| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675267 | A. Building<br>B. Wing | 12/18/2024 |

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

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|---|---|
| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27140<br><br>Based on interview and record review the facility failed to ensure accurate assessments were completed for 7 of 20 residents (Residents #16, #19, #29, #30, #34, #41, and #53) reviewed for accuracy of assessments.<br><br>The facility failed to ensure Residents ##16, #19, #29, #30, #34, #41, and #53's MDS assessment was accurately coded for Preadmission Screening and Resident Review (PASRR).<br><br>These failures could place residents at risk for not receiving the appropriate care and services to maintain the highest level of well-being.<br><br>Findings included:<br><br>1.A review of Resident #16's face sheet for December 2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included major depressive disorder, anxiety disorder, PTSD, borderline personality disorder, and insomnia.<br><br>A review of Resident #16's PASRR Level 1 screening done 11/12/2024 indicated she was positive for MI.<br><br>A review of Resident #16's PASRR Evaluation done 11/14/2024 indicated she was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services.<br><br>A review of Resident #16's admission MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had anxiety disorder, depression, and PTSD.<br><br>2. A review of Resident #19's face sheet for December 2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included anxiety disorder, psychotic disorder with hallucinations, psychotic disorder with delusions, parkinsonism, and dementia.<br><br>A review of Resident #19's PASRR Level 1 screening done 10/21/2022 indicated she was positive for MI.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident #19's PASRR Evaluation done 12/28/2022 indicated she was positive for MI. The resident had dementia so severe and could not be expected to benefit from PASRR specialized services. The resident was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services.<br><br>A review of Resident #19's significant change MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had anxiety disorder, depression, and psychotic disorder.<br><br>3. A review of Resident #29's face sheet for December 2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included bipolar disorder with psychotic features.<br><br>A review of Resident #29's PASRR Level 1 screening done 10/28/2022 indicated she was negative for mental illness. A Form 1012 was completed on 04/15/2023 and signed by the physician indicating the resident did not have dementia and had a mood disorder on admission. A new PASRR Level 1 was issued 11/15/2023 indicating positive for MI.<br><br>A review of Resident #29's PASRR Evaluation done 11/15/2023 indicated she was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services.<br><br>A review of Resident #29's annual MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had depression and bipolar disorder.<br><br>4. A review of Resident #30's face sheet for December 2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, depressive disorder, anxiety disorder, mood disorder, and sleep terrors.<br><br>A review of Resident #30's PASRR Level 1 screening done 04/18/2024 indicated she was positive for MI.<br><br>A review of Resident #30's PASRR Evaluation done 05/02/2024 indicated she was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services.<br><br>A review of Resident #30's significant change MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had anxiety disorder, depression, and schizophrenia.<br><br>5. A review of Resident #34's face sheet for December 2024 indicated he was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included delusional disorders, insomnia, depressive disorder, and dementia with major psychotic disturbance.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident #34's PASRR Level 1 screening done 05/28/2024 indicated she was negative for MI/ID/ID due to a primary diagnosis of dementia. A PASRR Evaluation was not performed due to the primary diagnosis of dementia but was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services.<br><br>A review of Resident #34's significant change MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had depression and psychotic disorder.<br><br>6. A review of Resident #41's face sheet for December 2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, anxiety disorder, and PTSD.<br><br>A review of Resident #41's PASRR Level 1 screening done 01/14/2022 indicated she was positive for MI.<br><br>A review of Resident #41's PASRR Evaluation done 01/17/2022 indicated she was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services.<br><br>A review of Resident #41's annual MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had schizophrenia and PTSD.<br><br>7. A review of Resident #53's face sheet for December 2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included anxiety, depression, and bipolar disorder.<br><br>A review of Resident #53's PASRR Level 1 screening done 05/08/2024 indicated she was positive for MI.<br><br>A review of Resident #53's PASRR Evaluation done 05/14/2024 indicated she was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services.<br><br>A review of Resident #53's admission MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had anxiety disorder, depression, and bipolar disorder.