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	03/25/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews, and record reviews, the facility failed to ensure that residents received care and services in accordance with professional standards of practice for 3 of 12 residents (Residents #11, #15, and #43) reviewed for quality of care.1. The facility failed to ensure neurological checks were performed on Resident #11 when she had an unwitnessed fall on 2/08/2026.2. The facility failed to ensure the full gamut of neurological checks were performed on Resident #15 after a fall on 3/12/2026.3. The facility failed to ensure neurological checks were performed on Resident #43 after an unwitnessed fall on 3/23/2026.This failure could place residents at risk of not receiving appropriate care and treatment and/or decline in their health.Findings include:1. Record review of Resident 11's facility face sheet, dated 3/25/2026, indicated Resident #11 was an [AGE] year-old female, readmitted [DATE], with diagnosis of Alzheimer's. Record review of Resident #11's quarterly MDS assessment, dated 02/11/2026, revealed a BIMS score of 00 that indicated Resident #11 had severely impaired cognition. She required minimal assistance with ADLs. Record review of Resident #11's comprehensive care plan, revision date 03/10/2026, indicated Resident #11 was at risk for falls related to confusion.Record review of Resident #11's fall event note dated 2/08/2026 indicated Resident #11 had an unwitnessed fall and the nurse did not initiate nor complete any neurological check following the fall. During an observation and attempted interview on 3/23/2026 at 10:13 am, Resident #11 was asleep in bed. She aroused and had no complaints. She was unable to answer questions.During an interview on 3/24/2026 at 4:10 pm, the ADON said she was the charge nurse for Resident #11 on 2/08/2026. She said the aide alerted her that Resident #11 was on the floor. She said when she arrived Resident #11 was on the floor with her feet elevated in a chair. She said she assessed her but forgot to start neurological checks. She said that with an unwitnessed fall a neurological assessment should be completed every 15 minutes following the fall for the first hour, then every hour, for 4 hours and then every 4 hours for a total of 72 hours of monitoring. She said the exact times were automatic in the electronic record. She said if they were not completed, a negative resident outcome could occur. 2. Record review of a facility face sheet dated 3/24/26 for Resident #15 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of sepsis (a life-threatening reaction to an infection that causes your immune system to harm healthy tissues and organs).Record review of a Medicare 5-day MDS dated [DATE] for Resident #15 indicated a BIMS score of 14, indicating intact cognitive status. He required partial/moderate assistance with most ADLs. He had not sustained any falls prior to admission or while a resident.Record review of a comprehensive care plan dated 2/22/26 for Resident #15 indicated he was at risk for falls.Record review of an incident report dated 3/12/26 at 4:00 pm for Resident #15 indicated he sustained a fall in his room, resulting in injuries to his head. There was no documentation of a neurological check on the incident report.Record review of Resident #15's electronic medical record indicated the following neurological checks: 3/12/26 at 6:20 pm; and 3/13/26 at 7:25 pm; and 3/14/26 at 02:27 am.There were no other neurological checks documented.During an observation and interview on 3/23/26 at 10:32 am Resident #15 was observed in his room lying down on his bed. He had multiple scabbed areas to his forehead and above his right eye. He also had a dark purple bruise observed to his right (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	eye. He said he had fallen recently in his bathroom, hitting his head. He had no complaints regarding the care he received after the fall.3. Record review of Resident 43's facility face sheet, dated 3/24/2026, indicated Resident #43 was a [AGE] year-old female, readmitted [DATE], with diagnosis of dementia. Record review of Resident #43's quarterly MDS assessment, dated 02/06/2026, revealed a BIMS score of 01 that indicated Resident #43 had severely impaired cognition. She required minimal assistance with ADL's. Record review of Resident #43's comprehensive care plan, revision date 02/17/2026, indicated Resident #43 was a fall risk. Record review of Resident #43's fall event note dated 3/23/2026 indicated Resident #43 had an unwitnessed fall on 3/23/2026 at 7:50 am. The nurse initiated a neurological assessment at the time of the fall but did not conduct another neurological check until 2:45 pm on 3/23/2026.During an observation and attempted interview on 03/23/2026 at 10:17 am, Resident #43 was sitting in a chair in her room. She was awake and alert, but unable to answer questions.During an interview on 3/23/2026 at 2:16 pm, LVN D said that she was assigned to the west side of the facility as the charge nurse. She said Resident #43 fell that morning at 7:50 am and she assessed her. She said she was not hurt, and she initiated neurological checks, but had gotten behind with other tasks and had not completed any other checks or entered her documentation. She said she was aware of the neurological check schedule and by not doing them, a negative outcome could occur. During an interview on 3/23/2026 at 4:33 pm, the DON said that she was new to the position for one week. She said when an unwitnessed fall occurred, or a fall resulting in head injury, neurological checks were always to be initiated and the resident should be assessed following the neurological check time frames to ensure no significant injury had occurred. She said that by not following through with neurological checks, resident safety could be compromised. She said that falls should be reviewed in the morning meeting to ensure the fall protocol was followed. During an interview on 3/23/2026 at 4:45pm, the Administrator said, regarding falls, she was not a clinician, but if a fall were to occur, the nurse should be following their fall management plan and contacting the family and doctor. She said missed neurological checks could result in unassessed neurological changes. She said she expected the nurses to always follow the facility's policy and procedures for falls.Record review of the Nurse Proficiency Audit for LVN D dated 2/20/2026 indicated LVN D was proficient in neurological assessments. Record review of the Nurse Proficiency Audit for the ADON dated 2/11/2026 indicated that the ADON was proficient in neurological assessments. Record review of the undated facility's policy titled Neurological Checks indicated, .Neurologic checks are a combination of objective observations and measurements done to evaluate neurologic status. The results of the checks assist to determine nervous system damage and/or deterioration.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide sufficient number of nursing staff on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans and the facility assessment for 7 of 31 (2026 in March 8, 12, 13, 14, 17, 20, and 23) days reviewed for care and services. The facility failed to provide sufficient CNAs according to the facility assessment on March 8, 12, 13, 14, 17, 20, and 23 in 2026. This failure placed residents at risk of inadequate supervision, an unsafe environment, falls, serious harm and injury, exacerbations of disease processes, abuse, and death.Findings Include: Record review of a grievance note dated 3/09/2026 indicated a family member filed a grievance due to being unable to find clinical staff over the weekend. The facility summary of findings indicated a CNA position was unfilled and the CNA from the other side of the facility had to float to provide care. Record review of a Raw Time Entry Report dated March 1, 2026 to March 25, 2026 day shift 6:00 am to 2:00 pm indicated:March 08, 2026 - 2 CNAs and 1 MA with census of 60 residents.March 12, 2026 - 3 CNAs and 1 MA with census of 60 residents.March 13, 2026 - 2 CNAs and 1 MA with census of 59 residents.March 14, 2026 - 3 CNAs and 0 MA with census of 59 residents.March 17, 2026 - 3 