

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/13/2025
NAME OF PROVIDER OR SUPPLIER  Greenbrier Nursing & Rehabilitation Center of Tyle		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0585  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.  (continued on next page)

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure prompt efforts were made to resolve grievances for 1 of 1 residents (Residents#1) reviewed for grievances. The facility did not ensure the grievance dated 4/26/25 regarding Resident #1's showers was resolved. This failure could place resident at risk for grievances not being addressed or resolved promptly. Findings included: Record review of the face sheet dated 8/8/25 indicated Resident #1 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, hemiplegia (muscle weakness or partial paralysis on one side of the body), diabetes, contracture (a structural change in the body's soft tissues, like muscles, tendons, ligaments, or skin, that causes them to stiffen and shorten) of the left hand, and hypertension (elevated blood pressure). Record review of the MDS dated [DATE] indicated Resident #1 was usually understood by others and sometimes understood others. The MDS indicated Resident #1 had a BIMS of 99 indicating he was unable to complete the interview. The MDS indicated Resident #1 required substantial/maximum assistance with personal hygiene and bathing. Record review of the care plan last revised 5/5/25 indicated Resident #1 had an ADL self-care performance deficit with interventions including charge nurse is to monitor to ensure shower is given on scheduled shower days and PRN. Record review of the Resident Grievance Report dated 4/26/25 indicated Resident #1's family had filed a grievance regarding Resident #1 appearing not to have received a shower in several days as evidenced by noticeable body odor and foul odor to his contracted hand. The Resident Grievance Report indicated the corrective action taken was the CNA (no name specified) was instructed to shower the resident and the nurses were instructed to provide hand hygiene at this time. The Resident Grievance Report indicated the charge nurse would monitor every Tuesday, Thursday, and Friday to ensure adequate showers were given. The Resident Grievance Report indicated the grievance was resolved. Record review of Resident #1's Documentation Survey Reports dated May 2025, June 2025, and July 2025 indicated Resident #1 was scheduled for showers on Tuesdays, Thursdays, and Saturdays. The Documentation Survey Report indicated: May 2025-Resident #1 was scheduled for 14 showers and did not receive 7 of the 14 scheduled showers. Resident #1 did not receive his showers on 5/1/25, 5/3/25, 5/6/25, 5/8/25, 5/20/25, 5/24/25, and 5/27/25. June 2025-Resident #1 was scheduled for 12 showers and did not receive 6 of the 12 scheduled showers. Resident #1 did not receive a shower on 6/3/25, 6/5/25, 6/7/25, 6/10/25, 6/17/25, or 6/19/25 July 2025-Resident #1 was scheduled for 14 showers and did not receive 10 of the 14 scheduled showers. Resident #1 did not receive a shower on 7/1/25, 7/3/25, 7/5/25, 7/8/25, 7/10/25, 7/12/25, 7/19/25, 7/22/25, 7/26/25, or 7/29/25. During an interview on 8/8/25 at 3:16 p.m. Resident #1's Family said Resident #1 was still not receiving his scheduled showers even after they filed a grievance regarding him not receiving showers on 4/23/25. Resident #1's Family said she was ensured by facility staff (name unknown) this issue would be resolved when she filed the grievance but has not seen any change. Resident #1's Family still had noticeable body odor when she visits. During an interview on 8/13/25 at 9:40 a.m. LVN A said he was familiar with Resident #1. LVN A said he had been given instruction regarding monitoring to ensure residents received their showers. LVN A said monitoring of showers was done by CNAs completing shower sheets and the nurses signing the shower sheets. During an interview on 8/13/25 at 9:55 a.m. the DON said showers were documented in the electronic medical records. The DON said Resident #1's family would occasionally give him his showers. The DON said the CNAs did not document when the family gave Resident #1 his showers. The DON said the only place showers were documented was in the electronic medical records. The DON said some CNAs used to fill out paper shower sheets, but she had not seen any paper shower sheets in a long time. The DON said if a date of a scheduled shower was left blank then it meant the shower was not provided or not documented. The DON said there was not a way to prove a shower was given if it was not documented. The DON said if 8, 8 was documented on a scheduled shower day it indicated activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity. The DON said there was no way to differentiate whether or not the activity occurred or the care was provided by non-facility staff. The DON said nurses monitored to ensure showers were given with paper shower sheets, visually, verbally, and in the electronic medical records. During an