STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675267	A. Building B. Wing	10/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Nursing & Rehabilitation Center of Tyle	3526 W Erwin St Tyler, TX 75702

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35340 Based on interview and record review, the facility failed to protect the residents' right to be free from verbal abuse by staff for 1 of 9 residents reviewed for abuse. (Resident #2) The facility failed to ensure Resident #2 was free from abuse when CNA B told Resident #2 to shut up on 11/25/23. This failure could place the residents at risk for increased risk for abuse and neglect. Findings included: Record review Resident #2's admission record, printed on 11/27/23, indicated he was a [AGE] year old male who admitted to facility on 1/27/23 with diagnoses including quadriplegia (a condition that causes the complete or severe loss of motor function in all four limbs), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), post laminectomy syndrome (means that a person is experiencing pain, and that they had a prior spinal surgery), acute and chronic respiratory failure with hypoxia (can occur when there's a problem with gas exchange between the lungs and blood, leading to low oxygen levels in the blood), hypertension (aka high blood pressure - when the pressure in your blood vessels is too high), mild intellectual disability (a neurodevelopmental disorder that affects a person's intellectual functioning and adaptive behavior. People with MID have an average mental age of 9-12 and an IQ of 52-69. They may have a slower rate of development in social, conceptual, and daily living skills) and autistic disorder (a developmental disability that affects how people communicate, interact with others, learn, and behave). Record review of Resident #2's quarterly MDS dated [DATE] indicated he had clear speech but had difficulty communicating some word or finishing thought but was able if prompted per given time; had clear comprehension. Resident #2 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated he had moderately impaired cognition. He required extensive assist with bed mobility, transfers, dressing, eating, personal hygiene and toileting. Resident #2 was incontinent of bladder and bowel. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675267	A. Building B. Wing	10/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Nursing & Rehabilitation Center of Tyle	3526 W Erwin St Tyler, TX 75702

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's progress note dated 11/27/23 typed by facility's SW revealed [Resident #2] approached SW in hallway to discuss an event that occurred on Saturday evening. SW ensured that no other residents or staff members were nearby and asked for [Resident #2] to explain what had occurred. [Resident #2] stated that a staff member had come into his room around 8pm on Saturday 11/25/23 evening when both patient and his roommate were present in the room and 'took my rights away'. SW requested for [Resident #2] to elaborate on this statement, to which [Resident #2] repeated that the staff member, had 'taken my rights away' and 'got into my face and told me to shut up'. [Resident #2] stated the staff member had made another aggressive statement to him, though SW could not understand [Resident #2's] speech even after asking [Resident #2] to repeat this statement. [Resident #2] could not identify the name of nor describe what this staff member looked like aside from using feminine pronouns to refer to this staff member and stating that he, 'did not see her yesterday' referring to Sunday 11/26/23. [Resident #2] denied being physically harmed and stated this incident had only occurred the one time. SW stated they would speak with the appropriate authorities to handle this report. [Resident #2] did not have further related concerns at [that] time. Following this conversation [Resident #2] reported this concern to the Administrator. SW then called [Resident #2's] RP to inform him that [Resident #2] had reported that a staff member had been verbally aggressive to him this weekend and that the Administrator was already informed and would begin investigation this report. [Resident #2's RP] stated [Resident #2] had not made mention of having any recent issues with staff though asked SW to keep him informed about the results of this investigation, to which SW agreed they would. Record review of facility's undated typed investigation summary revealed Incident: Allegation of verbal abuse; Date occurred: November 25, 2023, but reported on November 27, 2023 .at around 3:30pm, on November 27, 2023, .The payroll was reviewed and there was only one female employee who worked Saturday but not Sunday, [CNA B]. [CNA B] was scheduled off on Monday and scheduled to come in and give a statement and receive her suspension on Tuesday but called out sick. On Wednesday, November 29th, [CNA B] came in to speak with the administrator. [CNA B] was told that Resident #2 had alleged that she had gotten in his face and told to shut up to which she replied 'I probably did tell him to shut up but I didn't get up in his face'. [CNA B] was asked to put her statement in writing and then she received her suspension and asked to leave the building. In her statement, [CNA B] stated that she had gone into the resident's room because he was 'going on' about his mouth and she told him to be quiet. She also stated that she was not 'up in his face but standing on the side of the bed'. Due to [CNA B's] confession that she probably did tell him to shut up, the facility is substantiating the allegation, and [CNA B] will be terminated from her position. Actions taken by the facility: A psychosocial well-being assessment was conducted by the [SW]. [Resident #2] was not showing any signs of increased anxiety or sadness. [Resident #2] continued his normal day to day routines without any signs of decline. Abuse and neglect in-service conducted. Facility [SW] to follow up to assure no decline or distress as a result of the alleged incident. During an interview on 9/30/24 at 5:03 p.m., The SW said the incident between Resident #2 and CNA B happened so long ago, but she recalled Resident #2 telling her a staff member who they later learned was CNAB told him to shut up and she reported it to the Administrator. The SW said she could recall Resident #2 being precise and consistent with the story and she could tell that time was different from previous times and Resident #2 was serious regarding what had happened to him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675267	A. Building B. Wing	10/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Nursing & Rehabilitation Center of Tyle	3526 W Erwin St Tyler, TX 75702