CNAs and 1 MA with census of 57 residents.March 20, 2026 - 3 CNAs and 1 MA with census of 58 residents.March 23, 2026 - 3 CNAs and 1 MA with census of 58 residents. Record review of the Direct Care posting for 3/12/2026, 3/17/2026, 3/20/2026, and 3/23/2026 indicated there were 4 scheduled certified nurse aides and medication aide for the day shift and 3/14/2026, 3 scheduled certified nurse aides and medication aide. The resident census for those days were 57-60 residents. Record review of the direct care sign in sheets dated 3/08/2026, 3/12/2026, 3/13/2026, 3/14/2026, 3/17/2026, 3/20/2026, and 3/23/2026 indicated the facility had staffed 3 certified nurse aides and 1 medication aide on the schedule. Record review of the PBJ Staffing Data ReportFY Quarter 1 2026 (October 1 - December 31) indicated the facility had a 1-star staffing rating. Record review of a Resident List Report dated March 23, 2026 indicated the facility had 58 residents inhouse.During an observation on 03/23/2026 at 10:25 am, CNA A was off the secured unit at the computer charting outside the glass doors. She had eyesight of the secured unit hallway but not the residents in the dining room. She returned to the secured unit at 10:42 am. During an observation on 3/23/2026 at 12:00 pm, CNA A was off the secured unit to assist on the other side of the hall. There were no staff present on the secured unit until she returned at 12:08 pm. During an interview on 3/23/2026 at 12:20 pm, CNA A said she had been at the facility for about 3 weeks. She said she was assigned to the secured unit that day as well as 3 other residents on the other side of the unit. She said she had to leave to help the other aide because there were only 3 aides in total working that day. She said she would tell the nurse or aide that she was off the unit for them to supervise, but they were short and often could not stop to supervise the unit. She said on the day shift, there were many days, where only 3 aides showed up for the day shift. She said that having a shortage of nurse aides affected the resident's supervision and care and could result in injuries. During an interview on 3/23/2026 at 2:16 pm, LVN D said that she was assigned to the west side of the facility as the charge nurse with 34 residents and the other nurse on the east side had 24 residents. She said it was difficult for her to do everything in a timely manner. She said the aide on the unit also helped on the other side because of being shorthanded, and she had 2 CNAs for the west side and there was 1 aide on the east side today. She said that not having enough staff in the facility affects resident care and could result in injuries. During an interview on 03/23/2026 at 3:31 pm, a family member stated, at times when he visited, he must look for the aide and there were times that no aide was on the secured unit. He was told they were short staffed. During an interview on 3/23/2026 at 4:23 pm, the ADON said she was responsible for the nursing staff schedule. She said that the breakdown was to have 2 nurses on each shift, 5 nurse aides on the day shift, 4 nurse aides on the evening shift and 3 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurse aides on the night shift. She said that she and the treatment nurse were the ones that covered the shifts, and there were days that only 3 nurse aides were assigned. She said that she and the treatment nurse helped, but they had their own job responsibilities as well. She said the CNA assigned to the unit should not be assigned residents off the unit and should never leave the unit unsupervised. She said having insufficient staffing could result in delays in care and injuries. During an interview on 3/23/2026 at 4:33 pm, the DON said that she was new to the position for one week. She said she was not completely aware of the systems and staffing patterns. She said she knew there was a need for more nurse aides, but she was not aware there were only 3 nurse aides assigned for the day shift and that the CNA on the secured unit was leaving to help off the unit. She said she would speak with her corporate nurse to discuss the schedule. She said that being shorthanded could result in negative outcomes for the residents. During an interview on 3/23/2026 at 4:45 pm, the Administrator said there was no policy for staffing, and they used the facility assessment. She said that the facility assessment was current but that they did not follow the nurse staffing numbers in the assessment. She said they calculated the number based on census and that currently with 58 residents, there should be 4 1/2 nurse aides on day shift, 4 nurse aides on evening shift and 3 nurse aides on night shift. She said she was not aware there were only 3 nurse aides assigned for that day nor any other day. She said management staff were responsible for filling in and helping. She said the nurse aide on the unit should not be leaving the unit unless someone else came to supervise and she was not aware the nurse aide on the unit was being assigned residents off the unit. She said that decreased staffing could result in care issues. During an interview on 3/24/2026 at 7:54 am, CNA E was present on the secured unit. She said that she was assigned to the secured unit most of the time and that she would also have residents outside the unit to care for when they were short nurse aides for the shift. She said that the nurse and medication aide was to supervise the unit when she was off but that did not always happen. She said that on the days there were only 3 nurse aides on the schedule, they worked together and did their best. She said that when working short staff, some tasks such as showers and toileting were missed. She said that management staff would help, but they had their own duties and could not stay on the hall the entire time. She said having insufficient staff could result in resident injuries, poor hygiene and overall health issues. During an interview on 3/24/2026 at 2:45 pm, the Treatment Nurse said she was assigned to the hall yesterday around 11 am when the assigned nurse aide had to leave. She said she was the treatment nurse but frequently had to help work on the floor. Record review of the Facility assessment dated [DATE] indicated, .staff assignments were based on resident centered collaborative care and nurse staffing for certified nurse aide on the day shift would be 5 and medication aide 1 .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assures accurate acquiring, receiving, dispensing, and administering of medications for 1 of 2 medication storage rooms (East Wing) reviewed for pharmacy services.The facility failed to remove (2) expired vials of pneumococcal vaccine and bisacodyl suppositories (used to treat constipation) from the refrigerator in the medication room on the East Wing on 3/24/2026.This failure could place residents at risk for the unsafe administration of medications, not receiving prescribed doses of ordered medications and infection. Findings included:During an observation on 3/24/2026 at 11:39 am, the medication on the East Wing refrigerator revealed:-(2) vials of pneumococcal vaccine expired [DATE].- a box of bisacodyl 10 mg suppositories dispensed date 9/27/2024 and prescription said do not use after 9/27/2025.-(1) box of bisacodyl 10 mg expired 4/2025.During an interview on 3/24/2026 at 11:39 am, LVN B said the Transport CNA was responsible for checking the medication carts and medication rooms for expired medications monthly. She said medications would not be as effective if given past their expiration dates. During an interview on 3/24/2026 at 1:34 pm, the Transport CNA said he was responsible for checking the medication carts and medication rooms but not the refrigerators. He said it had been more than a month or longer since he last checked them because he had been on transport taking residents to appointments. He said the staff assigned to the carts should also check them along with the Pharmacy Consultant when they came to the facility. He said medication errors could occur or a reaction to the medications if they were given and expired.During an interview on 3/25/2026 at 10:31 am, the Pharmacy Consultant said she visited the facility every other month and her last visit was 2/11/26. She said when she was at the facility she destroyed drugs, checked medication carts and rooms, observed a medication pass, and provided the facility with recommendations. She said when her visit was complete, she would send the facility a copy of her audit. She said if she found anything that was expired, she would remove them. She said if medications were given past the expiration dates, they could lose efficacy.During an interview on 3/25/2026 at 2:43 pm, the Administrator said the Pharmacy Consultant did audits of the carts and rooms in the facility. She said she sent a report to the facility after every visit. She said the Transport Aide used to be responsible for central supply and he would restock things and was not aware that he was checking the medication rooms or carts. She said if medications were given past their expiration dates, they might lose potency and the residents would not be given the appropriate strength.Record review of a policy titled Medication Storage in the Facility undated indicated, .Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. 13. Outdated medications are immediately removed from stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exists .

