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	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 1 of 22 residents reviewed for resident rights. (Resident #44) The facility failed to ensure Resident #44's bathroom light was functioning properly and not flashing on and off rapidly. This failure could place residents at risk for diminished quality of life in an environment that is not homelike. Findings included:During an observation and interview on 8/11/25 at 10:43 a.m. Resident #44's bathroom door was open, and his bathroom light was flashing rapidly. Resident #44 said it bothered him that the light was flashing rapidly. He said he did not know how long it had been flashing. Surveyor asked what about the light flashing bothered him and he was unable to give a reply. Resident #44 was on the locked unit . During an observation on 8/12/25 at 9:30 a.m. it was observed the light in Resident #44's bathroom was still flashing on and off rapidly.During an interview on 8/13/25 at 11:04 a.m., the Maintenance Director said he ordered more lights on 8/12/25 and they should be delivered on 8/13/25 so he could fix the lights. He said he ordered 4-bathroom lights in total. He said that the bathroom light in room [ROOM NUMBER] was not reported to him nor was it in his maintenance logbook. He said that staff are required to report issues such as a malfunctioning light in the logbook. He said that he did know that the lights were flashing and that is why he ordered the new lights. Record review of the facility's maintenance log revealed that there was no report of Resident #44's bathroom light malfunctioning. During an interview on 08/13/2025 at 2:45 p.m., the Administrator said that a flashing light could make an uncomfortable environment for residents. He said that he expects that his maintenance staff ensure that lighting is kept comfortable for all residents. He said it is the responsibility of the Maintenance Director to ensure that such issues were fixed. Record review of the facility's policy revised on August 2020 titled Resident Rooms and Environment indicated that the purpose of the policy was to, To provide residents with a safe, clean, comfortable and homelike environment. The Facility provides residents with a safe, clean, comfortable, and homelike environment. Facility Staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. This shall include ensuring that residents can receive care and services safely and that the physical layout of the Facility maximizes resident independence and does not pose a safety risk. To this end, the Facility encourages residents to use their personal belongings to the extent possible. Lighting that is comfortable (minimum glare) yet adequate (suitable to the task).

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan to meet resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment for 1 of 6 residents (Resident #30) reviewed for care plans. The facility failed to ensure a care plan was developed for Resident #30's medication of Clonazepam used to produce a calming effect on the brain and nerves, which helps to reduce anxiety, prevent seizures, and promote relaxation. This failure could place the residents at increased risk of not having their individual needs met and a decreased quality of life. Findings included: Record review of Resident #30's face sheet, dated 08/13/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included, anxiety (a feeling of fear, dread, and uneasiness), depression (a serious mental disorder characterized by persistent sadness, loss of interest in activities, and difficulty functioning in daily life), and dementia (the loss of cognitive functioning - thinking, remembering, and reasoning). Record review of Resident #30's quarterly MDS assessment, dated 06/09/25, indicated Resident #30 was understood and was usually understood by others. Resident #30's BIMS score was 03 indicating her cognition was severely impaired. The MDS indicated Resident #30 required maximum assistance with her ADLs. The MDS indicated Resident #30 received an antianxiety medication during the 7-day look back period. Record review of Resident #30's comprehensive care plan, last reviewed 06/30/25 did not indicate a care plan for Clonazepam. Record review of Resident #30's Physician order dated 07/14/25 revealed Resident #30 had Clonazepam Oral Tablet 0.5 MG (Clonazepam). Give 1 tablet by mouth in the morning for anxiety. Record review of Resident #30's Physician order dated 07/14/25 revealed Resident #30 had Clonazepam Oral Tablet 1 MG (Clonazepam). Give 1 tablet by mouth at bedtime for anxiety. During an observation and interview on 08/13/25 at 4:30 p.m., the MDS Coordinator said she was responsible to update the care plans when she did the admission, quarterly, annual, or significant change MDS. She said