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/6/24 at 11:55 a.m., The Administrator said she was the abuse coordinator and followed their abuse policy, did criminal history checks upon hire, did in-services with her staff and reported everything to the state. The Administrator said CNA B was terminated due to the incident and said she could not control other human behaviors. Record review of employee disciplinary report dated 12/4/23 revealed: Employee name: CNA B; Hired date: 2/10/23; Date of Infraction: 11/25/23; Type of Disciplinary Action: Discharge; Specific Reasons for Disciplinary Action: [CNA B] has failed to adhere to the Corporate Code of Conduct. On 11/28/23 [CNA B] was placed on an investigation suspension on allegations of violating resident's rights. The allegations towards [CNA B] were found to be substantiated. [CNA B] is aware of residents' rights as indicated by her signature on the employee handbook acknowledgment. Corrective Plan of Action, including time frames: Per [Facility's name] employee handbook: this employee meets criteria for termination. CNA B will be terminated effective immediately. Record review of revised abuse policy dated 9/9/24 revealed The resident has the right to be free from abuse . Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675267	A. Building B. Wing	10/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Nursing & Rehabilitation Center of Tyle	3526 W Erwin St Tyler, TX 75702

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35340 Based on interview and record review, the facility failed to ensure the right to be free from misappropriation of property was provided for 1 of 7 residents reviewed for misappropriation of property. (Resident #3) The facility failed to ensure Resident #3 was free from misappropriation of property when CNA C was caught on camera stealing snacks from Resident #3's personal refrigerator. This failure could place residents at risk for decreased quality of life, misappropriation of property, and dignity. Findings included: Record review of Resident #3's admission record, printed on 11/29/23 indicated she was an [AGE] year-old female who admitted to facility on 10/23/23 with diagnoses including senile degeneration of brain (is a condition that causes a gradual decline in cognitive abilities. It can lead to memory loss, impaired thinking, and a loss of independence in daily activities), hypertension (aka high blood pressure - when the pressure in your blood vessels is too high), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), vascular dementia(is a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain) and protein calorie malnutrition (is the state of inadequate intake of food). Record review of Resident #3's admission MDS dated [DATE] indicated she had clear speech but had difficulty communicating some word or finishing thought but was able if prompted per given time. Resident #3 had a BIMS score of 2, which indicated severe cognitive impairment. She required limited assistance with bed mobility, transfer, personal hygiene and toileting. She was frequently incontinent of bladder and occasionally incontinent of bowel. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675267	A. Building B. Wing	10/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Nursing & Rehabilitation Center of Tyle	3526 W Erwin St Tyler, TX 75702