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately inform the resident, consult with the resident's physician; and notify, consistent with his or her authority, the resident representative where there was a significant change in the resident's physical, mental, or psychosocial status for 1 of 6 residents (Resident #43) reviewed for resident rights.The facility failed to inform Resident #43's responsible party when she fell on 3/23/2026. This failure could place residents at risk of not having family members or representatives notified of changes in condition and allowing them to participate in care decisions.Findings Include: Record review of Resident 43's face sheet, dated 3/24/2026, indicated Resident #43 was a [AGE] year-old female, admitted [DATE], with diagnosis of dementia. Record review of Resident #43's quarterly MDS assessment, dated 02/06/2026, revealed a BIMS score of 01 that indicated Resident #43 had severely impaired cognition. She required minimal assistance with ADLs. Record review of Resident #43's comprehensive care plan, revision date 02/17/2026, indicated Resident #43 was a fall risk. Record review of a grievance note dated 3/19/2026 indicated Resident #43's family filed a grievance with concerns around interventions to address recent falls and results of recent tests performed. Record review of Resident #43's fall event note dated 3/23/2026 indicated Resident #43's family was not notified of her fall. During an interview on 03/23/2026 at 3:40 pm, Resident #43's family member said the nurse had not called about the fall that morning, and that happened in the past when she would have falls or changes in her condition. During an interview on 3/23/2026 at 2:16 pm, LVN D said that she was assigned to the west side of the facility as the charge nurse. She said CNA A told her about Resident #43's fall at 7:50 am, and she assessed her. She said she notified the doctor but had not called the family. She said there was only her and another nurse on the other side, and it was difficult for her to do everything in a timely manner. She said the family had the right to be kept aware of the resident changes. During an interview on 3/23/2026 at 4:33 pm, the DON said that she was new to the position for one week. She said that with each incident the doctor and the family should be notified as soon as the resident was safe. She said the family had the right to know what had happened, and what the plan would be going forward to prevent further incidents. During an interview on 3/23/2026 at 4:45 pm, the Administrator said anytime an incident occurred with a resident, the nurse should be notifying the family. She said that falls should be reviewed in the morning meeting and nurse management should review that all things were put in place and proper notification occurred. She said that families should always be kept informed of any changes and expected the staff to follow the facility's policy for resident rights. Record review of the Nurse Proficiency Audit for LVN D dated 2/20/2026 indicated LVN D was proficient in resident rights and documentation. Record review of an undated facility policy titled Notifying the Physician of Change in Status indicated, .5. The resident' s family member or legal guardian should be notified of significant change in resident' s status unless the resident has specified otherwise.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess each resident quarterly, once every three months, using the quarterly review instrument specified by the state and approved by CMS for 1 of 17 residents (Resident # 14) reviewed for resident assessments. The facility failed to ensure Resident # 14 had a quarterly MDS assessment completed within three months from the previous assessment on 2/21/26.This failure could place residents at risk of not receiving necessary care or receiving inappropriate care for their conditions.Findings included:Record review of a facility face sheet dated 3/25/26 for Resident #14 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs). Record review of a quarterly MDS assessment dated [DATE] for Resident #14 indicated a BIMS score of 8, which indicated moderately impaired cognition and an Assessment Reference Date of 11/21/25. The quarterly assessment was due 2/21/26, but was not put in the system 3/20/26, and showed in progress; which was 27 days overdue.During an interview on 3/25/26 at 9:17 am, the MDS nurse said she was unsure how she missed doing the assessment, but she said assessments should be done every 3 months and he should have had one in February. She said if assessments were not completed appropriately, they could be inaccurate, and since care plans were triggered from the assessments, the care plans may not be updated accordingly. She said she would keep better track when assessments were due going forward. During an interview on 03/25/2026 at 11:00 am, the DON said she had only been employed at the facility 2 weeks and could not speak on anything that happened before she started. She said if MDS assessments were not completed appropriately, then care plans may not be updated as needed and staff may not know how to care for residents. She said she would ensure the MDS nurse completed assessments appropriately going forward. During an interview on 03/25/2026 at 11:16 am, the Administrator said that it was very unusual for the MDS nurse to miss an assessment, and she was unsure how that happened. She said that the MDS triggered their payments, quality measures, and care plans. She said if assessments were not completed appropriately, then care plans could miss getting updated when needed. She said she would ensure MDS completed assessments timely going forward.Record review of the facility's policy titled Resident assessment dated 2003 reflected, .The facility will examine each resident and review the minimum data set expanded core elements specified in RAI no less than once every three (3) months and as appropriate .