she could not say who was responsible for acute care plans. She said she was made aware of any residents' change(s) in the morning meeting. The MDS Coordinator looked at Resident #30's care plan and said she did not see her Clonazepam added to her care plan. She said care plans were done to establish a plan of care for all residents. During an interview on 08/13/25 at 4:36 p.m., the DON said the MDS Coordinator was responsible for the care plans, but she was the overseer. The DON said she and the other nurse managers were supposed to do the acute care plans. She said they talked about all resident's changes (orders, behaviors, etc.,) during the morning stand-up meeting. She said she could not say why Resident #30's care plan was not updated to include her Clonazepam. The DON said the purpose of the care plans was to keep everyone informed of the resident's care. During an interview on 08/13/25 at 4:52 p.m., the Administrator said the MDS Coordinator, and the DON were responsible for the care plans, and he was the overseer. The Administrator said they had morning meetings daily and discussed any changes with a resident. He stated he expected the administration nurses to update the care plan during that meeting. He said care plans were done for the care the resident needed. Record review of the facility's policy titled, Care Planning, revised 10/24/22, indicated, Policy: To ensure that a comprehensive person-centered care plan developed for each resident based on their individual assessed needs. The IDT will revise the comprehensive care plan as needed at the following intervals: A per RAI schedule, B. as dictated by changes in the resident condition, E. other times as appropriate or necessary.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **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 incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 2 residents (Resident #74) reviewed for treatment and services related to indwelling catheters. The facility failed to ensure Resident #74's foley catheter was secured on 08/11/25. This failure could place residents at risk for urinary tract infections and a decreased quality of life. Findings included: Record review of Resident #74's face sheet, dated 08/13/25, reflected Resident #74 was an [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included benign prostatic hyperplasia without lower urinary tract (enlargement of the prostate which did not result in difficulty urinating). Record review of Resident #74's quarterly MDS dated [DATE] reflected Resident #74 sometimes understood others and sometimes was understood by others. The assessment reflected Resident #74 had short- and long-term problems. Resident #74 was dependent with toileting. The assessment indicated Resident #74 had an indwelling catheter (tube inserted into the bladder). Record review of Resident #74's comprehensive care plan revised 11/09/23 reflected he had BPH with obstructive uropathy (urine flow is obstructed) and required a suprapubic catheter. The care plan interventions included: ensure leg strap was in place to secure foley. The intervention was revised on 08/12/25 after surveyor intervention that Resident #74 was non-compliant-pulls off strap. Record review of Resident #74's order summary report dated 08/12/25 reflected to check placement of s/p catheter securement device every shift with a start date of 05/14/25. During an observation and interview on 08/11/25 at 3:23 p.m., Resident #74 was in his wheelchair in his room. ADON C and ADON D showed the state surveyor Resident #74's foley catheter which was not secured to his leg. ADON C stated she did not know why the catheter was not secured to his leg. ADON C stated the catheters were checked daily by the nurses to ensure they were secured. ADON C stated she was the 6a-2p charge nurse for Resident #74, and the catheter was secured when she completed his head-to-toe assessment during her shift. The foley catheter strap was nowhere to be found in Resident #74's pants. ADON C stated if the catheter was not secured it could cause trauma which could lead to an infection. During an interview on 08/11/25 at 4:00 p.m., RN E stated she was Resident #74's 2p-10p charge nurse. RN E stated she did not know why Resident #74's catheter was not secured. RN E stated the catheters were checked every shift by the nurses to ensure they were secured. RN E stated she had not completed an assessment to ensure his catheter was secured because Resident #74 was in the day area. RN E stated it was important his catheter was secured to prevent trauma to his urethra (tube that carried urine from the bladder to the outside of the body). During an interview on 08/13/25 at 4:00 p.m., the DON stated charge nurses, and CNAs should be checking to ensure the foley catheters were secured. The DON stated