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Administrator's typed statement dated 11/29/23 revealed Phone interview with responsible party for [Resident #3's]. Last night, at around 3:15am, [Resident #3's RP] called the facility and reported that the male aide that assisted [Resident #3] to the restroom had taken snacks from the resident's refrigerator. [Administrator] called [Resident #3's RP] this morning and asked her to give me a description of what she observed. She stated that she had been watching [Resident #3]on the camera when [Resident #3] started to get up out of bed. She told [Resident #3], through the camera speaker, to use the call light and ask for help, which she observed her [Resident #3] do. [Resident #3's RP] stated that a male aide entered [Resident #3's] room sometime between 3:05 and 3:10am. He was seen taking her to the bathroom and leaving her there, partially closing the door, and then stepped out of the room. One or two minutes later he re-entered the room, walked passed the bathroom and to [Resident #3] refrigerator. He was observed opening the refrigerator, taking an item out and putting it in his pocket. He then did this 2 more times before going into the bathroom and exiting the bathroom with the resident, helping her into bed and then he left the room. [Administrator] reviewed [facility's] camera footage, which points into the secured unit. [Resident #3's] room is the first door on the left and [Administrator] have an unobstructed view of who enters and exit this room. At 3:06[am] the employee, [CNA C], is seen sitting in the doorway of room [ROOM NUMBER], which is directly across the hall from [Resident #3] room. [CNA C] is seen getting up and entering [Resident #3's] room at 3:06am. At 3:08am he exits the room and walks across the hall to the overbed table he had been sitting at and takes a drink of his soda. At 3:09:37am [CNA C] re-enters [Resident #3's] room and then exits the room at 3:12am and returns to the chair in the doorway across the hall. [CNA C] is seen then placing his soda can and another drink on the floor next to the overbed table. The times observed on the camera support the account given by [Resident #3's RP]. Signed [Administrator]. Record review of facility's undated typed investigation summary revealed Incident: Misappropriation -Theft; . [CNA C] was notified later that morning that he needed to come in and speak with the administrator. When [CNA C] came in he was asked to give a statement regarding the incident earlier that morning. [CNA C] stated that he did indeed take some snack items out of [Resident #3] refrigerator but that he didn't take them for himself, but for the resident in room [ROOM NUMBER]. [CNA C] stated that she [resident] was hungry and that there were not any snacks available otherwise to give her. When it was explained that you cannot take from a resident for any reason he asked 'am I going to lose my job behind this?'. It was explained that an investigation was being conducted and that a decision would be made after it was completed. [CNA C] then stated that he had put the snacks back after the nurse told him that the family had called. The local police department was notified and a report was filed with an officer. The case number [number]. The family member did not see the snacks being returned and review of the facility footage showed the [CNA C] member did go back into [Resident #3] room one more time during the shift but he did not have any items in his hand when he entered. Facility is substantiating the theft and the staff member will be terminated as a result. Action taken by the facility: Social Worker conducted interviews with cognizant residents with not other issues identified. A psychosocial well-being was completed on [Resident #3] with no indication of decline or distress as a result of the event. Facility will continue to run background checks on all new hires. Facility will continue to in-service all new hires on abuse/neglect and how to report incidents. Facility completed in-service training on misappropriation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675267	A. Building B. Wing	10/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Nursing & Rehabilitation Center of Tyle	3526 W Erwin St Tyler, TX 75702