interview on 8/13/25 at 10:38 a.m. the DON said they had looked and could not find any paper shower sheets for Resident #1. During an interview on 8/13/25 at 10:57 a.m. the SW said when a grievance came to her she wrote up the complaint in the electronic medical records and distributed it to the appropriate</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 hygiene were provided for 1 of 5 (Resident #1) residents reviewed for ADLs. The facility failed to ensure Resident #1 received his scheduled showers in May 2025, June 2025, and July 2025 These failures could place residents at risk of not receiving services/care and decreased quality of life. Findings Include: Record review of the face sheet dated 8/8/25 indicated Resident #1 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, hemiplegia (muscle weakness or partial paralysis on one side of the body), diabetes, contracture (a structural change in the body's soft tissues, like muscles, tendons, ligaments, or skin, that causes them to stiffen and shorten) of the left hand, and hypertension (elevated blood pressure). Record review of the MDS dated [DATE] indicated Resident #1 was usually understood by others and sometimes understood others. The MDS indicated Resident #1 had a BIMS of 99 indicating he was unable to complete the interview. The MDS indicated Resident #1 required substantial/maximum assistance with personal hygiene and bathing. Record review of the care plan last revised 5/5/25 indicated Resident #1 had an ADL self-care performance deficit with interventions including charge nurse is to monitor to ensure shower is given on scheduled shower days and PRN. Record review of Resident #1's Documentation Survey Reports dated May 2025, June 2025, and July 2025 indicated Resident #1 was scheduled for showers on Tuesdays, Thursdays, and Saturdays. The Documentation Survey Report indicated: May 2025-Resident #1 was scheduled for 14 showers and did not receive 7 of the 14 scheduled showers. Resident #1 did not receive his showers on 5/1/25, 5/3/25, 5/6/25, 5/8/25, 5/20/25, 5/24/25, and 5/27/25. June 2025-Resident #1 was scheduled for 12 showers and did not receive 6 of the 12 scheduled showers. Resident #1 did not receive a shower on 6/3/25, 6/5/25, 6/7/25, 6/10/25, 6/17/25, or 6/19/25. July 2025-Resident #1 was scheduled for 14 showers and did not receive 10 of the 14 scheduled showers. Resident #1 did not receive a shower on 7/1/25, 7/3/25, 7/5/25, 7/8/25, 7/10/25, 7/12/25, 7/19/25, 7/22/25, 7/26/25, or 7/29/25. During an interview on 8/13/25 at 9:40 a.m. LVN A said he was familiar with Resident #1. LVN A said he had been given instruction regarding monitoring to ensure residents received their showers. LVN A said monitoring of showers was done by CNAs completing shower sheets and the nurses signing the shower sheets. LVN A said he was not aware of Resident #1 refusing any showers. LVN A said the importance of residents receiving their scheduled showers was to maintain hygiene and for skin inspections. During an observation on 8/8/25 at 12:35 p.m. Resident #1 was lying in bed with the head of the bed elevated and sleeping. Resident #1 was observed to covered from feet to shoulders with a sheet and blanket. During an interview on 8/13/25 at 9:47 a.m. CNA B said he worked the 2:00 p.m. to 10:00 p.m. shift at the facility. CNA B said he was familiar with Resident #1. CNA B said he was not sure of what days were Resident #1's shower days but his showers were usually given early in the shift. CNA B said Resident #1 did not refuse showers. CNA B said showers were documented in the electronic medical records. CNA B said the facility had a paper shower schedule but there was not a place to check off on the paper shower schedule. CNA B said paper shower sheets were not filled out when showers were given. CNA B said all charting was done electronically. CNA B said facility CNAs provided showers to Resident #1 most of the time. CNA B said Resident #1's family provided his showers some of the time. CNA B the importance of resident receiving their scheduled showers was to maintain humanity, keep them comfortable, and for hygiene. During an interview on 8/13/25 at 9:55 a.m. the DON said showers were documented in the electronic medical records. The DON said Resident #1's family would occasionally give him his showers. The DON said the CNAs did not document when the facility gave Resident #1 his showers. The DON said the only place showers were documented was in the electronic medical records. The DON said some CNAs used to fill out paper shower sheets, but she had not seen any paper shower sheets in a long time. The DON said if a date of a scheduled shower was left blank then it meant the shower was not provided or not documented. The DON said there was not a way to prove a shower was given if it was not documented. The DON said if 8, 8 was documented on a scheduled shower day it indicated activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity. The DON said there was no way to differentiate whether or not the activity occurred, or