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to make sure a comprehensive care plan was prepared by an interdisciplinary team, that included but not limited to the participation of the resident and the resident representative for 1 of 17 residents (Resident #7) reviewed for care plans.1. The facility failed to ensure Resident #7's representative was invited to attend the resident's care plan conferences.2. The facility failed to ensure care plan conferences were held quarterly for Resident #7.This failure could place residents at risk of not receiving the care and services to meet their needs.Findings include:Record review of a facility face sheet dated 3/23/26 for Resident #7 indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnosis of Alzheimer's disease. Face sheet indicated his daughter was his RP.Record review of a comprehensive MDS assessment dated [DATE] for Resident #7 indicated a BIMS score of 00, indicating a severe cognitive impairment. He was dependent on staff for assistance with all ADLs. He was always incontinent of bowel and bladder. Resident #7 and his representative were active in participating in the assessment and goal setting.Record review of a care plan conference dated 1/14/25 for Resident #7 indicated Resident #7 nor his representative attended. The Care Plan Conference form indicated Resident #7, and his representative were unable to attend. Record review of Resident #7's electronic medical record indicated there was no documentation of a quarterly care plan conference in April of 2025 or until 09/09/25.Record review of a care plan conference dated 9/9/25 for Resident #7 indicated Resident #7 did not attend due to not understanding the purpose of the meeting and indicated that his representative did not attend due to prior commitments.Record review of an electronic medical record for Resident #7 indicated there was no documentation of a quarterly care plan conference in December 2025.Record review of a care plan conference dated 1/6/26 for Resident #7 indicated Resident #7 did not attend due to not understanding the purpose of the meeting and indicated that his representative was unable to attend.During an interview on 03/24/2026 at 8:55 am, the Social Worker said she was responsible for coordinating the care plan meetings and notifying family members in advance. She said she did not send out letters because families were not receiving them. She said she would notify them either by phone, or in person, but said she had not been documenting the notifications. She said there was had been a gap in Resident #7's quarterly meetings around the time last year when she took responsibility for coordinating the meetings from the MDS nurse. She was unsure exactly what happened or how it got missed. During an interview on 3/24/26 at 3:45 pm, Resident #7's representative said she had not been invited either by phone, letter, or in person to attend a care plan meeting within the last year. During an interview on 03/25/2026 at 10:50 am, the Social Worker said if families were not involved in care plan meetings, the facility may not be informed of resident's baseline, their routine at home prior to admission, and families may not be aware of resident's condition. She said, going forward, she would ensure families/responsible parties were invited to meetings and ensure that meetings were held appropriately. She said if meetings were not held as required, care plans may not be updated as needed, and staff may not be aware of the residents' needs.During an interview on 03/25/2026 at 11:00 am, the DON said she had only been there 2 weeks, and could not speak on anything that happened before she started. She said the Social Worker was responsible for coordination of the meetings and notifying family members in advance. She said that care plan meetings should be held at least quarterly and families should be invited when appropriate. She said if families were not invited to meetings, they may not know what is going on with the residents or may not be able to contribute to resident's care. She said if meetings were not held timely and as required, care plans may not be updated as needed and staff may not know how to care for residents. During an interview on 03/25/2026 at 11:16 am, the Administrator said the social worker coordinated the care plan meetings and invited the family members. She said they were going (continued on next page)

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	675267	A. Building B. Wing	03/25/2026

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to go back to sending letters ahead of time for the care plan meetings. She said if meetings were not held timely or involved family members then families may not be included in resident care. She said she would ensure meetings were held timely going forward and that family members were invited.Record review of the facility's undated policy titled Comprehensive Care Planning, reflected, .The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preference and needs of the resident and in response to current interventions .The facility will provide the resident and resident representative, if applicable with advance notice of care planning conferences to enable resident/resident representative participation in care planning can be accomplished in many forms such as holding care planning conferences at a time the resident representative is available to participate, holding conference calls or video conferencing .Facility are expected to facilitate the residents' and if applicable, the resident representatives' participation in the care planning process .

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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 personal hygiene for 1 of 6 residents reviewed for ADL care. (Resident #2)The facility failed to ensure Resident #2 received timely incontinent care on 3/23/2026.This failure could place residents at risk of embarrassment, discomfort, and skin breakdown. Findings included:Record review of an admission Record for Resident #2 dated 3/25/2026 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia (a decline in mental ability that can interfere with daily life), GERD (acid reflux disease), and anxiety disorder (a persistent, excessive and uncontrollable fear, worry or dread that interferes with daily life).Record review of a Significant Change MDS Assessment for Resident #2 dated 2/26/2026 indicated she had severe impairment in cognition with a BIMS score of 0. She required substantial/maximal assistance with toileting hygiene. Her urinary continence was not rated but she was always incontinent of bowel.Record review of a care plan for Resident #2 dated 10/18/2023 indicated she had bladder and bowel incontinence with interventions to check resident every two hours and assist with toileting as needed.During an observation on 3/23/2026 at 12:20 pm, Resident #2 was in the dining room eating lunch.During an observation on 3/23/2026 at 2:00 pm, Resident #2 was sitting in a wheelchair in the lobby with other residents holding a baby doll.During an observation on 3/23/2026 at 2:27 pm, Resident #2 was in the lobby standing up by her wheelchair with staff present. The back of her pants was soaked with urine. Staff took the resident to her room to change her.During an interview on 3/24/2026 at 2:45 pm, the Treatment Nurse said she was assigned to the hall where Resident #2 resided 3/23/2026, and around 11 am the assigned nurse aide had to leave for the day. She said she was the Treatment Nurse for the facility, but frequently had to help work on the floor. She said she was going back and forth yesterday between halls and the secure unit. She said she tried to check the residents at least every two hours, and she checked some of the residents who were in bed and took the residents who were up to their rooms to get changed. She said she checked Resident #2 before lunch on 3/23/2026 and after lunch did not make it back to check on her because it was almost 2 pm and the unit staff needed relief. She said after lunch on 3/23/2026, they placed Resident #2 in the lobby, and she was not aware she had an accident where she urinated on herself. She said it would make her feel bad if she was left wet and there were not enough staff to care for the residents.During an interview on 3/25/2026 at 11:10 am, the DON said she had been in the facility for two weeks. She said incontinent care should be provided every 2 hours. She said she was aware of Resident #2 on 3/23/2026 being left wet for an undetermined amount of time. She said she would not feel good if she was dependent on staff to provide care for her. She said it would be a dignity issue. During an interview on 3/25/2026 at 2:43 pm, the Administrator said care should be provided as needed and the staff should conduct frequent checks and usually it was every 2 hours. She said she was not aware that Resident #2 was wet and not checked every 2 hours on 3/23/2026. She said it would make her feel like it was a dignity issue and could be a comfort issue. She said she expected the staff to make sure the residents were clean and dry. Surveyor requested a copy of the facility policy on ADL Care on 3/25/2026, but none was provided. The facility did not have specific policy related to ADL Care.