she was responsible for monitoring and overseeing catheter securement by daily rounds. The DON stated she had not noticed any issues with the foley catheters not being secured. The DON stated it was important for Resident #74's foley catheter to be secured to prevent an injury. During an interview on 08/13/25 at 4:26 p.m., the Administrator stated catheters should be always secured. The Administrator stated the DON was responsible for monitoring and overseeing by frequent rounding. The Administrator stated it was important for the foley catheter to be secured to prevent an injury occurring. Record review of the facility's policy titled, Care of Catheter, revised 06/2020 reflected. To prevent catheter-associated urinary tract infections while ensuring that residents are not given indwelling catheters unless medically necessary. III. Proper Techniques for Urinary Catheter Maintenance. c. anchor the catheter with a leg strap to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents maintained acceptable parameters of nutritional status for 2 of 22 residents (Residents #75 and #39) reviewed for nutrition. 1. The facility did not ensure Resident #75 was given chopped meats for lunch on 08/11/25 as ordered by the physician. 2. The facility did not ensure Resident #39 was given chopped meats for lunch on 08/11/25. This failure could place residents at risk for choking, poor intake, weight loss, and unmet nutritional needs. Findings Included: 1. Record review of Resident #75's face sheet dated 08/13/25 indicated he was an [AGE] year-old female who admitted to the facility on [DATE] dysphagia (medical term for difficulty swallowing), dementia (a general term for a decline in mental ability severe enough to interfere with daily life), and malnutrition (a serious condition resulting from an imbalance in nutrient intake, leading to deficiencies or excesses that negatively impact health). Record review of Resident #75's quarterly MDS dated [DATE] indicated she usually understood and was usually understood by others. The MDS also indicated she had a BIMS score of 03s which meant he was severely cognitively impaired. The MDS indicated Resident #75 required assistance with her ADLs including eating. Resident #75 did not have a 5% weight loss or more in the last month or loss of 10% or more in last 6 months. Record review of Resident #75's comprehensive care plan dated 04/23/25 indicated she had a regular diet, regular consistency, with thin liquids. The care plan interventions included: serve diet as ordered by the physician. Record review of Resident #75's physician order summary report dated 05/20/25 indicated she had an order for a regular with chopped meat texture, thin consistency. Record review of Resident #75's lunch meal ticket dated 08/11/25, reflected chopped meats. During a dining observation and interview on 08/11/2025 at 12:04 p.m., Resident #75 was eating her lunch and had taken 1-2 bites of her whole fish sandwich when the state surveyor saw her tray card which read chopped meat. CNA N said she served Resident #75 her lunch tray but did not see that her tray card said chopped meats. CNA N took the lunch tray back to the kitchen staff and they prepared the correct diet with chopped meats. 2.Record review of Resident #39's face sheet, dated 08/13/25, reflected Resident #39 was a [AGE] year-old female, readmitted to the facility on [DATE] with a diagnosis which included malnutrition (a serious condition resulting from an imbalance in nutrient intake, leading to deficiencies or excesses that negatively impact health). dementia (a general term for a decline in mental ability severe enough to interfere with daily life), and bipolar (a mental illness characterized by extreme shifts in mood, energy, and activity levels). Record review of Resident #39's quarterly MDS assessment, dated 07/08/25, reflected Resident #39 rarely made herself understood, and was rarely understood by others. Resident #39's was severely modified with daily decision making. Resident #39 required assistance with all ADLs including eating. Resident #39 did not have a 5% weight loss or more in the last month or loss of 10% or more in last 6 months. Record review of Resident #39's comprehensive care plan revised on 06/17/25, reflected Resident #39 had a potential for nutritional problems and a diet order other than regular with chopped meats. The care plan interventions were to serve diet as ordered by the physician and RD assess per facility protocol. Record review of Resident #39's physician order summary report, dated 01/25/22, reflected regular texture, regular with thin liquid consistency. Record review of Resident #39's lunch meal ticket dated 08/11/25, reflected regular with chopped meats. During a dining observation and interview on 08/11/2025 at 12:04 p.m., Resident #39 was served