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 12/17/2024 at 12:05 PM, the MDS Coordinator said the facility used the RAI Version 3.0 Manual as the policy for completing MDS assessments. She said Section A 1500 indicated if the resident was positive for mental illness, intellectual disability or developmental disability. She said she did not realize the Section I Active Diagnoses was related to Section A PASRR screening documentation. She said the local authority had found residents that did not qualify for PASRR services because they did not meet the PASRR definition for mental illness for specialized services and thought she had to answer no because they did not qualify for services. She said she did not know Section A had to be coded as positive for mental illness, intellectual disability or developmental disability even though they did not qualify for PASRR services. The Regional Reimbursement Consultant, who was also present at that time, said she thought the local authority made the determination whether the resident was positive for a mental illness. She said she thought that indicated they no longer had the mental illness instead of meeting the PASRR definition for mental illness for specialized services. She said it was very confusing since the RAI was not clear. She said the RAI manual was used to ascertain accuracy of the MDS.<br><br>37495<br><br>41695<br><br>47204 |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41695<br><br>Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications for 1 of 2 residents reviewed for tube feeding management (Resident #31).<br><br>The facility failed to follow their policy for administering medications via gastrostomy tube.<br><br>This failure placed the resident at risk for not receiving his medication dose as ordered and at risk for a punctured gastrostomy tube and possible leakage of medications, formula, and/or water into the abdominal cavity.<br><br>Findings include:<br><br>Record review of Resident #31's clinical records indicated the resident was admitted to the facility on [DATE] with diagnoses of gastro-esophageal reflux, major depression, hemiplegia, and hemiparesis following cerebrovascular disease, hypertension and dementia.<br><br>Record review of Resident #31's physician's orders dated 9/14/2024 indicated the gastric tube was to be checked every shift by auscultation prior to meds, formula, and water flushes.<br><br>Record review of Resident #31's medical records indicated there was no physician's order for unclogging enteral feeding tube.<br><br>Record review of Resident #31's most recent care plan indicated there were no instructions or directions for unclog the resident's gastric tube.<br><br>During an observation of medication administration on 12/17/24 at 08:55AM, LVN A used a 60 cc (cubic centimeter) syringe to administer medications to Resident # 31 via withouth checking gastrostromy tube placement first. LVN A disconnected the syringe from the tubing port, poured 30 ccs of water into the syringe, inserted the syringe tip into the tube port, and using the syringe plunger, pushed the water into the tube. LVN A disconnected the syringe from the tube port, removed the plunger from the syringe, and re-inserted the syringe tip into the tube port. LVN A then poured the medication (Celecoxib 200 mg, gabapentin 200 mg cap, Tylenol with codeine#4, doxycycline Hyclate 100 mg, baclofen 10 mg and buspirone HCL 5 mg) mixed with a small amount of water into the syringe. The liquid did not drain from the syringe, indicating the gastric tube was clogged. After several attempts of repositioning and massaging the tube, LVN A moved the syringe back and forth and medication would not flow, so the LVN A placed the plunger in the syringe and pushed the medication. LVN A did not auscultate the abdomen for bowel sounds nor did he check placement by auscultating the abdomen while instilling air into the tubing prior to aspiration of stomach contents.<br><br>During an interview on 12/17/2024 at 10:50 AM, LVN A stated he thought that you could mix all medication together to administer via gastric tube and if difficult he thought you could push to assist the medication administration, he also said he was nervous and forgot to check for placement.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/17/2024 at 10:59 AM with the DON she said that LVN A was oriented to do treatments and as the Treatment Nurse and he was oriented as a floor nurse. The DON said it was her error that LVN A did not know the policy on gastric tube administration of medication, but she assumed as a LVN he should have been aware of not being able to mix medication and most of all to check for placement before administrating any medications.<br><br>Record review of a policy and procedure document titled Gastrostomy Tube Medication Administration indicated the following actions are to be taken prior to aspiration of stomach contents:<br><br>6. Check the placement of the tube y aspiration of contents or auscultation. Elevate the resident per facility policy.<br><br>7. Flush the tube with 30 ml water or according to physician order<br><br>8. Administer one medication at a time with a flush of 5-10 ml water or the amount ordered by the physician, between each medication and after the final medication is administered.<br><br>9. Once all medications have been administered, flush the tube with 30 ml water or according to physician's order.<br><br>10. Do not force any medication or fluid into the tube. Allow gravity to work. If necessary, gentle pressure may be applied after repositioning of the resident . |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41695<br><br>Based on observation, interview and record review, the facility failed to ensure pharmaceutical services were provided to meet the needs of 1 of 2 residents reviewed for pharmacy services (Residents #31).