

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER Evergreen Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Ruthlynn Dr Longview, TX 75601	

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote resident self-determination through support of resident choice for 4 of 19 residents reviewed for resident rights. (Resident #16, Resident #33, Resident #40, and Resident #64). The facility failed to ensure Resident #16, Resident #33, Resident #40, and Resident #64 were allowed to smoke two cigarettes during the facility smoking times. This failure could place dependent residents at risk for feelings of depression or lack self-determination and decreased quality of life. Findings included: 1. Record review of Resident #16's face sheet, dated 08/25/25, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included major depressive disorder (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and chronic obstructive pulmonary disease (a chronic lung disease that causes inflammation and narrowing of the airways, leading to airflow obstruction). Record review of Resident #16's admission MDS assessment, dated 07/14/25, indicated she had a BIMS score of 15, which indicated intact cognition. She was able to make herself understood and she was able to understand others. During an interview on 08/25/2025 at 10:06 AM, Resident #16 said she wished that she was able to smoke 2 cigarettes when she goes out to smoke at the designated smoking times. She said she had asked before and the staff always gave an excuse such as I forgot or I have to ask someone. She said the Administrator told her I have to ask corporate. She said she was going to go to the 10:30AM smoke time on this day and was going to ask the staff if she could have a second cigarette. During an interview on 08/25/25 at 10:41AM Resident #16 said at the 10:30AM smoke time on this day, she asked Dietary Aide B if she could have a second cigarette and Dietary Aide B would not let her have a second cigarette. She said the staff that supervised the residents during smoke times only brought enough cigarettes outside for each resident to have one cigarette. During an interview on 08/26/25 at 9:57AM Resident #16 said it made her upset that she was unable to have a second cigarette at the smoke times. She said she did not understand why she could not have 2 cigarettes in this facility when other nursing facilities allowed her to have two cigarettes at a smoke time. 2. Record review of Resident #33's face sheet, dated 08/25/25, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included anxiety disorder (A mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and chronic obstructive pulmonary disease (a chronic lung disease that causes inflammation and narrowing of the airways, leading to airflow obstruction). Record review of Resident #33's quarterly MDS assessment, dated 06/27/25, indicated he had a BIMS score of 12, which indicated moderate cognitive impairment. He was able to make himself understood and he was able to understand others. During an interview on 08/25/2025 at 9:50 AM, Resident #33 said he wished that he could have 2 cigarettes when he goes out to smoke at the designated smoking times. He said he thought the residents could not have 2 cigarettes when they go out to smoke. During an interview on 08/26/25 at 9:55AM, Resident #33 said it made him upset that the facility did not allow him to have two cigarettes at a smoking time. He said he has asked in the past and the staff would not let him have a second cigarette. 3. Record review of Resident #40's face sheet, dated 08/26/25, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (a chronic lung disease that causes inflammation and narrowing of the airways, leading to airflow obstruction). Record review of Resident #40's admission MDS assessment, dated 08/15/25, indicated she had a BIMS score of 15, which indicated intact cognition. She was able to make herself understood and she was able to understand others. During an interview on 08/26/25 at 10:04AM Resident #40 said the staff did not allow the residents to smoke 2 cigarettes at a smoke time. She said she has asked in the past and the staff told her No, we cannot do that. She said the staff only brought enough cigarettes for each resident to have one. She said it made her upset she could not have two cigarettes at a smoke time because she was not always able to make it to all of the smoking times. She said she took a diuretic medication that makes her use the bathroom often and she was not always able to make it outside at the smoking times. 4. Record review of Resident #64's face sheet, dated 08/26/25, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included heart failure (a condition where the heart muscle is weakened or stiffened, making it unable to pump blood effectively). Record review of Resident #64's quarterly MDS assessment, dated 05/23/25 indicated she had a BIMS score of 14 which indicated intact cognition. She was able to make</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>(continued on next page)</p>