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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 a medication error rate of less than 5 percent. There were 2 errors out of 30 opportunities, resulting in a 6.67% percent medication error involving 1 of 4 residents (Resident #32) reviewed for pharmacy services. LVN B administered an incorrect dose of Novolog insulin (used to treat diabetes) to Resident #32 on 3/24/2026 during a medication pass.LVN B failed to administer a dose of Novolin R (used to treat diabetes) to Resident #32 on 3/24/2026 during a medication pass.These failures could place residents at risk for inaccurate drug administration resulting in decline in health and decreased quality of life.Findings included:Record review of an admission Record for Resident #32 dated 3/25/2026 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia (a decline in mental ability that can interfere with daily life), and diabetes mellitus.Record review of a Quarterly MDS Assessment for Resident #32 dated 1/17/2026 indicated he did not have any impairment in thinking with a BIMS score of 15. During the seven look back period he received insulin injections.Record review of a care plan for Resident #32 revised on 8/12/2025 indicated he had diabetes mellitus with interventions to give diabetic medications as ordered by doctor. Record review of active physician orders for Resident #32 dated 3/25/2026 indicated an order for Novolin R flex pan 100 unit/ml inject 25 units subcutaneously one time a day and an order for Novolog flex pen 100 units/ml per sliding scale: if 250-299=4 units; 300-349=6 units; 350-399=8 and to call the hospice agency. Record review of Resident #32's blood sugars (normal blood sugar ranges before meals range from 70-130):3/24/2026 4:16 pm blood sugar was 147.3/24/2026 7:50 pm blood sugar was 192.3/25/2026 6:58 am blood sugar was 207.During an observation on 3/24/2026 at 11:01 am, LVN B checked Resident #32's blood sugar and it was 255. LVN B said the resident would receive 25 units of Novolin R and would get 4 units of NovoLog per sliding scale for a total of 29 units. LVN B took the NovoLog flex pen out of the medication care and dialed it to 29 units. This Surveyor questioned LVN B about the dosage of insulin and she said the pen was for both insulins Novolog and Novolin R and administered 29 units of Novolog insulin to the resident.During an interview on 3/24/2026 at 1:30 pm, LVN B said she used one pen when she administered the insulin to Resident #32. She said the 4 units of Novolog (rapid acting insulin) should have been from his NovoLog pen instead of all being from the Novolin (short acting insulin) pen. She said the resident could have a reaction to the insulin if he was given the wrong dosage that could cause his blood sugar to drop. She said she should have looked at the MAR first and compared the orders before administering medications and she did not check the orders. She said she was not sure what happened that day and why she gave the resident 29 units of Novolog. She said the resident had a separate insulin pen for Novolin R in the medication cart. She said the resident's blood sugar could drop or get too high if the correct dose was not given.During an observation on 3/24/2026 at 1:35 pm, the medication cart that LVN B was assigned to for that day revealed 1 insulin pen for Novolog, 1 pen for Novolin R, and 1 pen for Lantus that were prescribed to Resident #32.During an interview on 3/25/2026 at 11:10 am, the DON said she had been employed at the facility for 2 weeks. She said staff should follow the rights of medications that included the right medication and dosage. She said she was made aware of the incident with Resident #32 when he received the wrong dose of insulin. She said they contacted the NP, made changes to his orders, and received new orders to check his blood sugar TID and prn. She said he had not had any issues since the incident with his blood sugar dropping or getting too high. She said she planned to in-service the staff and would provide a 1:1 education with LVN B. She said there was a risk for a resident's blood sugar to drop, or they might not receive enough insulin if not given the correct medication or dose.During an interview on 3/245/2026 at 10:31 am, the Pharmacy Consultant said she visited the facility every other month and her last visit was February 11, 2026. She said when she was at the facility she helped to destroy drugs, checked medication carts and rooms, observed a medication (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pass, and provided the facility with recommendations. She said when her visit was complete, she would send the facility a copy of her audit. She said Resident #32's order for insulin that included Novolin R and Novolog were both short acting insulins that both had similar onsets of actions including peak actions. She said Novolin R would act longer, but should not make a huge difference. She said she tried to make recommendations for the simplification of insulin regimens as it could make it difficult with room for errors if not. She said there was a risk for hypoglycemia but since both were short acting it would be less of a risk.During an interview on 3/25/2026 at 2:43 PM, the Administrator said staff should verify the correct medicine, dosage, the right resident, and should check to make sure the order was correct before administering any medicine. She said if residents were given too much insulin, their blood sugar could drop. She said they started an in-service with the staff and planned to provide LVN B with 1:1 education, and put a monitoring tool in place. She said the nurse called and notified everyone including the physician and an error report and they were told to monitor Resident #32.Record review of an Audit for LVN B dated 6/30/2025 indicated she was satisfactory with medication administration.Record review of the facility's policy titled Medication Discrepancies and Adverse medication reactions dated March 2025 indicated, .Medication discrepancies and adverse medication reactions are documented and reported to the residents' attending physician and designated personnel/committee of the facility .