a whole fish sandwich and her tray card said chopped meats. CNA N said she served Resident #39 her lunch tray but did not see her card said chopped meats. CNA N took the lunch tray back to the kitchen staff and they prepared the correct diet of chopped meats. During an interview on 08/11/2025 at 1:15 p.m., Resident #39 was unable to say what her correct diet was supposed to be. During an interview on 08/13/25 at 12:14 p.m., the Dietary Manager said a resident with chopped meat diet, means the meat should be cut into smaller pieces. He said the cook was responsible for ensuring the meat was cut before serving. He said it would be hard for Resident #39 and Resident # 75 to cut their meat. He said he did random spot checks of trays being served out of the kitchen. The Dietary Manager said it was important to ensure residents received the correct diet order for proper nutrients. During an observation and interview on 08/13/25 at 12:57 p.m., [NAME] H said she prepared Resident #75 and Resident #39's tray. She said she thought chopped meats meant she should have cut the fish sandwich into four pieces. She reviewed her diet recipe for chopped meats and verified she should have cut the fish into 4 pieces, she said she missed that on the recipe and did not cut Resident #75's or Resident #39's sandwich. She said by not following the

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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. Based on observation, interview, and record review, the facility failed to establish a system of receipt of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 1 storage area reviewed for expired and discontinued medications. The facility failed to keep a record of receipt of controlled medications awaiting disposition to allow accurate and periodic reconciliation. This failure could place residents at risk for loss of prescribed medications, residents' safety, and drug diversion. Findings included: During an observation and interview on 08/13/25 at 3:20 p.m., the following medications were observed in the controlled medication storage cabinet awaiting to be disposed:*Hydrocodone/APAP 5-325mg- 114 tablets RX# 88263964*Alprazolam 0.5 mg-12 tablets RX# 88285870*Diazepam 2mg- 56 tablets RX# 88264002*Diazepam 5mg- 15 tablets RX# 88263734*Lorazepam 0.5mg- 9 tablets RX# C0412656 *The DON said the controlled medications awaiting to be disposed were kept in the locked cabinet behind a locked door. The DON said she was the only one with the key to the door and the cabinet. The DON said her process when she reconciled medications that needed to be disposed of was as follows: When medications were brought to her, she checked the narcotic medication count and verified the count with the nurse, the nurse and herself signed the narcotic sheet. She stated she then placed the medication in the locked box. The DON said the pharmacy consultant and herself were responsible for reconciling the narcotic medications. The DON said she did not reconcile the medication prior to her and the pharmacist destroying the expired or discontinued medication. The DON said medications would not come up missing as she did not leave the cabinet, or the door unlocked. Record review of the facility's medication destruction binder on 08/13/25, indicated the last medication destruction was completed on 07/22/25. During an interview on 08/13/25 at 4:52 p.m., the Administrator said when narcotic medications were discontinued, they were given to the DON with the narcotic count sheet and kept locked. The Administrator said ideally, the narcotic medication should be logged as the DON received them, but the count was verified on the narcotic count sheet. The Administrator said the DON and the pharmacy consultant were responsible for ensuring the narcotic medications were accurately reconciled. The Administrator said if the narcotic medications were not reconciled then medications could come up missing. Record review of the facility's policy Narcotic Administration, revised 06/2025, indicated, To ensure the secure storage accurately administration, proper documentation, and responsible disposal of narcotics (controlled) substance in accordance with the federal (DEA) state regulations, and CMS guidelines. Controlled substance must be handled with the highest degree of accountability and security. Only authorized and licensed personnel may manage, administrator, or dispose of these medications. Procedure: Discontinued or expired medications :2 licensed nurses must document and witness the removal of discontinued or expired narcotics from active inventory. Medications must be stored, clearly labeled area pending destruction. Destructions of narcotics: Disposal must comply with DEA and State Board of nursing requirements, and a signed destruction log must be maintained.

