., it was revealed that the flooring under Resident #5's bed and wallpaper behind the headboard in Resident #5's room were coming loose. During an observation and interview on 07/06/26 at 11:26 a.m., CNA C said the tile on the floor had been coming up for months, and the peeling of the wallpaper had been an on and off issue. She said the Maintenance Supervisor had fixed the wallpaper before, but it kept coming down. She said any maintenance issues were to be written in the maintenance book. She said she thought the Maintenance Supervisor was aware of the floor tile since it had been there for months. During an observation on 07/06/26 at 1:47 p.m., the baseboard was noted to be peeling away from wall by room [ROOM NUMBER] on Hall 300. During an interview on 07/06/26 at 2:00 p.m., LVN A said she had not noticed the tile on the floor peeling up in Resident #5's room. She said she noticed the wallpaper peeling on the wall. She said she had not reported it to the maintenance Supervisor but she would. During an interview on 07/07/26 at 11:20 a.m., the Maintenance Supervisor said he was not aware of floor tile or wallpaper coming a loose in Resident #5's room. He said he was not aware of the base board coming loose from the wall by room [ROOM NUMBER]. He said he would look at those items. He said he expected staff to write any issues they saw that requires his attention in the maintenance book. During an interview on 07/07/26 at 1:22 p.m., the Maintenance Supervisor said he fixed the baseboard and wallpaper in Resident #5's room. He said he would have to order the tile for Resident #5's floor. During an interview on 07/09/26 at 3:20 p.m., Resident #5 said she did not like seeing her floor coming apart and her wallpaper peeling. She said she was happy the floor had been fixed and was ready for the wallpaper to be completed. She said staff were aware and she thanked the surveyor. During an interview on 07/09/26 at 5:34 p.m., the DON said she expected staff to report any building issues to the maintenance man. She said (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff were supposed to write about any issues in the maintenance book as soon as they saw them. She said it was important to have a safe and homelike environment to prevent residents from feeling uncomfortable in their own home. During an interview on 07/09/26 at 6:09 p.m., the Administrator said she did not expect floor tile or wallpaper to come loose. She said she expected staff when they saw any issues such as wallpaper or tile coming loose to place it in the maintenance book. She said the Maintenance Supervisor was the oversee of the building repairs. She said it was important for all residents to have a safe and homelike environment. Record review of the facility's policy titled, Resident Rights, revised 02/20/21, revealed, 8. Safe environment. The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Record review of the facility's policy titled, Maintenance Inspection, revised 04/11/22, revealed, Policy: It is the policy of this facility to utilize a maintenance inspection checklist in order to assure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Policy Explanation and Compliance Guidelines: 1. The Director of Maintenance Services will perform routine inspections of the facility. 3. All opportunities will be corrected immediately by maintenance personnel. 4. The maintenance repair log will be reviewed daily to identify items for inspection and/or repair. 5. The Maintenance will review repairs completed in the Morning Meeting.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4910 Wellington 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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to follow their own established smoking policy for the 1 of 2 residents (Resident #40) reviewed for smoking policies. The facility failed to follow the smoking policy and ensure Resident #40 had a safe smoking evaluation completed quarterly. This failure could place residents at risk of an unsafe smoking environment and an increased risk of injury related to smoking. Finding included: Record review of face sheet dated 07/09/2026 revealed Resident #40 was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of dementia (loss of memory, thinking, and reasoning skills). Record review of care plan dated 01/26/2024 revealed Resident #40 was a smoker and was at risk of injury. Resident #40 was a dependent smoker and required direct supervision to smoke. Resident #40 interventions included to perform smoking assessment according to facility policy. Record review of Quarterly MDS dated [DATE] revealed Resident #40 had a BIMS of 15 indicating no cognitive impairment. MDS assessment indicated Resident #40 had upper extremity impairment to both sides range of motion. Record review of Smoking Evaluation dated 03/09/2026 revealed resident was a dependent smoker required assistance and supervision to smoke. Record review revealed no updated Smoking Evaluation. Observation on 07/06/2026 at 1:45 p.m. revealed Resident #40 smoking. It was observed Resident #40 having difficulty holding the cigarette in his hand. Interview on 07/06/2026 at 2:45 p.m., Resident #40 stated that he was a smoker and went out on some smoking breaks but not all. Resident #40 stated that he smoked with observation and had no difficulty smoking. Interview on 07/06/2026 at 1:50 p.m., LVN D stated there were no residents that wore an apron at smoke break. LVN D stated she was unsure when smoking assessments were completed but knew they were done on admission. LVN D stated that all smoking residents were assessed to ensure they were safe smokers. 07/09/2026 3:51 p.m., RN K stated that nursing and the social work were responsible for safe smoking assessments. RN K stated smoking assessments were to be done on admission, change of condition, and quarterly. RN K stated Resident #40 should have had a safe smoking assessment at least quarterly to ensure he was a safe smoker. RN K stated that he was at risk of not being a safe smoker, burning himself or others. 07/09/2026 4:17 p.m., the DON stated Smoking Evaluation assessments were to be done quarterly according to the policy. She stated Resident #40 was at risk of change in assessment indicating a change in the ability of smoking. The DON stated assessments were supposed to be completed to ensure safe smoking and that the staff were aware of Resident #40 ability to smoke and recognize danger and fire. Interview on 07/09/2026 4:50 p.m., the Administrator stated she expected smoking assessments to be completed quarterly and according to policy. The Administrator stated smoking assessments were to be completed to ensure safe smoking. The Administrator stated smoking assessments were to be completed primarily by nursing and the social worker could assist. The Administrator stated smoking assessments were also done to ensure staff were aware of what precautions were needed for each resident. The Administrator stated that Resident #40 was at risk of needing changes to his assessment, burning himself, or burning other residents around him. Record review of smoking policy dated revision 7/14/2024 revealed the facility must evaluate patients that smoke/use smokeless tobacco, utilizing the Smoking Evaluation/Smokeless Tobacco Tool: (a) upon admission; (b) quarterly (c) when a previous non-smoking patient takes up smoking or when a patient takes up the use of smokeless tobacco (d) if unsafe smoking practices are observed in a current smoker; or a smokeless Tobacco user can no longer manage the use of, or cleaning/storage abilities.		