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	06/19/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview and record review the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 2 of 5 residents (Resident #2, and Resident #3) reviewed for abuse. The facility failed to protect Resident #2 from Resident #1, when Resident #1 pulled Resident #2's hair, which resulted in Resident #2's fall, and Resident #2 having to go to the ER for evaluation on 04/30/2024. The facility failed to protect Resident #3 from Resident #1, when Resident #1 hit Resident #3 on the chest on 05/10/2024. These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: 1. Record review of a face sheet dated 06/19/2024 indicated Resident #1 was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizoaffective disorder (a condition that can make you feel detached from reality and can affect our mood) and dementia in other diseases classified elsewhere with other behavioral disturbance (deterioration of memory, language, and other thinking abilities with behaviors). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #1 was rarely/never able to make himself understood and sometimes understood others. The MDS assessment indicated Resident #1 had a short-term and long-term memory problem. The MDS assessment indicated Resident #1 did not experience hallucinations or delusions. The MDS assessment indicated Resident #1 exhibited verbal behavioral symptoms directed towards others 1 to 3 days in the 7 day look back period. The MDS assessment did not indicate Resident #1 exhibited physical or other behavioral symptoms directed towards others. The MDS assessment indicated Resident #1's behaviors did not put others at significant risk for physical injury. The MDS assessment indicated Resident #1's behaviors significantly disrupted care or living environment. The MDS assessment indicated Resident #1 required substantial/maximal assistance with toileting hygiene, bathing, lower body , and partial to moderate assistance with upper body dressing and personal hygiene. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Greenville Gardens	3500 Park St Greenville, TX 75401

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan last reviewed 06/03/2024 indicated he had a behavior problem related to dementia with psychosis, schizoaffective disorder and had aggression, agitation, anxiety, and hit staff. Resident #1's care plan included to intervene as necessary to protect the rights and safety of others, approach/speak to him in a calm manner, divert attention., remove from situation and take to alternate location as needed. Record review of Resident #1's Progress Note dated 04/30/2024 indicated, This nurse observe the resident running down the hallway, aggressive with fist up, combative and screaming, attacking staff and residents, was separated from the staff and other residents, resident immediately removed away from residents, assisted by staff to the room to be place in bed, support is provided, assessment performed V/S (blood pressure, pulse, heart rate, respirations, and oxygen saturation):120/83,79,18,97.4,98%, no pain or discomfort, ROM completed able to move all extremities, No neuro changes, doctor, family, and DON notified, doctor orders send to ER for evaluation Author RN A. Record review of Resident #1's Progress Note dated 05/10/2024 indicated, This nurse observe the resident running down the hallway, aggressive with fist up, combative and screaming, attacking staff and resident, was separated from the staff and other residents, resident immediately removed away from residents, assisted by staff to the room to be place in bed, support provided assessment performed V/S (blood pressure, pulse, heart rate, respirations, and oxygen saturation): 124/72,83,18,97.3,96%, denies pain or discomfort, ROM completed able to move all extremities, no neuro changes, MD, Family and DON notified Author RN A. 2. Record review of a face sheet dated 06/19/2024 indicated Resident #2 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (deterioration of memory, language, and other thinking abilities without behaviors). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #2 was able to make herself understood and understood others. The MDS assessment indicated Resident #2 had a BIMS score of 4, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #2 required partial/moderate assistance with toileting hygiene, bathing, dressing, and personal hygiene. Record review of Resident #2's care plan last reviewed 05/09/2024 indicated she was an elopement risk/wanderer as evidenced by disoriented to place, and she wandered aimlessly and was admitted to the secured unit. Record review of Resident #2's Progress Note dated 04/30/2024 indicated Resident was standing on the hallway when another pulled residents hair causing resident to fall to the ground. Head to toe assessment, resident right hand swollen V/S (vital signs (blood pressure, pulse, heart rate, respirations, and oxygen saturation) obtained 120/79,68,98,18,97.3, resident assisted to w/c (wheelchair) and place at the nursing station in staff sight. Resident displayed no signs of pain, Neuro (neurological) check initiated, MD, family (no answer left voicemail message) and DON were notified. Dr. (doctor) orders send to ER for Evaluation Author RN A. Record review of Resident #2's Emergency Department discharge information dated 04/30/2024 indicated discharge diagnosis of fall and hand contusion (injury to the skin and tissue of the hand caused by trauma or impact). (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an attempted interview on 06/19/2024 at 11:55 AM, Resident #2 was non-interviewable. 