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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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel for 2 of 22 residents (Residents #25 and #62) reviewed for medications at their bedside. 1. The facility did not ensure Resident #25's hydrocortisone cream (topical ointment used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions) was not left on her dresser. 2. The facility did not ensure Resident #62's omeprazole (used to treat excess stomach acid) was not left on her bedside table. These failures could place residents at risk for misuse of medication, overdose, drug diversions, adverse reactions of medications, and not receiving the therapeutic benefit of medications.Findings included: 1. Record review of Resident #25's face sheet, dated 08/13/25, reflected Resident #25 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy (brain chemical imbalance in the blood). Record review of Resident #25's quarterly MDS assessment, dated 07/12/25, reflected Resident #25 made herself understood and understood others. Resident #25's BIMS score was 12, which indicated her cognition was moderately impaired. Record review of Resident #25's comprehensive care plan revised on 02/13/25 reflected Resident #20 had impaired cognitive function/dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life) or impaired thought processes related Alzheimer's (progressive disease that destroys memory and other important mental functions), dementia, AMS, and acute or chronic metabolic encephalopathy. The care plan interventions included administer medications as ordered. Record review of Resident #25's order summary report dated 08/11/25 reflected there was no order for hydrocortisone cream in the summary. During an interview and observation on 08/11/25 at 2:45 p.m., a tube labeled hydrocortisone cream 1% was observed on Resident #25's dresser. Resident #25 stated a staff gave her the tube of medication when she was on Hall 200. Resident #25 stated she could not remember the staff name. Resident #25 stated she used the medication for her hemorrhoids (swollen inflamed veins in the rectum). 2. Record review of Resident #62's face sheet, dated 08/13/25, reflected Resident #62 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included bipolar (a disorder associated with episodes of mood swings ranging from depression lows to manic highs). Record review of Resident #62's quarterly MDS, dated [DATE], reflected Resident #62 made herself understood and understood others. Resident #62's BIMS score was 13, which indicated her cognition was intact. Record review of Resident #62's comprehensive care plan revised on 05/28/24 reflected Resident #62 had an ADL Self-Care Performance Deficit related to PAD (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). The care plan interventions included x1 staff participation with personal hygiene. Record review of Resident #62's order summary report dated 08/11/25 reflected there was no order for omeprazole in the summary. During an interview and observation on 08/11/25 at 3:57 p.m., a bottled labeled omeprazole was observed on Resident #62's bedside table. Resident #62 stated she bought the medication herself from the store for her gut. Resident #62 stated staff were aware of her having the medication at her bedside. During an interview on 08/13/25 at 3:11 p.m., ADON C stated she was the 6a-2p charge nurse for Resident #25 and #62. ADON C stated neither resident had been evaluated for self-administration of medications. ADON C stated if a resident was able to self- administer, he/she must be assessed for competence, complete a medication self-administration evaluation and an order from the physician must be obtained. ADON C stated during rounds, the Housekeeping Manager alerted her to come in Resident #25 room, and once she went in the room, the Housekeeping Manager showed her the hydrocortisone cream on her dresser. The Housekeeping Manager stated she removed the medication and educated Resident #25 that she was not allowed to keep the cream in her room. ADON C stated she was unaware Resident #62 had omeprazole on her bedside table. ADON C stated medications should be stored on the medication cart. ADON C stated it was important to ensure medications were not left at bedside for resident safety. During an interview on 08/13/25 beginning at 4:00 p.m., the DON stated she expected medications to be stored on the medication cart. The DON stated if a resident was able to self-administer, he/she must be assessed, and obtain an order. The DON stated all staff should be ensuring medications were not left at bedside. The DON stated she was responsible for monitoring medications at bedside by daily rounds and ambassador rounds completed by the Housekeeping Manager. The DON stated during her rounds on 08/11/25, there were no medications at bedside. The DON stated it was important to ensure

