STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675367	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Gardens	3500 Park St Greenville, TX 75401

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 7 residents (Resident #1) reviewed for accidents. The facility failed to ensure Resident #1's safety while smoking. Resident #1 was allowed to sit on a public roadway in a space used by cars to parallel park where he could have been injured in a vehicle and pedestrian accident. An IJ was identified on 4/09/2024 at 3:45 PM. The IJ template was provided to the facility on [DATE] at 4:49 PM. While the IJ was removed on 4/10/2024, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk of harm, severe injury, and possible death to residents who require supervision. The findings included: Record review of a face sheet dated 4/10/2024 indicated Resident #1 was a [AGE] year-old male who admitted on [DATE] with the diagnoses which included: difficulty walking, unsteadiness on feet, abnormalities of gait and mobility, lack of coordination, abnormal posture, history of falls and encephalopathy (a disease that affects brain structure or function causing altered mental state and confusion). Record review of the Quarterly MDS dated [DATE] indicated Resident #1 was understood and understood others. The MDS indicated Resident #1's BIMS score was 15 indicating he had no cognitive deficits. The MDS in Section GG Functional Abilities and Goals indicated Resident #1 required set up with showers and personal hygiene. The MDS indicated Resident #1 required supervision or touching assistance with sit to stand, chair/bed-to-chair transfers, and toilet transfers. The MDS indicated Resident #1 was unable to walk 10 feet due to his medical condition or safety. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of a comprehensive care plan dated 3/15/2023 indicated Resident #1 was a smoker. The care plan goal was Resident #1 would smoke in designated areas without occurrence of injury. The care plan interventions for Resident #1 were performing the smoking assessment according to facility policy, explaining where designated smoking areas were and smoking times, monitoring when smoking to assure Resident #1's safety, and to keep all smoking material at the nurse's station. The comprehensive care plan also indicated Resident #1 was at risk to fall related to his gait/balance problems and use of psychoactive drugs. The goal of the care plan was Resident #1 would not sustain serious injury through the next review. The interventions included to ensure the call light was within reach and educate the resident on safety reminders. Record review of the consolidated physician's orders dated April 2024 indicated Resident #1 was administered Gabapentin (anticonvulsant medication used to treat pain) 300 milligrams at 8:00 AM, Xanax (anti-anxiety) 0.5 milligrams at 9:00 AM, Cyclobenzaprine (muscle relaxer) 10 milligrams at 9:00 AM, and Oxycodone 10 milligrams at 7:30 AM (narcotic pain medication). Record review of a Safe Smoking Evaluation dated 3/14/2023 indicated Resident #1 smoked, knew the locations of designated smoking areas, could go to the smoking areas independently, independently light his own smoking materials safely, could extinguish smoking materials completely and in the appropriate receptacles, and dispose of ashes or another tobacco-related residue. The assessment indicated Resident #1 did not have shaking when smoking, did not fall asleep while smoking, had not had past incidents with smoking materials, no visible burn marks on clothing, and no dexterity issues. The Summary of the Safe Smoking Evaluation reflected Resident #1 was safe to smoke with minimal supervision, and all smoking materials would be kept at the nurse's station. Record review of a Smoking by Residents policy dated November 2023 indicated on 11/22/2023 Resident #1 signed a copy indicating when clothing was found to have cigarette burn holes the smoker must wear an apron to protect themselves from burns regardless of whether the resident was assessed as independent for smoking. All smoking materials will be stored in a secure area to ensure they were kept safe. Smoking sessions would be supervised by facility staff members. The policy indicated the first, second, third offense rules and the discharge process after found smoking when smoking privileges were removed. Record review of a smoking notice violation dated 2/26/2024 indicated Resident #1 was provided a first offense regarding non-compliance with the smoking rules/policy. The smoking policy indicated in Section XIV. Response to resident non-compliance with smoking rules included: A. First Offense: a written letter issued to the resident and/or family regarding non-compliance. B. Second Offense: a written letter issued to the resident and /or family referencing the first offense letter and advising that a third offense results in the loss of smoking privileges. C. Third Offense: A written letter issued to the resident and/or family outlining the non-compliant behavior. At this time the resident loses their smoking privileges. D. Residents observed smoking following revocation of smoking privileges is issued a 30-day notice of discharge if their non-compliant behavior endangers other individuals (e.g. continuing to smoke in areas where oxygen is in use). The clinical/behavioral status of the resident endangering other individuals at the facility will be documented by an associated physician in accordance with Policy no._AD_04-Transfers and Discharge. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of a smoking notice violation dated 3/11/2024 indicated Resident #1 was provided a letter to inform him of his second offense regarding non-compliance with the smoking rules/policy. The violation indicated Resident #1 was observed smoking outside of smoke times on March 9, 2024, at 5:45 a.m. The letter again indicated Resident #1 received a copy of the policy. Record review of the Resident Out on Pass Log Version 1.0 indicated Resident #1's last signed out on pass time was on 4/08/2024. In the section of accompanied by was written 9:00 - 1130 the log failed to specify if the time was morning or night. The pre-printed log in the categories listed did not indicate the time Resident #1 signed himself out, the licensed nurse's initials, the expected time of return, the time of return and then again, the licensed nurse's initials. The log had no sign out date for 4/09/2024. During an observation as the surveyors themselves were looking for a parking space on 4/09/2024 at 9:00 a.m., revealed Resident #1 was noted to be sitting on the left side of the roadway that was in the front of the nursing facility. Resident #1 was sitting in his wheelchair in front of a passenger car facing the roadway while smoking his cigarette. Resident #1 was facing the facility sitting in front of a parked vehicle closest to the front passenger side. Resident #1 had an entire car length between him and the next paralleled parked SUV. The surrounding area behind Resident #1 was the roadside curb, brush, and residential fencing. The were not any public sidewalks available for use by a pedestrian. During an observation and interview on 4/09/2024 at 10:10 a.m., the DON was asked where the surveyor could find Resident #1. The surveyor informed the DON Resident #1 was not in his room. The DON asked Resident #1's nurse, RN A, the whereabouts of Resident #1 and she asked, Did you check his restroom? The surveyor indicated the bathroom had not been checked for his presence. The DON opened and looked at the Resident Sign Out Logbook then closed the book. The DON walked to the front door and viewed out the glass doors as though she was looking for someone. The DON said Resident #1 went outside, across the street at his leisure to smoke. RN A returned from Resident #1's room to the DON and surveyor and indicated Resident #1 was not in his restroom. The nurse opened the secured glass doors, walked down the facility driveway, and found Resident #1. Resident #1 was sitting in the roadway smoking. The area Resident #1 was seated was facing the roadway more closely to the passenger side of a red colored passenger car. Resident #1 had an entire car length space to his right just behind a large SUV. Resident #1 was found to be smoking sitting directly on the roadway, with a curb, brush, and residential fencing boundary present directly behind his wheelchair. Resident #1 was sitting in an area in which there were no sidewalks provided off the roadway. Resident #1 was assisted back inside the facility by RN A. During an interview on 4/09/2024 at 10:17 a.m., Resident #1 said he had been smoking across the street because he was not allowed to smoke on the premises due to his 30-day letter. Resident #1 said he had not signed himself out but left out of the building on his signature from 4/08/2024. Resident #1 said he felt safe outside in the street because he sat close to the curb. Resident #1 said he smoked early in the mornings between 5:30 a.m. and 6:00 a.m. when the air was freshest, and he said he felt as though he could breathe better. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 4/09/2024 at 10:57 a.m., RN A said she was Resident #1's nurse. RN A said 4/08/2024 was her first day outside the secured unit assignment having been assigned to Resident #1. RN A was unsure how Resident #1 had his cigarettes and was found outside the facility. RN A said it was very important for the CNAs, or other staff to let her know when a resident was leaving the facility. RN A said she was not aware where Resident #1 was until she started looking for him. During an interview on 4/09/2024 at 11:07 a.m., Resident #1 said he had a package of cigarettes and a lighter on his person but was not allowed to smoke on the premises. During an interview on 4/09/2024 at 11:17 a.m., the local Ombudsman said she was assisting Resident #1 with his discharge appeals process. The Ombudsman said she was aware Resident #1 smoked outside, and he had his own smoking materials. During an interview on 4/09/2024 at 12:51 p.m., Resident #1 said there were so many residents sitting in the foyer of the facility he could not get to the sign out book this morning. Resident #1 said the Receptionist opened the door for him this morning. Resident #1 said he did not have the code to the front door. Resident #1 said he usually stayed outside