3. Record review of a face sheet dated 06/19/2024 indicated Resident #3 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (deterioration of memory, language, and other thinking abilities without behaviors). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #3 was able to make himself understood and understood others. The MDS assessment indicated Resident #3 had a BIMS score of 6, which indicated his cognition was severely impaired. The MDS assessment indicated Resident #3 required partial/moderate assistance with toileting and upper body dressing, dependent for bathing, and set-up or clean-up assistance with personal hygiene. Record review of Resident #3's care plan last reviewed 05/23/2024 indicated he was an elopement risk/wanderer as evidenced by disoriented to place, impaired safety awareness, and significantly intrudes on the privacy or activities. Record review of Resident #3's Progress Note dated 05/10/2024 indicated, Resident sitting in the dining room when another resident hit him on the chest, head to toe assessment, denies pain or discomfort, resident immediately removed away from resident, support is provided, resident V/S (vital signs): 119/78, 69, 18,97.3, no neuro changes, MD notified, Family and DON Author RN A. During an attempted interview on 06/19/2024 at 11:38 AM, Resident #3 had inattention and was unable to answer questions appropriately. During an interview starting on 06/19/2024 at 2:23 PM, Resident #1's family member assisted with a phone interview with Resident #1. Resident #1 was asked if he remembered hitting a man while at the nursing facility. Resident #1 said he had hit a man and the man had hit him but was unable to provide further details. Resident #1 was asked if he remember an incident where he pulled a woman's hair and she had fallen. Resident #1 said he did not remember. During an attempted phone interview on 06/19/2024 at 3:33 PM, the previous Administrator did not answer the phone. During an interview on 06/19/2024 at 3:38 PM, RN A said Resident #1 was aggressive and would attack the residents and staff by punching them. RN A said she witnessed the incident with Resident #2. RN A said Resident #2 was standing in the hall and Resident #1 ran down the hallway and pulled Resident #2's hair and made her fall. RN A said Resident #2 did not have any injuries, but she was sent out to the ER for evaluation as a precaution. RN A said she witnessed the incident with Resident #3. RN A said Resident #3 was sitting in the dining room and Resident #1 walked by and hit Resident #3 on the chest. RN A said Resident #3 experienced no injuries. RN A said the previous administrator was notified of both incidents. RN A said Resident #1 hitting Resident #3 and pulling Resident #2's hair and making her fall could be considered physical abuse. RN A said it was important for incidents of abuse to be reported to ensure they were investigated and to protect the residents. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/19/2024 at 4:14 PM, the DON said the doctor was notified of both the incidents between Resident #1 and Resident #2 and Resident #1 and Resident #3. The DON said since both incidents were witnessed and because Resident #1 had a diagnosis of dementia his actions could not be willful. During an interview on 06/19/2024 at 5:53 PM, the Administrator said he was not at the facility when the incidents between Resident #1 and Resident #2 and Resident #1 and Resident #3 occurred. The Administrator was asked if the resident-to-resident altercations between Resident #1 and Resident #2 and Resident #1 and Resident #3 could be considered abuse. The Administrator responded he could not respond because he did not know what had happened. Record review of the facility's policy titled, Violence Between Residents, revised 2020, indicated, To protect the health and safety of residents by ensuring that altercations between residents are promptly reported, investigated, and addressed by the Facility .A. Facility Staff monitors residents for aggressive or inappropriate behavior toward other residents, family members, visitors, or Facility Staff .Report incidents, findings, and corrective measures to appropriate agencies . Record review of the facility's policy titled, Abuse Prevention and Prohibition Program, revised 10/24/2022, indicated, .Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property .The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents .

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, for 2 of 5 residents (Resident #2, and Resident #3) reviewed for abuse. The facility failed to implement their policy on reporting abuse when Resident #1 pulled Resident #2's hair which caused Resident #2 to fall and be sent to the ER for evaluation on 04/30/2024. The facility failed to implement their policy on reporting abuse when Resident #1 hit Resident #3 on the chest on 05/10/2024. The facility failed to implement their abuse policy to prevent Resident #1 from pulling Resident #2's hair on 4/30/2024, and hitting Resident #3 on the chest on 5/10/2024 These failures could place residents at risk of unreported abuse, neglect, exploitation, and a decreased quality of life. Findings included: Record review of the facility's policy titled, Abuse Prevention and Prohibition Program, revised 10/24/2022, indicated, .Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property .The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents . The Facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents that qualify .Immediately but no later than 2 hours after forming the suspicion-if alleged violation involves abuse or results in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman (if applicable per state regulation) . 1. Record review of a face sheet dated 06/19/2024 indicated Resident #1 was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizoaffective disorder (a condition that can make you feel detached from reality and can affect our mood) and dementia in other diseases classified elsewhere with other behavioral disturbance (deterioration of memory, language, and other thinking abilities with behaviors). (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #1 was rarely/never able to make himself understood and sometimes understood others. The MDS assessment indicated Resident #1 had a short-term and long-term memory problem. The MDS assessment indicated Resident #1 did not experience hallucinations or delusions. The MDS assessment indicated Resident #1 exhibited verbal behavioral symptoms directed towards others 1 to 3 days in the 7 day look back period. The MDS assessment did not indicate Resident #1 exhibited physical or other behavioral symptoms directed towards others. The MDS assessment indicated Resident #1's behaviors did not put others at significant risk for physical injury. The MDS assessment indicated Resident #1's behaviors significantly disrupted care or living environment. The MDS assessment indicated Resident #1 required substantial/maximal assistance with toileting hygiene, bathing, lower body , and partial to moderate assistance with upper body dressing and personal hygiene. Record review of Resident #1's care plan last reviewed 06/03/2024 indicated he had a behavior problem related to dementia with psychosis, schizoaffective disorder and had aggression, agitation, anxiety, and hit staff. Resident #1's care plan included to intervene as necessary to protect the rights and safety of others, approach/speak to him in a calm manner, divert attention., remove from situation and take to alternate location as needed. Record review of Resident #1's Progress Note dated 04/30/2024 indicated, This nurse observe the resident running down the hallway, aggressive with fist up, combative and screaming, attacking staff and residents, was separated from the staff and other residents, resident immediately removed away from residents, assisted by staff to the room to be place in bed, support is provided, assessment performed V/S (blood pressure, pulse, heart rate, respirations, and oxygen saturation): 120/83,79,18,97.4,98%, no pain or discomfort, ROM completed able to move all extremities, No neuro changes, doctor, family, and DON notified, doctor orders send to ER for evaluation Author RN A. Record review of Resident #1's Progress Note dated 05/10/2024 indicated, This nurse observe the resident running down the hallway, aggressive with fist up, combative and screaming, attacking staff and resident, was separated from the staff and other residents, resident immediately removed away from residents, assisted by staff to the room to be place in bed, support provided assessment performed V/S (blood pressure, pulse, heart rate, respirations, and oxygen saturation): 124/72,83,18,97.3,96%, denies pain or discomfort, ROM completed able to move all extremities, no neuro changes, MD, Family and DON notified Author RN A. 2. Record review of a face sheet dated 06/19/2024 indicated Resident #2 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (deterioration of memory, language, and other thinking abilities without behaviors). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #2 was able to make herself understood and understood others. The MDS assessment indicated Resident #2 had a BIMS score of 4, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #2 required partial/moderate assistance with toileting hygiene, bathing, dressing, and personal hygiene. Record review of Resident #2's care plan last reviewed 05/09/2024 indicated she was an elopement risk/wanderer as evidenced by disoriented to place, and she wandered aimlessly and was admitted to the secured unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Greenville Gardens	3500 Park St Greenville, TX 75401