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of summary findings dated 11/30/23 and completed by SW revealed On 11/29/23 [Resident #3's family member] reported that she had witnessed a staff member take a drink from [Resident #3's] personal refrigerator without resident's consent. [Resident #3] was asleep at the time of this incident and, during a social service interview conducted on 11/30/23, reported that she did not recall this incident occurring. During discussion with [Resident #3] she denied having any concerns with staff, stating that 'everyone has been real nice here'. [Resident #3] body language was relaxed throughout this discussion. A further look at [Resident #3] electronic medical chart showed no evidence that [Resident #3] mood nor behavior had significantly changed following this incident. [Resident #3] health condition had remained stable, and hospice intervention was put into place prior to this incident occurring. Given these observation, care planning is not recommended at this time. During an interview on 10/6/24 at 11:55 a.m., The Administrator said she was the abuse coordinator and followed their abuse policy, did criminal history checks upon hire, did in-services with her staff and reported everything to the state. The Administrator said CNA C was terminated due to the incident and said she could not control other human behaviors. Record review of employee disciplinary report dated 12/4/23 revealed: Employee name: CNA C; Hired date: 11/06/23; Date of Infraction: 11/25923; Type of Disciplinary Action: Discharge; Specific Reasons for Disciplinary Action: [CNA C] has failed to adhere to the Corporate Code of Conduct. On 11/28/23 [CNA C] was placed on an investigatory suspension for allegations of misappropriation of resident funds. The allegation towards [CNA C] were found to be substantiated. Per [Facility's name] employee handbook: this employee meets criteria for termination. CNA C will be terminated effective immediately. Record review of revised abuse policy dated 9/9/24 revealed The resident has the right to be free from abuse, neglect, misappropriation of resident property, . The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675267	A. Building B. Wing	10/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Nursing & Rehabilitation Center of Tyle	3526 W Erwin St Tyler, TX 75702

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 - Few	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** 35340 Based on interview and record review, the facility failed develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet residents' mental and psychosocial needs, for 1 of 9 residents reviewed for care plans. (Resident #1) The facility failed to document Resident # 1's skin condition on her comprehensive care plan. This failure could affect residents in the facility by placing them at risk of not receiving care and services related to their identified needs to maintain or reach their highest practicable physical, mental, and psychosocial well-being. Findings included: Record review of undated admission record printed on 9/28/24 indicated Resident #1 was an [AGE] year-old female who admitted on [DATE] and discharged on [DATE] to an acute care hospital with diagnoses including Alzheimer's disease (a gradual decline in memory, thinking, behavior and social skills. These changes affect a person's ability to function), hypertension (aka high blood pressure - when the pressure in your blood vessels is too high), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), protein calorie malnutrition (happens when you are not consuming enough protein and calories. This can lead to muscle loss, fat loss, and your body not working as it usually would), dementia with behavioral disturbance (disturbances stem from anxiety or agitation that can quickly turn into verbal or physical aggression), and Cognitive Communication Deficit (Difficulty finding the right words, Trouble understanding language, Difficulty with reading). Record review of Resident #1's discharge MDS dated [DATE] indicated in section M - Skin Conditions: that Resident #1 had one or more unhealed pressure ulcer/injury that was not present upon admission. Record review of Resident #1's initial wound evaluation and management summary dated 6/6/24 indicated Resident #1 had a wound on her left ankle. and Record review of Resident #1's wound evaluation and management summaries completed by a wound physician indicated Resident #1 had a wound on her left ankle on the following dates: *6/20/24, *7/4/24, *7/11/24, *7/18/24 and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675267	A. Building B. Wing	10/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Nursing & Rehabilitation Center of Tyle	3526 W Erwin St Tyler, TX 75702

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 - Few	*7/25/24. Record review of Resident #1's revised care plan dated 7/07/24 revealed no documentation about Resident #1's skin condition or pressure ulcer/injury. During an interview on 09/30/24 at 5:13pm, The DON said both the treatment nurse and her was responsible for adding the treatments and skin conditions onto the care plans. The DON reviewed Resident #1's care plan and said she was not aware Resident #1 did not have skin conditions care planned. She said she was ultimately responsible for making sure the care plans were accurate, but she dropped the ball and did not catch Resident #1's care plan error. Record review of facility's undated comprehensive care planning policy revealed The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the 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 comprehensive assessment.