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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 residents were free from significant medication errors for 1 of 4 residents (Resident #32) reviewed for significant medication errors.The facility failed to ensure LVN B administered the correct dose of Novolog and Novolin R insulin (used to treat diabetes) to Resident #32 on 3/24/2026 during a medication pass.This failure could place residents at risk of not receiving desired therapeutic outcomes, increased side effects, or a decline in health.Findings included:Record review of an admission Record for Resident #32 dated 3/25/2026 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia (a decline in mental ability that can interfere with daily life), Parkinson's Disease (a movement disorder that worsens over time), diabetes mellitus, and bipolar disorder (mental health condition that causes extreme mood swings).Record review of active physician orders for Resident #32 dated 3/25/2026 indicated an order for Novolin R flex pan 100 unit/ml inject 25 units subcutaneously one time a day and an order for Novolog flex pen 100 units/ml per sliding scale: if 250-299=4 units; 300-349=6 units; 350-399=8 and to call the hospice agency.Record review of a Quarterly MDS Assessment for Resident #32 dated 1/17/2026 indicated he did not have any impairment in thinking with a BIMS score of 15. During the seven look back period he received insulin injections.Record review of a care plan for Resident #32 revised on 8/12/2025 indicated he had diabetes mellitus with interventions to give diabetic medications as ordered by doctor. Record review of Resident #32's blood sugars revealed:-3/24/2026 at 4:16 pm, blood sugar was 147,3/24/2026 at 7:50 pm, blood sugar was 192,and on-3/25/2026 at 6:58 am, blood sugar was 207.During an observation on 3/24/2026 at 11:01 am, LVN B checked Resident #32's blood sugar and it was 255. LVN B said the resident would receive 25 units of Novolin R and would get 4 units of NovoLog per sliding scale for a total of 29 units. LVN B took the NovoLog flex pen out of the medication cart and dialed it to 29 units. This Surveyor questioned LVN B about the dosage of insulin and she said the pen was for both insulins Novolog and Novolin R and administered 29 units of Novolog insulin to the resident.During an interview on 3/24/2026 at 1:30 pm, LVN B said she used one pen when she administered the insulin to Resident #32. She said the 4 units of Novolog should have been from his NovoLog pen instead of all being from the Novolin pen. She said the resident could have a reaction to the insulin if he were given the wrong dosage that could cause his blood sugar to drop. She said she should have looked at the MAR first and compared the orders before administering medications and she did not check the orders. She said she was not sure what happened that day and why she gave the resident 29 units of Novolog. She said the resident had a separate insulin pen for Novolin R in the medication cart.Record review of an Audit for LVN B dated 6/30/2025 indicated she was satisfactory with medication administration.During an observation on 3/24/2026 at 1:35 pm, the medication cart that LVN B was assigned to for that day revealed 1 insulin pen for Novolog, 1 pen for Novolin R, and 1 pen for Lantus that was prescribed to Resident #32.During an interview on 3/25/2026 at 11:10 am, the DON said she had been employed at the facility for 2 weeks. She said staff should follow the rights of medications that included the right medication and dosage. She said she was aware of the incident with Resident #32 when he received the wrong dose of insulin. She said they contacted the NP, made changes to his orders, and received new orders to check his blood sugar TID and prn. She said he has not had any issues since the incident with his blood sugar dropping or getting too high. She said she planned to in-service the staff and would provide a 1:1 education with LVN B. She said there was a risk for a resident's blood sugar to drop, or they might not receive enough insulin if not given the correct medication or dose.During an interview on 3/245/2026 at 10:31 am, the Pharmacy Consultant said she visited the facility every other month and her last visit was 2/11/26. She said when she was at the facility she helped to destroy drugs, checked medication carts and rooms, observed a medication pass, and provided the facility with recommendations. She said when her visit (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was complete, she would send the facility a copy of her audit. She said Resident #32's order for insulin that included Novolin R and Novolog were both short acting insulins that both had similar onsets of actions including peak actions. She said Novolin R would act longer but should not make a huge difference. She said she tried to make recommendations for the simplification of insulin regimens as if could make it difficult and room for errors if not. She said there was a risk for hypoglycemia but since both were short acting it would be less of a risk.During an interview on 3/25/2026 at 2:43 pm, the Administrator said staff should verify the correct medicine, dosage, the right resident, and should check to make sure the order was correct before administering any medicine. She said if residents were given too much insulin their blood sugar could drop. She said they started an in-service with the staff and planned to provide LVN B with 1:1 education and put a monitoring tool in place. She said the nurse called and notified everyone including the physician and an error report and was told to monitor Resident #32.Record review of a facility policy titled Medication Discrepancies and Adverse medication reactions dated 3/2025 indicated, .Medication discrepancies and adverse medication reactions are documented and reported to the residents' attending physician and designated personnel/committee of the facility .Record review of a facility policy titled Medication Administration Procedures undated indicated, .20. The 10 rights of medication should always be adhered to: 2. right medication; 3. right dose .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 2 medication storage rooms (East Wing) and 1 of 4 medication carts (East Wing) reviewed for labeling and storage.The facility failed to store an unopened insulin pen in the refrigerator on 3/24/2026 it was in the East Wing nurse medication cart.These deficient practices could place residents at risk for not receiving the intended therapeutic effects of their medications causing a health decline. Findings included:During an observation on 3/24/2026 at 11:04 am, the nurse medication cart for the East Wing was checked. LVN B was present. There was an insulin pen for Resident #18 that was unopened in a box. The insulin was degludec pen, and the order was to inject 20 units daily. The prescription was filled at a local pharmacy on 12/16/2025. The box said to keep in a cold place until first use. Store at 36 to 46 degrees.During an interview on 3/24/2026 at 11:39 am, LVN B said the Transport CNA was responsible for checking the medication carts and medication rooms for expired medications monthly. She said insulin should be stored in the refrigerator if it was not opened, and if not stored at the proper temperature would not be as effective. She said she would call the pharmacy and NP to get a new prescription for the insulin for Resident #18. She said she did not check the medication cart but only about once a week. She said Resident #18 brought the insulin in from home when he admitted on [DATE] and it was found in his room. She said someone placed it in the medication cart and said the resident told the staff the insulin did not need to be refrigerated. She said medications would not be as effective if given past their expiration dates. During an interview on 3/24/2026 at 1:34 pm, the Transport CNA said he was responsible for checking the medication carts and medication rooms but not the refrigerators. He said it had been more than a month or longer since he last checked them because he had been on transports taking residents to appointments. He said the staff assigned to the carts should also check them along with the Pharmacy Consultant when they came to the facility. He said medication errors could occur or a reaction to the medications if they were given and expired. During an interview on 3/25/2026 at 10:31 am, the Pharmacy Consultant said she visited the facility every other month and her last visit was 2/11/26. She said when she was at the facility she destroyed drugs, checked medication carts and rooms, observed a medication pass, and provided the facility with recommendations. She said when her visit was complete, she would send the facility a copy of her audit. She said if she found anything that was expired, she would remove them. She said unopened insulin should be stored in the refrigerator, if not it could go bad and not retain its use. She said if medications were given past the expiration dates, they could lose efficacy.During an interview on 3/25/2026 at 2:43 pm, the Administrator said the Pharmacy Consultant did audits of the carts and rooms in the facility. She said she sent a report to the facility after every visit. She said the Transport Aide used to be responsible for central supply and he would restock things and was not aware that he was checking the medication rooms or carts. She said if medications were given past their expiration dates, they might lose potency and the residents would not be given the appropriate strength. She said the unopened insulin should be stored in the refrigerator. Record review of a policy titled Medication Storage in the Facility undated indicated, .Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier.11. Medications requiring refrigeration or temperatures between 36 degrees and 46 degrees are kept in a refrigerator. Medications requiring storage in a cool place are refrigerated unless otherwise directed on the label. 13. Outdated medications are immediately removed from stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exists .