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Progress Note dated 04/30/2024 indicated Resident was standing on the hallway when another pulled residents hair causing resident to fall to the ground. Head to toe assessment, resident right hand swollen V/S (blood pressure, pulse, heart rate, respirations, and oxygen saturation) obtained 120/79,68,98,18,97.3, resident assisted to w/c (wheelchair) and place at the nursing station in staff sight. Resident displayed no signs of pain, Neuro (neurological) check initiated, MD, family (no answer left voicemail message) and DON were notified. Dr. (doctor) orders send to ER for Evaluation Author RN A. Record review of Resident #2's Emergency Department discharge information dated 04/30/2024 indicated discharge diagnosis of fall and hand contusion (injury to the skin and tissue of the hand caused by trauma or impact). During an attempted interview on 06/19/2024 at 11:55 AM, Resident #2 was non-interviewable. 3. Record review of a face sheet dated 06/19/2024 indicated Resident #3 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (deterioration of memory, language, and other thinking abilities without behaviors). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #3 was able to make himself understood and understood others. The MDS assessment indicated Resident #3 had a BIMS score of 6, which indicated his cognition was severely impaired. The MDS assessment indicated Resident #3 required partial/moderate assistance with toileting and upper body dressing, dependent for bathing, and set-up or clean-up assistance with personal hygiene. Record review of Resident #3's care plan last reviewed 05/23/2024 indicated he was an elopement risk/wanderer as evidenced by disoriented to place, impaired safety awareness, and significantly intrudes on the privacy or activities. Record review of Resident #3's Progress Note dated 05/10/2024 indicated, Resident sitting in the dining room when another resident hit him on the chest, head to toe assessment, denies pain or discomfort, resident immediately removed away from resident, support is provided, resident V/S (blood pressure, pulse, heart rate, respirations, and oxygen saturation): 119/78, 69,18,97.3, no neuro changes, MD notified, Family and DON Author RN A. During an attempted interview on 06/19/2024 at 11:38 AM, Resident #3 had inattention and was unable to answer questions appropriately. During an interview starting on 06/19/2024 at 2:23 PM, Resident #1's family member assisted with a phone interview with Resident #1. Resident #1 was asked if he remembered hitting a man while at the nursing facility. Resident #1 said he had hit a man and the man had hit him but was unable to provide further details. Resident #1 was asked if he remember an incident where he pulled a woman's hair and she had fallen. Resident #1 said he did not remember. During an attempted phone interview on 06/19/2024 at 3:33 PM, the previous Administrator did not answer the phone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Greenville Gardens	3500 Park St Greenville, TX 75401

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/19/2024 at 3:38 PM, RN A said Resident #1 was aggressive and would attack the residents and staff by punching them. RN A said she witnessed the incident with Resident #2. RN A said Resident #2 was standing in the hall and Resident #1 ran down the hallway and pulled Resident #2's hair and made her fall. RN A said Resident #2 did not have any injuries, but she was sent out to the ER for evaluation as a precaution. RN A said she witnessed the incident with Resident #3. RN A said Resident #3 was sitting in the dining room and Resident #1 walked by and hit Resident #3 on the chest. RN A said Resident #3 experienced no injuries. RN A said the previous administrator was notified of both incidents. RN A said Resident #1 hitting Resident #3 and pulling Resident #2's hair and making her fall could be considered physical abuse. RN A said it was important for incidents of abuse to be reported to ensure they were investigated and to protect the residents. During an interview on 06/19/2024 at 4:14 PM, the DON said the doctor was notified of both the incidents between Resident #1 and Resident #2 and Resident #1 and Resident #3. The DON said these incidents were not reported to HHSC because when they report it is based on a case-by-case scenario. The DON said since both incidents were witnessed and because Resident #1 had a diagnosis of dementia his actions could not be willful, therefore, they were not required to report the incidents to HHSC. During an interview on 06/19/2024 at 5:38 PM, the DON said if there was an abuse allegation, and it was not reported to HHSC it placed residents at risk for more abuse. The DON said the facility's policy regarding resident-to-resident altercations was to remove the resident from the other resident, notify the doctor, determine what happened and what led to the aggression. The DON said per the policy a resident-to-resident altercation was not considered abuse because it was not willful. During an interview on 06/19/2024 at 5:53 PM, the Administrator said he was not at the facility when the incidents between Resident #1 and Resident #2 and Resident #1 and Resident #3 occurred. The Administrator said he could not tell if based on the policy the incidents should have been reported to HHSC because he was not aware of what took place. The Administrator said if he had been the Administrator when the incidents occurred, he would have reported the incidents to ensure they were investigated thoroughly. The Administrator was asked if the resident-to-resident altercations between Resident #1 and Resident #2 and Resident #1 and Resident #3 could be considered abuse. The Administrator responded he could not respond because he did not know what had happened.