the care was provided by non-facility staff. The DON said nurses monitored to ensure showers were given with paper shower sheets, visually verbally, and in the electronic medical records. The DON</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, 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 1 of 2 staff (CNA C) and 1 of 5 residents (Resident #2) reviewed for infection control. The facility failed to ensure CNA C changed gloves and performed hand hygiene during Resident #2's incontinent care. These failures could place residents and staff at risk for cross-contamination, spread of infection and could potentially affect all others in the building. Findings Include:Record review of the face sheet dated 8/8/25 indicated Resident #2 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including senile degeneration of the brain, dementia, anxiety, and hypertension (elevated blood pressure). Record review of the MDS dated [DATE] indicated Resident #2 usually understood others and was usually understood by others. The MDS indicated Resident #2 had a BIMS of 05 and was severely cognitively impaired. The MDS indicated Resident #2 was dependent for toileting. Record review of the care plan last revised 4/3/25 indicated Resident #2 had an ADL self-care performance deficit with intervention including requiring extensive assistance of 2 staff members for toileting. During an observation on 8/8/25 at 1:32 p.m. CNA C performed a mechanical lift (a device designed to safely move individuals with limited mobility from one position to another, reducing risk of injury to both the patient and caregiver) transfer and incontinent care with assistance from CNA D on Resident #2. CNA C had gloves on when surveyor entered Resident #2's room. After CNA C transferred Resident #2 to her bed, she did not change her gloves or perform hand hygiene. CNA C pulled down Resident #2's pants and opened her brief. CNA C did not change gloves or perform hand hygiene. CNA C used disposable wipes to wipe Resident #2's pelvic and vaginal area. CNA C and CNA D rolled Resident #2 on her side and CNA C rolled the wet brief and mechanical lift pad up. CNA C did not change her gloves or perform hand hygiene. CNA C used disposable wipes to wipe Resident #2's bottom. CNA C did not change gloves or perform hand hygiene. CNA C put clean brief under Resident #2. CNA C and CNA D rolled Resident #2 on to her other side. CNA D removed the rolled up wet brief and mechanical lift pad and bagged the items in separate trash bags. CNA C rolled Resident #2 back on to her back and fastened the clean brief. CNA C changed Resident #2 into clean clothing. During an interview on 8/8/25 at 1:50 p.m. CNA C said gloves should be changed when providing care and going from dirty to clean or from one area to another. CNA C said she probably should have changed her gloves after transferring Resident #2 and before starting incontinent care. CNA C said she should have changed her gloves after wiping Resident #2 and before putting on a clean brief. CNA C said she did not change her gloves or perform hand hygiene while providing care because she was nervous with the surveyor watching her. CNA C said the importance of changing gloves and proper hand hygiene was to prevent the spread of bacteria and for infection control. During an interview on 8/13/25 at 11:15 am the DON said during incontinent care she expected staff to change their gloves and perform hand hygiene after removing the dirty brief and cleaning the resident prior to putting on a clean brief and changing the resident into clean clothes. The DON said she expected staff to change gloves and perform hand hygiene after performing a mechanical lift transfer and prior to providing incontinent care. The DON said the importance of changing gloves and performing hand hygiene was to prevent cross contamination and for infection control. Record review of the facility's undated Fundamentals of Infection Control Precautions policy indicated, A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility.Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene.Before and after assisting a resident with toileting.After handling soiled or used linens, dressings, bedpans, catheters, and urinals.After removing gloves or aprons.Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections. Record review of the facility's Perineal (the area of skin and tissue between the vulva (the external female genital organs) (in females) or scrotum (in males) and the anus) Care policy dated 4/25/22 indicated, An incontinent resident of urine and/or bowl should be identified, assessed, and provided appropriate treatment and services to restore as much normal bladder/bowel function as possible.Procedure Content.Start: 10. Perform Hand Hygiene 11. [NAME] (put on) gloves and all other PPE per standard precautions.Back.21. Gently perform care to the buttocks and anal area, working from front to back without contaminating the perineal area 24. Doff (take off) gloves and PPE 25. Perform Hand Hygiene. Conclude</p>		