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed ensure each resident receives and the facility provides food that accommodates residents' food preferences for 1 of 22 residents (Resident #40) reviewed for food preferences and the accommodation of resident's meal choices. The facility did not honor Resident #40's preference for dislike of tomatoes products and green peas on 07/21/25, 08/07/25, and 08/10/25. This failure could result in a decrease in resident choices, diminished interest in meals, and weight loss. Findings included: Record review of Resident #40's face sheet, dated 08/13/25, reflected Resident #40 was a [AGE] year-old female, readmitted to the facility on [DATE] with a diagnosis which included chronic systolic (congestive) heart failure (condition where the heart's left ventricle was weakened and cannot contract forcefully enough to pump an adequate amount of blood throughout the body). Record review of Resident #40's quarterly MDS assessment, dated 06/15/25, reflected Resident #40 made herself understood, and understood others. Resident #40's BIMS score was 14, which indicated her cognition was intact. Resident #40 was independent with eating. Resident #40 had not had a 5% weight loss or more in the last month or loss of 10% or more in the last 6 months. Record review of Resident #40's comprehensive care plan revised on 06/11/24, reflected Resident #40 had the potential for nutritional problem related diet restrictions and morbid obesity. The care plan interventions included provide, serve diet as ordered. Record review of Resident #40's order summary report dated 08/13/25 reflected there was not an order for her dislikes. Record review of the residents' dietary cards reflected Resident #40 disliked green peas and tomato products. Record review of a photographic record submitted by Resident #40 on 08/11/25 revealed Resident #40 received buttered peas on 07/21/25, five way mixed vegetables that included green peas on 08/07/25 and spaghetti with meat sauce on 08/10/25. During an interview on 08/11/25 at 3:38 p.m., Resident #40 stated she did not like tomato products or green peas, and she continued to receive tomatoes products and green peas after she had told the kitchen staff, she did not like it. Resident #40 stated she received spaghetti with tomato sauce on yesterday (08/10/25). Resident #40 stated she felt they don't take my feelings into consideration and they don't care. During an interview on 08/12/25 at 4:30 p.m., the Dietary Manager stated he was aware that Resident #40 dislike tomato products and green peas and expected she did not receive those food items. The Dietary Manager stated he had spoken with her a few times about when she received something she did not like to ask for an alternative. The Dietary Manager stated he was not aware that she received spaghetti with tomato meat sauce on yesterday (08/10/25). The Dietary Manager stated the cook was responsible for ensuring she received an alternative if those items were on the menu. The Dietary Manager stated he had in serviced the staff but it's time to take disciplinary actions. The Dietary Manager stated he was responsible for overseeing by monitoring meals and in servicing staff. The Dietary Manager stated it was important for Resident #40's food dislikes to be followed to prevent the potential of weight loss. During an interview on 08/13/25 at 4:26 p.m., the Administrator stated he expected food preferences/dislikes to be followed. The Administrator stated the Dietary Manager was responsible for monitoring and overseeing by spot checks during meal service. The Administrator stated it was important for their food preferences/dislikes to be followed because it was their right and prevent potential weight loss. Record review of the facility's policy titled Resident Rights-Accommodation of Needs revised 08/2020 indicated. To ensure that the Facility provides an environment and services that meet residents' individual needs. I. Residents' individual needs and preferences are accommodated.

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	08/13/2025

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

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 3 residents (Resident #50) reviewed for hospice services. The facility failed to obtain Resident #50's most current hospice certification, plan of care, nurse visit notes, interdisciplinary meetings, and medication profile. This deficient practice could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. Findings included: Record review of a face sheet dated 08/12/2025 indicated Resident #50 was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included cerebral atherosclerosis (arteries in the brain become narrowed or blocked due to plaque buildup which can result in serious health issues such as stroke and cognitive impairments). Record review of Resident #50's Quarterly MDS assessment dated [DATE] indicated he was rarely/never understood and rarely/never understood others. The MDS assessment indicated the Staff Assessment for Mental Status was completed due to him being rarely/never understood. The Staff Assessment for Mental Status for Resident #50 indicated he had a long-term and short-term memory problem. The MDS assessment indicated Resident #50 received hospice care while a resident at the facility. Record review of Resident #50's care plan with a date initiated of 01/20/2025, indicated he had a terminal prognosis related to cerebral atherosclerosis, and the interventions included to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. Record review of Resident #50's Order Summary Report dated 08/12/2025 indicated to admit to hospice with an order date of 02/06/2025. Record review of Resident #50's hospice binder indicated Initial Plan of Care and Interdisciplinary Care Plan dated 11/22/2024, indicated Resident #50 was admitted to hospice for routine home care. There was no current plan of care to indicate Resident #50 was receiving routine nursing home care or an updated Interdisciplinary Care Plan. Plan of care review dated 12/18/2024. There