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source were reported immediately, but no later than 2 hours after the allegation was made, for 2 of 5 residents (Resident #2, and Resident #3) reviewed for abuse and neglect reporting. The facility failed to report to HHSC when Resident #1 pulled Resident #2's hair which caused Resident #2 to fall and be sent to the ER for evaluation on 04/30/2024. The facility failed to report to HHSC when Resident #1 hit Resident #3 on the chest on 05/10/2024. These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: 1. Record review of a face sheet dated 06/19/2024 indicated Resident #1 was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizoaffective disorder (a condition that can make you feel detached from reality and can affect our mood) and dementia in other diseases classified elsewhere with other behavioral disturbance (deterioration of memory, language, and other thinking abilities with behaviors). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #1 was rarely/never able to make himself understood and sometimes understood others. The MDS assessment indicated Resident #1 had a short-term and long-term memory problem. The MDS assessment indicated Resident #1 did not experience hallucinations or delusions. The MDS assessment indicated Resident #1 exhibited verbal behavioral symptoms directed towards others 1 to 3 days in the 7 day look back period. The MDS assessment did not indicate Resident #1 exhibited physical or other behavioral symptoms directed towards others. The MDS assessment indicated Resident #1's behaviors did not put others at significant risk for physical injury. The MDS assessment indicated Resident #1's behaviors significantly disrupted care or living environment. The MDS assessment indicated Resident #1 required substantial/maximal assistance with toileting hygiene, bathing, lower body , and partial to moderate assistance with upper body dressing and personal hygiene. Record review of Resident #1's care plan last reviewed 06/03/2024 indicated he had a behavior problem related to dementia with psychosis, schizoaffective disorder and had aggression, agitation, anxiety, and hit staff. Resident #1's care plan included to intervene as necessary to protect the rights and safety of others, approach/speak to him in a calm manner, divert attention., remove from situation and take to alternate location as needed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Progress Note dated 04/30/2024 indicated, This nurse observe the resident running down the hallway, aggressive with fist up, combative and screaming, attacking staff and residents, was separated from the staff and other residents, resident immediately removed away from residents, assisted by staff to the room to be place in bed, support is provided, assessment performed V/S (blood pressure, pulse, heart rate, respirations, and oxygen saturation):120/83,79,18,97.4,98%, no pain or discomfort, ROM completed able to move all extremities, No neuro changes, doctor, family, and DON notified, doctor orders send to ER for evaluation Author RN A. Record review of Resident #1's Progress Note dated 05/10/2024 indicated, This nurse observe the resident running down the hallway, aggressive with fist up, combative and screaming, attacking staff and resident, was separated from the staff and other residents, resident immediately removed away from residents, assisted by staff to the room to be place in bed, support provided assessment performed V/S (blood pressure, pulse, heart rate, respirations, and oxygen saturation): 124/72,83,18,97.3,96%, denies pain or discomfort, ROM completed able to move all extremities, no neuro changes, MD, Family and DON notified Author RN A. 2. Record review of a face sheet dated 06/19/2024 indicated Resident #2 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (deterioration of memory, language, and other thinking abilities without behaviors). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #2 was able to make herself understood and understood others. The MDS assessment indicated Resident #2 had a BIMS score of 4, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #2 required partial/moderate assistance with toileting hygiene, bathing, dressing, and personal hygiene. Record review of Resident #2's care plan last reviewed 05/09/2024 indicated she was an elopement risk/wanderer as evidenced by disoriented to place, and she wandered aimlessly and was admitted to the secured unit. Record review of Resident #2's Progress Note dated 04/30/2024 indicated Resident was standing on the hallway when another pulled residents hair causing resident to fall to the ground. Head to toe assessment, resident right hand swollen V/S (blood pressure, pulse, heart rate, respirations, and oxygen saturation) obtained 120/79,68,98,18,97.3, resident assisted to w/c (wheelchair) and place at the nursing station in staff sight. Resident displayed no signs of pain, Neuro (neurological) check initiated, MD, family (no answer left voicemail message) and DON were notified. Dr. (doctor) orders send to ER for Evaluation Author RN A. Record review of Resident #2's Emergency Department discharge information dated 04/30/2024 indicated discharge diagnosis of fall and hand contusion (injury to the skin and tissue of the hand caused by trauma or impact). During an attempted interview on 06/19/2024 at 11:55 AM, Resident #2 was non-interviewable. (continued on next page)