on the street about an hour at a time smoking, drinking his coffee, and looking at his iPad. During an interview on 4/09/2024 at 12:52 p.m., the SW said she was aware Resident #1 smoked outside across the street. The SW said due to Resident #1's smoking habits his smoking privileges on the premises had been removed. The SW said when Resident #1 signed out essentially he was out on pass. The SW said Resident #1 should have signed out to smoke for safety. The SW said the nurse should have documented Resident #1 was out on pass. During an interview on 4/09/2024 at 1:13 p.m., the Receptionist said she had been employed at the facility for almost 2 weeks. The Receptionist said she was told she could let Resident #1 and one other resident go outside. The Receptionist said since she had been told Resident #1 could go outside, she just allowed him to exit the building. The Receptionist said she was unable to recall who said Resident #1 could exit the building to smoke. During an interview on 4/09/2024 at 1:17 p.m., the DON said when she looked out the front door of the facility, she just overlooked Resident #1 because she did not see him as he was closer to the parked car. The DON said she had spoken to Resident #1 about sitting closer to the curb when sitting in the street to smoke. The DON said Resident #1 should have signed himself out, then he could be let out. The DON said she was told Resident #1 smoked across the street because he was non-compliant with the rules to be able to smoke at the facility during designated smoke times. During an interview on 4/06/2024 at 4:06 a.m., the Administrator said Resident #1 smoked outside across the street because his smoking privileges had been taken away because he had been caught smoking outside the policy. The Administrator said Resident #1 should not have had cigarettes on his person, but the Administrator said every time the cigarettes and lighters were taken up Resident #1 obtained Th. The Administrator said the street was a busy residential street with employees and resident family's coming and goings. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of a Smoking by Resident policy dated November 2023 indicated the purpose of the policy was to respect resident choice to smoke and to maintain a safe healthy environment for both smokers and non-smokers. The policy indicated smoking was not allowed anywhere inside the facility, the facility permits smoking only in the areas designated by the Facility's Safety Committee, the facility discourages smoking by residents and ensures that those residents who choose to smoke do so safely, residents who want to smoke will be assessed for their ability to smoke safely prior to being allowed to smoke independently in these areas .Procedures V. Residents will be allowed to smoke in designed smoking areas only X. All Smoking sessions will be supervised by Facility Staff members XXIV. Response to resident non-compliance with smoking rules include A. First Offense: A letter issued to the resident and/or family regarding non-compliance. B. Second Offense: A written letter issued to the resident and/or family referencing the first offense letter and advising that a third offense results in the loss of smoking privileges. C. Third offense: A written letter issued to the resident and/or family outlining the non-compliant behavior. At this time the resident loses their smoking privileges. D. Residents observed smoking following revocation of smoking privileges is issued a 30-day notice of discharge if their non-compliant behavior endangers other individuals. The clinical/behavioral status of the resident endangering other individuals at the Facility will be documented by an associated physician in accordance with policy no. AD-04-Transfer and Discharge. Record review of an Out on Pass policy and procedure dated 8/2020 indicated the purpose was to provide resident with the opportunity to participate in family and community life in ways that support well-being and optimal functioning. Policy . It is the policy of the facility to meet residents' physical psychosocial needs to go out on pass. The Facility will make reasonable efforts to ensure the resident safety and uphold resident rights. I When a resident request to go out on pass, the interdisciplinary Team will assess the resident's ability to participate in activities outside the facility, while taking into consideration the resident's decision-making capacity, physical disabilities, and ability to take medications without supervision V. Licensed Nurses A. Prior to the resident leaving on pass, a Licensed Nurse will assess the residents physical and mental status .VI. The Resident/Responsible Person A. The resident/responsible person is encouraged to give the facility reasonable notice when anticipating going out on pass. B. The resident/responsible person will verbally notify a Licensed nurse prior to going out on pass and will sign out and back in on Resident Out on Pass Log. The Administrator and Regional Director was notified an IJ was identified on 4/09/2024 at 4:35 p.m. The IJ template was provided to the facility on [DATE] at 4:49 p.m. The Facility's plan of removal was accepted on 4/10/2024 at 