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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 observation, interview, and record review, the facility failed to employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition services for 1 of 1 kitchen reviewed for competent dietary support personnel. (Dietary Aide G) Dietary Aide G was preparing food and did not have a valid Food Handler's License. This failure could place residents in the facility who eat in the dining room at risk for food-borne illnesses. Findings Include: During an interview on 3/24/2026 at 11:20 am, Dietary Aide G said she had been employed at the facility since August of 2025. Dietary Aide G said she was responsible for preparing drinks and desserts as well as refilling the coffee/drink bar in the lobby and preparing trays. Dietary Aide G said she did not have a valid food handler's license. Dietary Aide G said she could not recall when her license expired and she did not have time to renew it. Dietary Aide G said she always practiced sanitary food handling practices and said not having a license did not pose any risk to residents. During an interview on 3/24/26 at 11:40 AM, the DM said she hired Dietary Aide G to work in the kitchen and knew at that time she did not have a valid food handler's license. The DM said she got busy with other things and did not get the dietary aide's food handler's license renewed. The DM said she did not feel there was any risk to residents or staff working in the kitchen without a valid food handler's license. The DM said the staff in question, Dietary Aide G, always observed sanitary practices and she had no concerns with having her working in the kitchen without a valid food handler's license. The DM said she would ensure Dietary Aide G completed her license renewal that day and going forward would ensure all staff members maintained current competencies for their employment. During an interview on 3/25/26 at 12:37 p.m., the Administrator said the DM was responsible for ensuring all kitchen staff had a valid food handler's license. The Administrator said she was not aware the facility had employed a dietary aide with an expired license. The Administrator said she felt there was no risk posed to residents due to Dietary Aide G performing their job duties under the supervision of a registered dietary manager. The Administrator said she was not sure if there was a policy that covered kitchen staff qualifications. A kitchen staffing policy was requested from the facility and was not provided. Review of food handler's licenses revealed Dietary Aide G completed a Food Handler Certificate Program on 3/25/26.

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	675267	A. Building B. Wing	03/25/2026

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food under sanitary conditions in 1 of 1 facility kitchens. There was expired coleslaw in a facility refrigerator. This failure could place residents who ate meals prepared in the kitchen at risk for food borne illness.Findings included: During an observation on 3/23/26 at 9:50 a.m. of facility refrigerator revealed a bag of coleslaw dated with the use by date of 3/20/26. During an interview on 03/24/26 at 11:30 a.m., [NAME] H said all kitchen staff were responsible for spot-checking and removing expired food from the refrigerators. [NAME] H said there was not any set schedule or assignment of who should be checking for expired food items and when they should be doing it. [NAME] H said there was no risk to residents if the coleslaw dated use by 3/20/26 had been served to residents. During an interview on 3/24/26 at 11:40 a.m., the DM said all kitchen staff were responsible for ensuring food in the refrigerator was properly labeled/dated and expired food to be removed. The DM said she didn't believe the food (coleslaw) in question was expired, only misdated. DM said the food was improperly dated when stored and presented no risk to residents if it had been served. During an interview on 3/25/26 at 12:37 p.m., the Administrator said the DM was responsible for supervision of the kitchen staff. The ADM said she was not sure what frequency the refrigerators were scheduled to be cleaned out, but she believed they were checked every day in the morning for expired items. The Administrator said the risk to residents would depend on the item and there was no risk from the coleslaw dated use by 3/20/26 if it had been served. Review of an undated facility policy titled Food Storage and Supplies indicated .Perishable items that are refrigerated are dated once opened and used within 7 days if they do not have an expiration date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 establish and 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 4 staff (CNA C) reviewed for infection control.The facility failed to ensure CNA C washed or sanitized her hands when incontinent care was provided to Resident #2 on 3/24/2026.These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices.Findings included:Record review of an admission Record for Resident #2 dated 3/25/2026 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia (a decline in mental ability that can interfere with daily life), GERD (acid reflux disease), and anxiety disorder (a persistent, excessive and uncontrollable fear, worry or dread that interferes with daily life).Record review of a Significant Change MDS Assessment for Resident #2 dated 2/26/2026 indicated she had severe impairment in cognition with a BIMS score of 0. She required substantial/maximal assistance with toileting hygiene. Her urinary continence was not rated but was always incontinent of bowel.Record review of a care plan for Resident #2 dated 10/18/2023 indicated she had bladder and bowel incontinence with interventions to check resident every two hours and assist with toileting as needed.During an observation on 3/24/2026 at 1:44 pm, CNA C took Resident #2 to the bathroom to provide incontinent care. CNA C placed gloves on her hands without washing or sanitizing them. She helped the resident to stand and positioned her on the toilet. Resident #2 urinated in the toilet. CNA C had the resident stand and used a wipe to clean the resident's perineal area from front to back and placed the wipe in the trash along with her gloves. CNA C applied gloves without washing or sanitizing her hands and wiped the perineal area again with another wipe and placed the wipe in the trash. CNA C removed the glove from her left hand and placed it in the trash and applied a glove only to her left hand and wiped the resident again from front to back and placed the wipe in the trash. CNA C removed her gloves and put them in the trash and placed a brief on the resident without wearing any gloves and positioned the resident back in her wheelchair. CNA C washed her hands and wheeled the resident back into the hallway.During an interview on 3/24/2026 at 1:55 pm, CNA C said she should have washed her hands before care was started, and she forgot