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	675367	A. Building B. Wing	06/19/2024

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Record review of a face sheet dated 06/19/2024 indicated Resident #3 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (deterioration of memory, language, and other thinking abilities without behaviors). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #3 was able to make himself understood and understood others. The MDS assessment indicated Resident #3 had a BIMS score of 6, which indicated his cognition was severely impaired. The MDS assessment indicated Resident #3 required partial/moderate assistance with toileting and upper body dressing, dependent for bathing, and set-up or clean-up assistance with personal hygiene. Record review of Resident #3's care plan last reviewed 05/23/2024 indicated he was an elopement risk/wanderer as evidenced by disoriented to place, impaired safety awareness, and significantly intrudes on the privacy or activities. Record review of Resident #3's Progress Note dated 05/10/2024 indicated, Resident sitting in the dining room when another resident hit him on the chest, head to toe assessment, denies pain or discomfort, resident immediately removed away from resident, support is provided, resident V/S (blood pressure, pulse, heart rate, respirations, and oxygen saturation): 119/78, 69,18,97.3, no neuro changes, MD notified, Family and DON Author RN A. During an attempted interview on 06/19/2024 at 11:38 AM, Resident #3 had inattention and was unable to answer questions appropriately. During an interview starting on 06/19/2024 at 2:23 PM, Resident #1's family member assisted with a phone interview with Resident #1. Resident #1 was asked if he remembered hitting a man while at the nursing facility. Resident #1 said he had hit a man and the man had hit him but was unable to provide further details. Resident #1 was asked if he remember an incident where he pulled a woman's hair and she had fallen. Resident #1 said he did not remember. During an attempted phone interview on 06/19/2024 at 3:33 PM, the previous Administrator did not answer the phone. During an interview on 06/19/2024 at 3:38 PM, RN A said Resident #1 was aggressive and would attack the residents and staff by punching them. RN A said she witnessed the incident with Resident #2. RN A said Resident #2 was standing in the hall and Resident #1 ran down the hallway and pulled Resident #2's hair and made her fall. RN A said Resident #2 did not have any injuries, but she was sent out to the ER for evaluation as a precaution. RN A said she witnessed the incident with Resident #3. RN A said Resident #3 was sitting in the dining room and Resident #1 walked by and hit Resident #3 on the chest. RN A said Resident #3 experienced no injuries. RN A said the previous administrator was notified of both incidents. RN A said Resident #1 hitting Resident #3 and pulling Resident #2's hair and making her fall could be considered physical abuse. RN A said it was important for incidents of abuse to be reported to ensure they were investigated and to protect the residents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/19/2024 at 4:14 PM, the DON said the doctor was notified of both the incidents between Resident #1 and Resident #2 and Resident #1 and Resident #3. The DON said these incidents were not reported to HHSC because when they report it is based on a case-by-case scenario. The DON said since both incidents were witnessed and because Resident #1 had a diagnosis of dementia his actions could not be willful, therefore, they were not required to report the incidents to HHSC. During an interview on 06/19/2024 at 5:38 PM, the DON said if there was an abuse allegation, and it was not reported to HHSC it placed residents at risk for more abuse. The DON said the facility's policy regarding resident-to-resident altercations was to remove the resident from the other resident, notify the doctor, determine what happened and what led to the aggression. The DON said per the policy a resident-to-resident altercation was not considered abuse because it was not willful. During an interview on 06/19/2024 at 5:53 PM, the Administrator said he was not at the facility when the incidents between Resident #1 and Resident #2 and Resident #1 and Resident #3 occurred. The Administrator said he could not tell if based on the policy the incidents should have been reported to HHSC because he was not aware of what took place. The Administrator said if he had been the Administrator when the incidents occurred, he would have reported the incidents to ensure they were investigated thoroughly. The Administrator was asked if the resident-to-resident altercations between Resident #1 and Resident #2 and Resident #1 and Resident #3 could be considered abuse. The Administrator responded he could not respond because he did not know what had happened. Record review of the facility's policy titled, Abuse Prevention and Prohibition Program, revised 10/24/2022, indicated, .Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property .The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents . The Facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents that qualify .Immediately but no later than 2 hours after forming the suspicion-if alleged violation involves abuse or results in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman (if applicable per state regulation) .