3:20 p.m. and included the following: PLAN OF REMOVAL FOR IMMEDIATE JEOPARDY To Whom it may concern, Summary of Details which lead to outcomes. F689 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 4/9/24 during a complaint survey at [facility name and address]. HHSC surveyor provided an IJ Template notification that the Survey Agency has determined that the conditions at the center constitute immediate jeopardy to resident health. The facility allegedly failed to provide supervisory services. When Resident #1 exited facility without signing self out on pass to sit on public street between two parked cars while he smoked. The notification of the alleged immediate jeopardy states as follows: Resident #1 was allowed to exit the building without signing out and sit on the public street between 2 parked cars while he smoked. Identify responsible staff/ what action taken. 1. Director of Nurses and Administrator educated by the Regional Nurse Consultant on the facility policy for signing out on pass completed on 4/9/24. 2. All Staff education on out on pass process started by the DON on 4/9/24 and completed on 4/10/24, no staff will resume assignment without being in serviced. 3. All new hires will be educated on this process by DON/Designee prior to starting work. This will be ongoing. 4. Resident #1 will be provided a safe designated smoking area located on property available to resident at all times. In-Service conducted. 1. Director of Nurses and Administrator educated by the Regional Nurse Consultant on the facility policy for signing out on pass completed on 4/9/24. 2. All Staff education on out on pass process started by the DON on 4/9/24 and completed on 4/10/24, no staff will resume assignment without being in serviced. 3. All new hires will be educated on this process by DON/Designee prior to starting work. This will be ongoing. Implementation of Changes Director of Nurses and Administrator were educated on the facility policy for signing out on pass completed on 4/9/24. All Staff education on out on pass process started by the DON on 4/9/24 and completed on 4/10/2024, no staff will resume assignment without being in serviced. Smoke assessment completed on all smokers in the facility, as well as education on smoke schedule and designated area. Residents who smoke that are determined to be safe to smoke will be assessed for any additional accommodations that may be needed to ensure resident safety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	All residents with BIMS of 11 (mildly impaired cognition) and below will not be allowed to sign out on pass without supervision. Facility will be respectful of resident's right to come and go from the facility by ensuring residents who are able to do so will sign in and out of the facility. Should a resident require a ride to a destination, facility will make attempt to accommodate said request. Residents who are deemed safe to go out on pass will be educated of potential safety concerns and IDT note will be placed in resident's chart. After an audit by the facility administrator no other residents are found to be signing out on pass to smoke off property or go elsewhere without facility assistance or support. All new hires will be educated on this process by DON/Designee prior to starting work. This will be ongoing. All re-education and assessments were initiated by the Regional Nurse Consultant for the DON/ Administrator. The changes were implemented effective on 4/9/24 and re-education is ongoing. Staff will not be allowed to work until they have been fully re-educated. All new hires will be educated on out on pass policy prior to resuming work by Administrator/DON/Designee. Facility Smoking Policy/Smoking assessments were reviewed with no changes required. Involvement of Medical Director The Medical Director met with the Interdisciplinary team on 4/9/24 and conducted an Ad HOC QAPI regarding ensuring patient safety by properly signing out on pass prior to exiting facility. The Medical Director was notified about the immediate Jeopardy on 4/9/24, the Plan of removal was reviewed and accepted by Medical Director. Involvement of QA An Ad Hoc QAPI meeting was held with the Medical Director, facility administrator, director of nursing, to review the plan of removal on 4/9/24. Who is responsible for the implementation of the process? The Director of Nursing and Administrator will be responsible for the implementation of Process. Please accept this letter as our plan of removal for the determination of Immediate Jeopardy issued on 4/9/24. On 4/10/2024 the surveyor confirmed the facility had implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Interview with the Administrator on 4/10/2024 at 5:00 p.m., indicated safer smoking arrangement for Resident #1 was implemented while completing the appeals process regarding the 30-day notice and sign out on pass process. Interview with the DON on 4/10/2024 at 5:16 p.m. indicated safer smoking arrangements for Resident #1 while completing the appeals process regarding the 30-day notice and the sign out on pass process. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the off Cycle (Ad hoc) QA Meeting Document, dated 4/09/2024 indicated an action plan was initiated and discussed for a safer smoking option for Resident #1, and the signing out process Record review of the Administrator and DON's training provided by the Regional Nurse Consultant dated 4/09/2024 regarding the facility's Out on Pass policy. The Out on Pass Policy dated 08/2020 indicated when a resident wished to go out on pass the interdisciplinary team would assess the resident's ability to participate in activities outside the facility, while taking into consideration the resident's decision-making capacity, physical disabilities, and ability to take medications without supervision lll. If the resident's use of the out on pass order conflicts with the resident's plan of care or jeopardizes the resident's safety, the Nursing Staff will notify the Attending Physician and Psychiatrist of the need to review the resident's status prior to the staff allowing the resident to leave the facility on a pass. IV. The order for a pass out of the facility may be discontinued by the Attending Physician or Psychiatrist at any time. Record review of the Out on Pass Book Monitoring Tool indicated the book was reviewed on 4/10/2024 with no concerns noted. Record review of the resident list of BIMS of 12 and higher tool dated 4/09/2024 indicated Resident #1 was on the list. Record review of the resident list of who sign out on pass to go smoke dated 4/09/2024 indicated Resident #1 was the only Resident who could sign himself out to smoke. Record review of In-Service Training Report dated 4/09/2024 revealed all staff were provided education on residents going out on pass and the sign in and out book. Record review of In-Service Training Report dated 4/10/2024 revealed all staff were provided education regarding the smoking policy and smoking times. Record review of the undated Out on Pass Monitoring Tool indicated a listing with the date, resident name, BIMs, smoking evaluation, accompanied/self, sign in/and out, and auditor's signature. Record review of the BIMS scores was considered cognitively intact of the residents who smoked and who could sign themselves out was 8 including Resident #1. Record review of the Smoking Assessments of the 10 residents who smoked indicated 8 required minimal supervision and two required direct supervision while smoking. During an observation on 4/10/2024 at 5:00 p.m., indicated Resident #1's smoking area was to the right of the front door of the facility. The area had a small table, proper ash trays, and proper trash can, and a fire extinguisher was available. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 4/10/2024 from 3:20 p.m. - 5:30 p.m., the Administrator, DON, MDS, AD, Maintenance Supervisor, Laundry Supervisor, SW, Staffing Coordinator, Medical Records, Transportation, Director of Nutrition, Housekeeping/Laundry Supervisor, Receptionist, RN A, CNAs B, F, K, O, LVN D, E, H, L and Q, Dietary aide P, Housekeeping M, and Laundry N could all explain the signing in/out process, including which residents could sign themselves out and the criteria to sign oneself out of the facility. The staff could explain the smoking processes and explained Resident #1 was the only individual who smoked outside of the main designated area. On 4/10/2024 at 5:25 p.m., the Administrator was informed the IJ was removed however, the facility remained out of compliance at a potential for harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

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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** 33249 Based on observation, interview, and record review, the facility failed to ensure that residents were free of significant medication errors for 1 of 2 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure MA R administered Resident#1's oxycodone 10 milligrams timely as scheduled on 3/10/2024 at 7:30 a.m. and 11:30 a.m. The facility failed to ensure MA R administered Resident #1's Lasix 40 milligrams timely as scheduled on 3/102024 at 8:00 a.m. The facility failed to ensure MA R administered Resident #1's Gabapentin 300 milligrams timely as scheduled on 3/102024 at 8:00 a.m. The facility failed to ensure MA R administered Resident #1's Aldactone 100 milligrams timely as scheduled on 3/102024 at 8:00 a.m. This failure could place the resident at risk of medical complications and not receiving the therapeutic effects of their medications. Findings Included: During an interview on 4/09/2024 at 10:17 a.m., Resident #1 said on 3/10/2024 his morning medications were administered after lunch. Resident #1 said he indicated to the weekend RN someone should be administering his medications. Record review of a face sheet dated 4/10/2024 indicated Resident #1 was a [AGE] year-old male who admitted on [DATE] with the diagnosis liver disease, high blood pressure, anxiety, and neuralgia (pain caused by damaged nerves). Record review of the Quarterly MDS dated [DATE] indicated Resident #1 was understood and understood others. The MDS indicated Resident #1's BIMS score was 15 indicating he had no cognitive deficits. Section J -Health Conditions indicated Resident #1 received scheduled pain medications. Section N- Medications of the MDS indicated Resident #1used diuretics and opioids. Record review of the comprehensive care plan dated 3/24/2023 indicated Resident #1 had a potential fluid deficit related to the use of diuretics. The goal of the care plan was Resident #1 would be free of symptoms of dehydration. The interventions included to administer medications as ordered. The comprehensive care plan indicated Resident #1 required pain management related to chronic pain. The goal of this care plan was Resident #1 would not have an interruption in normal activities due to his pain. The interventions for the pain care plan was monitor, record, and report to the nurse complaints of pain or requests for pain medications. The comprehensive care plan indicated Resident #1 had liver disease. The goal of the care plan was Resident #1 would be free of any symptoms of liver complications. The interventions for the care plan included to administer medications as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675367	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Gardens	3500 Park St Greenville, TX 75401

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the consolidated physician's orders dated April 9, 2024, indicated Resident #1 was ordered on 3/14/2023 Furosemide (diuretic) 40 milligrams two times daily for edema (fluid retention), oxycodone 10 milligrams four times daily started on 3/14/2023, Gabapentin 300 milligrams one two times daily for pain started on 3/14/2023, and Aldactone 100 milligrams two times daily started on 6/14/2023. Record review of a Medication Administration Audit Report dated 4/09/2024 revealed on 3/10/2024 Resident #1 received his ordered medications as follows: Oxycodone 10 milligrams scheduled for administration at 7:30 a.m. and received at 1:35 p.m. signed by MA R Oxycodone 10 milligrams scheduled for administration at 11:30 a.m. but received at 1:36 p.m. signed by MA R Lasix (furosemide) 40 milligrams scheduled for administration at 8:00 a.m. but received at 1:35 p.m. signed by MA R Gabapentin (Neurontin) 300 milligrams scheduled for administration at 8:00 a.m. but received at 1:35 p.m. signed by MA R Aldactone (Spironolactone) 100 milligrams scheduled for administration at 8:00 a.m. but received at 1:54 p. m. signed by MA R. Record review of the scheduling for March 2024 indicated MA R worked double weekend shifts starting at 6:00 a.m. and ending at 10:00 p.m. Record review of MA R's time sheet indicated she clocked in to work on Sunday 3/10/2024 at 12:12 p.m. During an interview on 4/10/2024 at 3:46 p.m., MA R said she had called in sick on the first shift of her tour of duty on 3/10/2024. MA R said she called in to the management as per protocol. MA R said when she arrived to work on 3/10/2024 for her second shift the medications had not been passed by the nursing staff on duty. MA R said she administered Resident #1's medications. During an interview on 4/11/2024 at 10:50 a.m., the weekend RN said the charge nurse had made her aware MA R had called off her first shift. The weekend RN said she expected the nurse and believed the nurse administered the medications. The weekend RN said Resident #1 could have had adverse reactions not having his blood pressure medications causing his blood pressure to be elevated, pain control issues due to his pain medications being administered late, and fluid overload related to his diuretic being late. The weekend RN indicated the medications should not have been administered too closely together to ensure the desired effectiveness. The weekend RN said she was responsible for the care of the residents on the weekend shifts. During an interview on 4/11/2024 at 2:54 p.m., the DON said she expected the residents to receive their medications timely. The DON said the nurse was responsible for ensuring the medications were administered. The DON said she was not the DON during the late administration, but she expected to be notified when medications were possibly going to be administered late. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675367	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Gardens	3500 Park St Greenville, TX 75401

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/11/2024 at 4:00 p.m., the Medical Director said he expected the medications to be administered as ordered. The Medical Director said medications should be evenly administered according to their hour of administration to ensure the medications were properly treating the disease in which the medication was prescribed. During an interview on 4/11/2024 at 4:20 p.m., the Administrator indicated he expected medications to be administered according to the orders. The Administrator said the DON was responsible for ensuring medications were accurately administered according to the rights of medication administration including right time. Record review of an undated Medication-Administration policy revealed the purpose was to provide practice standards for safe administration of medications for residents in the facility V. Medications may be administered one hour before or after the scheduled medication administration time. IV Nursing Staff will keep in mind the seven rights of medication when administering medications: D. Right time