was no current plan of care review. For Certification/Recertification for Benefit Period Number begin date 11/22/2024 through Recert due date 2/2/2025. There was no updated recertification. Resident #50's hospice medications were dated 1/21/2025. Resident #50's binder had no hospice nurses' notes. During an interview on 08/12/2025 at 12:41 PM, the Medical Records designee said she scanned the hospice documents weekly into the resident's electronic health record, and some of the documents were kept in the residents' hospice binders. The Medical Records designee said she was not responsible for ensuring the hospice documents were in the facility and updated. The Medical Records designee said she was only responsible for scanning the documents into the electronic health record. During an interview on 08/12/2025 at 2:12 PM, the hospice nurse said her nurse visits were two times a week. The hospice nurse said the resident's hospice binder should have an updated medication profile, hospice care plan, and interdisciplinary group meetings. The hospice nurse said she did not take the nurses notes to the facility. The hospice nurse said the updated care plans should be provided to the facility weekly, the interdisciplinary group meetings were completed every other week and should be provided to the facility probably monthly. The hospice nurse said she was responsible for bringing Resident #50's medication profile, hospice care plan, and interdisciplinary group meetings to the facility. The hospice nurse said she had not been bringing the hospice documents weekly, but she thought she was taking them monthly. The hospice nurse said she placed them in Resident #50's hospice binder. The hospice nurse said it was important for the medication profile, hospice care plan, and interdisciplinary group meetings to be provided to the facility for continuity of care. During an interview on 08/13/2025 at 2:56 PM, the DON said Resident #50 should have a hospice binder with all of the required hospice documents, and they should be up to date. The DON said they were trying to go electronic and there should also be documents uploaded in Resident #50's electronic health record. The DON said Medical Records was responsible for ensuring the hospice documents were in the electronic health record. The DON said it was important for the hospice documents to be in the facility and updated to ensure the proper care was given to the residents and for the patient information to be correct. During an interview on 08/13/2025 at 3:22 PM, the Administrator said he expected for the required hospice documents to be in the facility. The Administrator said Medical Records was responsible for ensuring the hospice documents were in the facility

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	675367	A. Building B. Wing	08/13/2025

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Greenville Gardens	3500 Park St Greenville, TX 75401

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 6 residents (Resident #20 and Resident #11) reviewed for infection control. 1.The facility failed to ensure staff wore PPE when entering Resident #20's room on 08/12/25 and 08/13/25 who was on contact isolation for Extended-spectrum beta-lactamase also known as ESBL (a group of bacteria that are resistant to many commonly used antibiotics. 2. The facility failed to ensure LVN F used proper hand hygiene when preforming blood sugar checks and given insulin for Resident #11 on 08/12/25. These failures could place residents and staff at risk for cross-contamination and the spread of infection.Findings included:1.Record review of Resident #20's face sheet, dated 08/13/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included, ESBL, dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), and diabetes (a chronic disease where the body doesn't produce enough insulin or can't effectively use the insulin it produces, leading to high blood sugar levels). Record review of Resident #20's quarterly MDS assessment, dated 05/08/25, indicated Resident #20 understood and was usually understood by others. Resident #20 BIMS score was 10 indicating she was moderately cognitive impaired. The MDS indicated Resident #20 required assistance with her ADLs and maximum assistance with toileting and showering. The MDS indicated Resident #20 was always incontinent of bowel and bladder. Record review of Resident #20's lab urinalysis drawn 08/07/25 and received 08/10/25 indicated a positive result of ESBL. Record review of Resident #20's comprehensive care plan, last reviewed 08/11/25 indicated she was on contact isolation and on antibiotic therapy related diagnosis of ESBL. The intervention was to give medication as ordered. Record review of Resident #20's Physician order dated 08/10/25 indicated Ciprofloxacin HCl oral tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet by mouth two times a day for UTI until 08/16/2025 for 5 Days. Record review of Resident #20's MAR dated 08/01/25 through 08/31/25 indicated she received her first dose of Ciprofloxacin HCl oral tablet 500 MG on 08/10/25 at 8:00 pm. Record review of Resident #20's Physician order dated 08/12/25 indicated Contact precautions every shift for 6 Days. During an observation on 08/11/25 at 10:40a.m., Resident #20 had a red sign by her doorway that said stop along with how to [NAME] and Doff PPE . The isolation cart was also outside her door with gowns, gloves, and mask. Resident #20 was in her bed. During an observation on 08/12/25 at 