<br><br>LVN A mixed Resident #31's gastrostomy tube medications and administered them together.<br><br>This failure could place residents at risk of not receiving medications as ordered by the physician.<br><br>Findings included:<br><br>Record review of Resident #31's clinical records indicated the resident was admitted to the facility on [DATE] with diagnoses of gastro-esophageal reflux, major depression, hemiplegia, and hemiparesis following cerebrovascular disease, hypertension, and dementia.<br><br>During an observation of medication administration on 12/17/24 at 08:55AM, LVN A used a 60 cc (cubic centimeter) syringe to administer medications to (Resident #31) LVN A mixed all medications (Celecoxib 200 mg, gabapentin 200 mg cap, Tylenol with codeine#4, doxycycline Hyclate 100 mg, baclofen 10 mg and buspirone HCL 5 mg) mixed with a small amount of water into the syringe.<br><br>During an interview on 12/17/2024 at 10:50 AM, LVN A stated he thought that you could mix all medication together to administer via gastric tube.<br><br>During an interview on 12/17/2024 at 10:59 AM with the DON said that LVN A was oriented to do treatments and as the Treatment Nurse and he was not oriented as a floor nurse. The DON said it was her error that LVN A did not know the policy on gastric tube administration of medication, but she assumed as a LVN he should have been aware of not being able to mix medication.<br><br>Record review of a policy and procedure document titled Gastrostomy Tube Medication Administration indicated the following actions are to be taken prior to aspiration of stomach contents:<br><br>6. Check the placement of the tube y aspiration of contents or auscultation. Elevate the resident per facility policy.<br><br>7. Flush the tube with 30 ml water or according to physician order<br><br>8. Administer one medication at a time with a flush of 5-10 ml water or the amount ordered by the physician, between each medication and after the final medication is administered.<br><br>9. Once all medications have been administered, flush the tube with 30 ml water or according to physician's order.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 10. Do not force any medication or fluid into the tube. Allow gravity to work. If necessary, gentle pressure may be applied after repositioning of the resident. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>37495<br><br>Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 1 of 5 residents (Resident #5) reviewed for safe and comfortable environment.<br><br>The facility failed to repair water discoloration marks and water leaks in the ceiling in Resident #5's room.<br><br>These failures could place residents at risk for a diminished quality of life and safe environment due to the lack of a well-kept environment.<br><br>The findings included:<br><br>During an observation on 12/16/24 at 2:50 p.m., there was water dripping from the privacy curtain track on the ceiling into a small trash can and water was on the floor extending out approximately 6 inches from the outside of the trash can in Resident #5's room. There was a brownish discolored area on the white ceiling, approximately 1 foot by 2-foot, around the area where the water was dripping.<br><br>During an observation and interview on 12/16/24 at 3:20 p.m., there was water dripping from the privacy curtain track on the ceiling into a small trash can in Resident #5's room. CNA B said Resident #5's ceiling has been leaking since she started working at the facility about 2 months. CNA B said she told the Maintenance Supervisor about the leak in the room when she saw it a little over a month ago, but it has not been fixed. CNA B said water on the floor could cause injury to a resident or a facility staff member if they slipped and fell in it. CNA B said the water on Resident #5's floor was a safety hazard.<br><br>During an observation and interview on 12/16/24 at 3:42 p.m., there was water dripping from the privacy curtain track on the ceiling into a small trash can in Resident #5's room. The Maintenance Supervisor said he had worked the facility for about 1 1/2 years. The Maintenance Supervisor said he was aware of the leak in Resident #5's room and has known about it since June 2024 and notified the Administrator and Area Maintenance Supervisor at that time. The Maintenance Supervisor said the Area Maintenance Supervisor asked him to get bids on replacing the roof. The Maintenance Supervisor said he submitted the bids to the corporate office and after they reviewed them they decided to have a contractor patch the leaking areas on the roof instead of replacing it. The Maintenance Supervisor said he had a contractor patched the roof a couple of times, but the roof still leaks. The Maintenance Supervisor said the roof would stop leaking if the roof was replaced.<br><br>During an interview on 12/16/24 at 4:38 p.m., the Administrator said she was not aware Resident #5's room has a water leak. The Administrator said they have had a contractor come out a couple of times to patch the roof. The Administrator said she called the corporate office this morning about replacing the roof because they had 2 empty rooms they were unable to use due to water leaks from the ceiling. The Administrator said the water on Resident #5's floor was a safety hazard and she needed to be moved to another room.<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of the facility's Resident Rights Storage of Medications policy, revised on 11/28/2016, indicated .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. |