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview, and record review, the facility failed to ensure residents were permitted to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility and failed to ensure a resident was not transferred or discharged for 1 of 3 residents (Resident #1) reviewed for discharge requirements. The facility failed to allow Resident #1 to return to the facility after being sent to the behavioral hospital for treatment. This failure could place residents at risk for inappropriate discharge from the facility and cause psychological harm. Findings included: Record review of a face sheet dated 06/19/2024 indicated Resident #1 was a [AGE] year-old male originally admitted to the facility on [DATE], readmitted on [DATE], and discharged on [DATE] with diagnoses which included schizoaffective disorder (a condition that can make you feel detached from reality and can affect our mood) and dementia in other diseases classified elsewhere with other behavioral disturbance (deterioration of memory, language, and other thinking abilities with behaviors). Record review of the Discharge MDS assessment indicated Resident #1 was discharged with return anticipated on 05/16/2024 to an inpatient psychiatric facility. The MDS assessment indicated Resident #1 had a short-term memory problem. The MDS assessment indicated Resident #1 had delusions. The MDS assessment indicated Resident #1 exhibited verbal and physical behavioral symptoms directed towards others 1 to 3 days in the 7 day look back period. The MDS assessment indicated Resident #1 required substantial/maximal assistance with toileting hygiene, bathing, lower body , and partial to moderate assistance with upper body dressing and personal hygiene. Record review of Resident #1's care plan revised 05/10/2024 indicated Resident #1 wished to be discharged to another facility to be closer to his family, and he had discharged to another facility but was readmitted to the facility. Interventions included to establish a pre-discharge plan with Resident #1/family/caregivers and evaluate progress and revise plan and to evaluate and discuss with Resident #1/ family/caregivers the prognosis for independent or assisted living. Identify, discuss, and address limitations, risks, benefits and needs for maximum independence. Record review of Resident #1's Order Summary Report dated active orders as of 05/01/2024 did not indicate any orders discharge orders. Record review of Resident #1's progress notes indicated: 05/03/2024: Social Worker spoke Resident #1's family member regarding referral to another nursing facility. Resident #1 family member did not want to move resident at this time due to recent changes in behavior . Author: Social Worker (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/10/2024: This nurse observe the resident running down the hallway, aggressive with fist up, combative and screaming, attacking staff and resident, was separated from the staff and other residents, resident immediately removed away from residents, assisted by staff to the room to be place in bed, support provided assessment performed V/S: 124/72,83,18,97.3,96%, denies pain or discomfort, ROM completed able to move all extremities, no neuro changes, MD, Family and DON notified Author RN A. 05/13/2024: Social worker sent clinicals to behavioral health hospitals family member aware Author: Social Worker 05/16/2024: Social Worker filed for emergency commitment with justice court judge signed off on mental health warrant. Family member aware of update. resident then discharged at this time, transported by Police Department to the behavioral hospital. Author: Social Worker. 05/16/2024: Resident left the unit transported by the Police Department to behavioral hospital call was made to report, family member was notified. Author: RN A. During an interview on 06/18/2024 at 4:34 PM, Discharge Planner B, the discharge planner at the behavioral hospital, said Resident #1 had discharged home to return with is family today (06/18/2024). Discharge Planner B said the nursing facility did not want to take Resident #1 back after he was stabilized and completed his treatment. Discharge Planner B said Marketing Coordinator C had gone to evaluate Resident #1 on 06/10/2024. The discharge planner said Marketing Coordinator C had notified her the nursing facility was not taking Resident #1 back that it was a corporate decision. During an interview on 06/19/2024 at 12:29 PM, the Social Worker said Resident #1 discharged to the behavioral hospital on 05/16/2024 due to aggressive behaviors and harming staff and residents. The Social Worker said he was potentially supposed to return to the facility. The Social Worker said she was not a part of the decision for Resident #1 to not return to the facility. The Social Worker said the Administrator and corporate had a meeting about allowing Resident #1 to return to the facility, and they had made the decision not to allow him to return due to his aggressive behavior. The Social Worker said prior to Resident #1 being sent to the behavioral hospital on 05/16/2024, his family member had wanted him placed at a facility closer to them, but at when he was sent to the behavioral hospital this was no longer the case. The Social Worker said typically when someone was discharged from the facility they planned for the discharge and set up necessary services. The Social Worker said she was not aware what the discharge process was when a resident was not allowed to return from the hospital because this was the first resident, she had encountered that was not allowed to return. During an interview on 06/19/2024 at 1:19 PM, the DON said when a resident discharged from the hospital corporate reviewed the residents' records prior to them returning to the facility to ensure the facility could meet their needs. The DON said Resident #1 was discharged to the behavioral hospital due to his behaviors that he was a hazard to himself, others, and staff. The DON said to her knowledge the behavioral hospital had not attempted to send Resident #1 back to the nursing facility. The DON said the only notification she received was that Resident #1 had discharged back home to his family. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/19/2024 at 2:02 PM, Regional Admission Coordinator D said Resident #1's family member wanted him at a facility closer to them. Regional Admission Coordinator D said Marketing Coordinator C had provided the behavioral hospital with a list of facilities closer to Resident #1's family. Regional Admission Coordinator D said they had assumed Resident #1 had been placed at a different facility. Regional Admission Coordinator D said to her knowledge Marketing Coordinator C had not gone to the behavioral hospital to evaluate Resident #1 for admission to the nursing facility. During an attempted interview on 06/19/2024 at 2:21 PM, Marketing Coordinator C did not answer the phone. During an interview on 06/19/2024 at 2:23 PM, Resident #1's family member said they were notified Resident #1 was sent to the behavioral hospital due to altercations with other residents by the Social Worker. The family member said they thought Resident #1 was going to return to the nursing facility after being discharged from the behavioral hospital. Resident #1's family member said prior to him going to the behavioral hospital she had wanted him to go to a facility closer to them, but it was attempted and not successful in the past. Resident #1's family member said her expectations were for him to return to the nursing facility after his stay at the behavioral hospital. Resident #1's family member said that is why she called the nursing facility to see if he had returned from the behavioral hospital stay. Resident #1's family member said on Friday (06/14/2024) she called the nursing facility and was told they had a bed for Resident #1, and on Monday (06/17/24) she had called the nursing facility to see if Resident #1 had returned, and she was told by the Administrator he would not return to the facility because they did not have a bed for him and the facility could not meet his needs. Resident #1's family member said when he discharged from the facility, they had not notified her of how long they would hold his bed. Resident #1's family member said prior to her calling on Monday 06/17/2024 nobody from the facility had contacted her to notify her Resident #1 would not be allowed to return to the facility. Resident #1's family member said Resident #1 had been discharged home to them yesterday, 06/18/2024, morning. Resident #1's family member said due to their older age and health issues they were able to care for Resident #1 for a few days, but not long-term. Resident #1's family member assisted with a phone interview with Resident #1. Resident #1 said he was feeling fine, and he wanted to return to the nursing facility. During an interview on 06/19/2024 at 3:01 PM, the Administrator said he was new to the facility and had only been at the facility for 5 days. The Administrator said they currently did not have a bed available on the secured unit for Resident #1. The Administrator said he had not talked to Resident #1's family member. The Administrator said he was not sure how long they were required to hold a bed. The Administrator said he did not know if Resident #1 had been discharged properly because he was not aware of the full extent of what happened with Resident #1. The Administrator said he believed the NP had deemed Resident #1 not appropriate to return to the facility because it was not safe for anybody. During an attempted phone interview on 06/19/2024 at 3:31 PM, the NP did not answer the phone. During an attempted phone interview on 06/19/2024 at 3:33 PM, the previous Administrator did not answer the phone. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/19/2024 at 5:53 PM, the Administrator said he messaged Marketing Coordinator C to inform her to answer the phone for a phone interview regarding Resident #1. Requested Resident #1's discharge summary from the Administrator at this time. During an attempted interview on 06/19/2024 at 6:22 PM, Marketing Coordinator C did not answer the phone. During an interview on 06/19/2024 at 6:30 PM, informed the Administrator Resident #1's discharge summary had not been provided. The Administrator said he would provide Resident #1's discharge summary. Resident #1's discharge summary was not received upon exit of the facility. Record review of an undated e-mail from the NP regarding Resident #1 addressed to the DON and the Administrator indicated, Good afternoon, due to previous physical altercations and aggression with staff and residents, I feel that it will be best for a patient to go to a more secure unit. Record review of the facility's policy titled, Transfer and Discharge, revised 10/24/2022, indicated, To ensure that residents are transferred and discharged from the Facility in compliance with state and federal laws and to provide complete, safe, and appropriate discharge planning and necessary information to the continuing care provider . C. In a situation where the Facility initiates discharge while the resident is in the hospital following emergency transfer, the Facility must have evidence that the resident's status at the time the resident seeks to return to the facility (not at the time the resident was transferred for acute care) meets one of the criteria for discharge outlined in the Policy Section I. A-F above. i. The resident has the right to return to the Facility pending an appeal of any facility-initiated discharge unless the return would endanger the health or safety of the resident or other individuals in the Facility. In this circumstance, the Facility must document the danger that the failure to transfer or discharge the resident would pose . H. The medical record will contain written documentation from a physician if the resident is transferred/ discharged because: i. The safety of individuals in the Facility is endangered by the resident's presence; or ii. The health of individuals in the Facility would otherwise be endangered by the resident's presence. I. The resident or his/her personal representative will be provided with a copy of the Discharge Care Plan and Discharge Summary .