9:00 a.m., The red sign that read stop was removed from the door but the sign on how to apply and remove PPE was still on the door along with the isolation cart. During an observation on 08/12/2025 at 9:12 a.m., CNA G knocked on Resident #20's door carrying cranberry juice. CNA G entered Resident #20's room without applying any PPE. CNA G exited Resident #20's room. During an interview on 08/12/2025 at 3:28 p.m., CNA G said she did not have to put on PPE just to deliver Resident #20 cranberry juice. She said she only had to wear PPE when she provided care. She said she knew Resident #20 was on contact isolation for ESBL in her urine. She said they did not have bags in the room to put linen in, she said she brought the linen out with her and disposal of it in the regular linen barrels. She said Resident #20 was incontinent of bowel and bladder. During an interview on 08/13/25 at 10:15 a.m., Housekeeper K, said she cleaned Resident #20's room this morning and did not wear any PPE (gown). She said she was not aware of anyone on contact isolation. She said if a resident were on isolation a sign would be outside their door indication what to wear. She looked at Resident #20's door and saw the signs, but said it was not indicating what PPE (gown, gloves) she needed to wear. She said she did not wear PPE (gown) when she cleaned Resident #20's room this morning. During an interview on 08/13/25 at 12:18 p.m., Laundry Aide L was in the laundry and showed surveyor what the staff used when a resident was under contact isolation (which included an apron and gloves). He said the facility did not have any residents under contact isolation, but when the facility did have residents under contact isolation, their laundry was sent out in yellow bags and washed separately from other residents to prevent the spread of infection. During an observation and interview on 08/13/25 at 2:43 p.m., RN M was in Resident #20's room talking to her about a television show. He was standing between her bedside table and the television without any PPE (gloves or gown). He said he saw the barrier precaution sign meaning if you were providing care for someone with a wound, etc., you would wear PPE. He said if they were on isolation then you should wear gown, gloves, and mask depending on the isolation. He went back to Resident #20's room and said she was

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective pest control program for the memory care unit. The facility did not maintain an effective pest control program to ensure the memory care unit was free of gnats and other flying insects. This could place residents at risk for an unsanitary environment. Findings include:During an observation and attempted interview on 8/11/25 at 10:18 a.m., Resident #70 had gnats in her water cup that was at her bedside. There were also gnats flying around the room. Resident #70 resided on the locked unit. During an observation and attempted interview on 8/11/25 at 10:20 a.m. Resident #64 was standing inside his room watching the TV. He did not answer any questions. There were several gnats flying around the room. During an observation on 8/11/25 at 12:20 p.m., Resident #22 was observed swatting at gnats and yelled out, Gnats! She had her lunch [NAME] and was in the process of eating lunch. During an observation on 8/12/25 at 11:40 a.m. there were gnats in the conference room. During an interview on 8/12/25 at 3:27 p.m. CNA A said the administrator would set traps but there are always gnats flying around. She said she did not know if any other measures were taken to control the gnats. She said that the gnats were bothersome to the residents as they will swat at them. During an interview on 08/13/25 at 11:04 a.m., the Maintenance Director, said he was aware of the gnats in the locked unit. He said they had the lights that attract flying bugs on the walls, and they could be effective. He said they also had a chemicals poured in the drain that can help prevent gnats. He said it could be bothersome and a health risk to residents having gnats or other flying bugs landing on them or in their drinks. He said they are doing as much as they can to keep the insects out of the building. During an interview on 08/13/2025 at 2:45 p.m. the Administrator said the facility should be reasonably pest free for the comfort of the residents. He said that gnats or other flying insects could be bothersome to residents. He said that it could also be unsanitary if a gnat or other insects were in residents water cups or landed on their food. He said it was the responsibility of the pest control company and the maintenance director to ensure the facility was reasonably free from pests such as gnats and other flying insects. Record review of the pest control log shows that the memory care unit was treated for gnats after the survey and observations began on 8/12/2025.Record review of a facility provided policy titled, Pest Control dated 8/2020 indicated that, To ensure the Facility is free of insects, rodents, and other pests that could compromise the health, safety, and comfort of residents, Facility Staff, and visitors. The Facility maintains an ongoing pest control program to ensure the building and grounds are kept free of insects, rodents, and other pests. The Administrator arranges for a pest control company (Company) to visit and inspect the Facility at least once a year.Facility Staff will report to the Housekeeping Supervisor an sign of rodents or insects, including ants, in the Facility.