that she should have washed or sanitized her hands between glove changes. She said her hands were clean after she removed her gloves when she placed the brief on Resident #2, She said she had been employed at the facility for 26 years and her last skills check-off was about a month ago. She said there was a risk of infections if they did not wash or sanitize their hands when care was provided or wore gloves when care was provided. Record review of a CNA Proficiency Audit for CNA C dated 7/23/2025 indicated she was satisfactory with perineal care for a female resident.During an interview on 3/25/2026 at 11:10 am, the DON said hand hygiene included washing or sanitizing should be performed before care, during, and after care and between glove changes. She said if staff did not follow protocol there was a risk of infections if they did not. She said staff should wear gloves when incontinent care was provided to the residents.During an interview on 3/25/2026 at 2:43 pm, the Administrator said staff should perform hand hygiene before and after. She said she expected her staff to follow policy and procedures as there was a risk of infections with not performing hand hygiene appropriately.Record review of a facility policy titled Fundamentals of Infection Control Precautions undated indicated, .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: when coming on duty; after removing gloves .

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. Based on observations, interviews, and records review, the facility failed to ensure handrails were firmly affixed to the wall in 1 of 2 shower rooms (East Unit shower room) reviewed for handrails. The facility failed to ensure a handrail in the shower room of the East Unit was securely affixed to the wall, it was observed to be loose and pulled away from the wall. This failure could place residents who use the shower room at risk for falls, injuries, and hospitalizations. Findings include: During an anonymous interview it was said she was concerned about a loose handrail in the shower of the East Wing shower room. They said a resident attempted to hold the rail, and it pulled away from the wall. During an observation on 3/24/26 at 2:10 p.m., of the shower room on the East Unit 1 of 2 shower stalls being used for resident showers had a shower handrail which was pulled away from and not firmly affixed to the wall. During an interview on 3/24/26 at 2:15 p.m., CNA C said she was unaware there was a loose shower handrail. CNA C said staff normally would submit a repair request by scanning a QR code which creates a maintenance request, but the facility had no maintenance man on staff. CNA C said there had been no maintenance man for approximately 1 week. CNA C said a loose handrail could cause a resident to fall. During an interview on 3/24/26 at 2:20 p.m., CNA F said she knew the shower rail was broken and had reported it using the maintenance repair request electronic form. CNA F said there was no maintenance man currently at the facility, so no repairs were made. CNA F said the shower rail had been broken for about a week. CNA F said she did not use that shower stall for residents due to the loose shower rail. CNA F said a loose handrail could cause a resident to fall. During an interview on 3/25/26 at 12:37 p.m., the ADM said she was unaware of the loose shower rail until that previous day. The ADM said she repaired the handrail herself because the facility had no maintenance director currently. The ADM said if staff were submitting tickets through the electronic reporting system she would not know about it because she had no access to the system. The ADM said a loose shower rail could be a fall risk but added residents were always showered under supervision of staff and most utilized a shower chair and did not stand to use the rail. The ADM said going forward she had interviews scheduled to hire a new maintenance director and she would continue to work with corporate maintenance to repair big issues in the facility. The ADM said she was working on minor issues herself and would ensure staff reported issues to her directly and not use the reporting system. Review of an undated facility policy titled Resident Rights indicated .The resident has a right to be treated with respect and dignity, including: .3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences .

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. Based on observation, interview, and record review, the facility failed to follow their own established smoking policy for 1 of 1 smoking areas.The facility failed to keep cigarette butts out of a trash can designated for trash.This failure could place residents at risk for injury, burns, and an unsafe smoking environment. Findings include:During an observation and interview on 3/24/2026 at 9:01 am, the smoking area had a trash can with a plastic liner with cigarette butts and trash. There was a red smoking can with a lock and it was indicated for the cigarette butts. Five residents were present with CNA K who were outside smoking. CNA K said when the residents were finished smoking, she would empty the ash trays into the red smoking can. She said staff were supposed to empty the ash trays after each break. CNA K observed the trash can and she said it had cigarette butts with trash and the butts should not be in the trash. She said there was a risk of residents going into the trash and getting them or there could be a risk of fire. She said Maintenance was responsible for emptying the red smoking cans, but they did not have a Maintenance Supervisor at the present time. During an interview on 3/25/2026 at 10:20 am, the HSK Supervisor said Maintenance was normally responsible for emptying the ashtrays into the red smoking cans, but he was terminated as of last week. She said she started checking the red cans this week and had a key to it. She said the cigarette butts go in the ash trays and at the end of smoke break they were emptied into the red cans. She said cigarette butts should never be placed in the trash as there could be a risk for fires.During an interview on 3/25/2026 at 2:43 pm, the Administrator said they had a resident that liked to empty the ashtrays into the trash. She said the person who supervised the smokers during the break should empty them into the red smoking can and going forward they would empty the ashtrays into the butt can (red smoking can). She said the previous Maintenance Supervisor was responsible for checking emptying the ash trays. She said the red can had a lock. She said after each smoke break the ashtrays were emptied into the red can. She said cigarette butts should not be placed in the trash as it was a risk of fires.Record review of a facility policy titled Smoking Policy undated indicated, .4. Ashtrays of noncombustible materials and safe design will be provided in all areas where smoking is permitted. Ashtrays will be a metal container with a self-closing cover device into which ashtrays may be emptied .