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review, the facility failed to promptly resolve grievances for 6 of 6 Anonymous residents reviewed for grievances during a confidential meeting. The facility failed to ensure 6 of 6 Anonymous residents' grievances related to wet napkins on room trays were promptly resolved. This deficient practice could place the residents at risk for decreased quality of life and feelings of neglect or hopelessness. The findings included: During a confidential interview on 8/26/25 at 2:00 P.M. 6 of 6 Anonymous residents indicated grievances were not addressed or resolved promptly. Anonymous residents indicated they had made complaints about the napkins being wet on the hall trays in several resident council meetings. Anonymous residents indicated the Activity Director was present during the resident council meetings and was aware of complaints about the wet napkins. Anonymous residents stated it was still happening during meal pass and made them feel like no cared how they felt. Record review of the resident council minutes for 6/2/25, 6/23/25, 6/30/25, 7/14/25, 7/21/25, 7/28/25, 8/4/25 and 8/12/25 indicated Napkins on trays are being wet when served to residents. During an interview on 8/27/25 at 12:25 P.M., the Activity Director stated she believed that complaints during resident council were considered grievances. The Activity Director stated she wrote down the minutes for the resident council meetings. She stated she wrote that the residents had been complaining about their napkins being wet on their trays. She stated the residents were saying the drinks on the tray was getting on the napkins. She stated she did not know exactly how many months the residents had complained about the wet napkins. She stated she wrote it down when the residents complained, she reported it in a stand down meeting and she reported it to the Dietary Manager. She stated she felt the wet napkins were an issue and if the residents were complaining about it the facility needed to fix it. She stated a negative effect of the wet napkins on the trays was the residents could not use the napkins. During an interview on 8/27/25 at 12:55 P.M., the Dietary Manager stated she thought she was notified about the wet napkins on the resident hall trays during the last resident council meeting and she thought the issue was resolved. She stated she was not aware that the residents had complained about the wet napkins for 3 months. She stated if she would have known the residents had complained that many times, she would have monitored the trays for wet napkins herself. She stated she did an in-service on the wet napkins before, and she thought it was all clear. She stated if the residents complained about something it should be taken care of. She stated a negative effect of residents having wet napkins would be they could not clean their hands and face. During an interview on 8/27/2025 at 1:07 P.M., the ADON D stated he was unaware of the numerous complaints of residents getting wet napkins with their meals. He stated a negative effect of wet napkins on trays was it would not allow residents to clean themselves appropriately and that no one wanted a wet napkin. He stated not resolving the complaints gave residents a sense that the facility did not care about them. During an interview on 8/27/25 at 1:11 P.M., the DON stated she was unaware of the resident council complaints. She stated she was not aware of the numerous complaints of wet napkins on trays. She stated she had never passed a tray with a wet napkin. She stated a negative effect of being served a wet napkin was the residents could not properly clean their hands with a wet napkin. She stated the residents' concerns needed to be addressed. She stated the residents needed to feel like they were being heard, because the facility was their home. During an interview on 8/27/25 at 1:25 P.M., the ADM stated that complaints during resident council were considered grievances. She stated she was unaware of the numerous complaints of wet napkins on the residents' trays. She stated the wet napkins was never brought up in a meeting. She stated she did not have an answer as to why the wet napkins were not corrected, because no one had mentioned it to her until today. She stated the Activity Director had never said a word to her about the residents complaining about wet napkins. She sated she truly did not know there was an issue with the napkins on the trays being wet. She stated the ADON had started an in-service to try to figure out why the napkins were getting wet on the trays. She stated a negative effect of wet napkins on the resident's food tray was they could not use them and the appearance of the wet napkins on the tray would not look nice. She stated it was important to address grievances and resident council complaints promptly, but she could not address what she did not know. Record review of Grievances and Complaints policy revised on February 2025 revealed Grievances Investigation: . A. Upon receiving a resident grievance/complaint form, the Grievance Official or designee begins an investigation into the allegations. The Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated. The department director of an involved employee is notified of the nature of the complaint</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, homelike environment maintaining a comfortable noise level for 1 of 18 residents (Resident #39) reviewed for dining services. The facility failed to ensure the noise level in the dining room was kept at a comfortable level for Resident #39 on 08/25/25 during the lunch meal. This failure could place residents at risk for a decreased quality of life. The findings included: Record review of the face sheet, dated 09/02/25, reflected Resident #39 was a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses of dementia (memory loss), history of a stroke, and a history of traumatic brain injury. Record review of the annual MDS assessment, dated 07/19/25, reflected Resident #39 had unclear speech, was usually understood by others, and was usually able to understand others. Resident #39's BIMS score was 3, which indicated severe cognitive impairment. The MDS reflected Resident #39 had no behaviors or refusal of care during the look-back period. Record review of the comprehensive care plan, revised 05/12/25, reflected Resident #39 had impaired cognitive function or thought processes. The interventions included: .reduce any distractions - turn off TV, radio, close door, etc. The care plan further reflected Resident #39 had potential for communication problems related to unclear speech. The interventions included: anticipate and meet needs. During an observation on 08/25/25 beginning at 11:44 AM, there were 18 residents sitting in the dining room. Gospel music was playing loudly, over a speaker. Resident #39 was sitting across the room in front of the television, which was on and playing. During an observation and interview on 08/25/25 beginning at 11:50 AM, Resident #39 placed her hands over her ears and stated, too loud. Resident #39 pointed at the television and shook her head side-to-side. Resident #39 shook her head yes, when asked if the music was often played too loudly. The surveyor alerted staff to Resident #39's request, and the music was turned down. During an interview on 08/27/25 beginning at 10:16 AM, LVN C stated the music was not normally played loudly with the television going at the same time in the dining room. LVN C stated Resident #39 had not complained about the music prior to 08/25/25. LVN C stated she was not in charge of the music in the dining room and was unsure who set it up. LVN C stated if the resident's complained about the noise level she would request the music be turned down. LVN C stated it was important to ensure the noise levels were kept at a comfortable level to make sure the environment remained comfortable. LVN C stated the facility was their home and it was hard to understand things happening elsewhere if the noise was too loud. During an interview on 08/27/25 beginning at 10:29 AM, the DON stated the AD was responsible for the entertainment in the dining room. The DON stated there had not been any complaints about the noise level in the dining room. The DON stated Resident #39 had not complained about the music being too loud. The DON stated it was important to ensure the noise level was kept at a comfortable level to maintain the residents best interest, cater to the residents, and ensure activities were conducted. During an interview on 08/27/25 beginning at 12:22 PM, the AD stated she was responsible for playing the music in the dining room. The AD stated the music and television were not usually playing at the same time. The AD stated if any resident's complained about the noise level of the music, it would have been turned down. The AD stated Resident #39 had not complained about the noise level of the music. The AD stated Resident #39 used to watch television in her room but had been watching television in the dining room more frequently. The AD stated it was important to ensure the noise level was kept at a comfortable level in the dining room because it was the residents right. During an interview on 08/27/25 beginning at 12:33 PM, the Administrator stated Resident #39 had not been herself recently because her long-time roommate was leaving the facility. The Administrator stated Resident #39 usually loved to listen to gospel music. The Administrator stated if any residents complained of the noise level of the music it should have been turned down. The Administrator stated all staff were responsible for monitoring the noise levels at the facility. The Administrator stated she expected the noise level to be kept at a comfortable level. The Administrator stated it was important to ensure the noise level was kept at comfortable levels so residents could hear what was going on during activities. Record review of the Resident Rooms and Environment policy, revised 08/2020, reflected .Facility staff aim to create a personalized, homelike atmosphere, playing close attention to the following comfortable noise levels.</p>		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure assessments accurately reflected the resident status for 2 of 19 residents (Resident #3 and Resident #12) reviewed for MDS assessment accuracy. The facility did not ensure Resident #3's and Resident #12's MDS assessments accurately identified a medication as an anti-platelet instead of an anticoagulant. These failures could place residents at risk for not receiving care and services to meet their needs. Findings included: 1. Record review of Resident #3's face sheet, dated 08/26/25, indicated she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included dementia (a group of conditions that cause a progressive decline in cognitive abilities), and type 2 diabetes mellitus (chronic disease where your body either doesn't produce enough insulin or doesn't use insulin properly, leading to high blood sugar levels). Record review of Resident #3's quarterly MDS assessment, dated 08/04/25, indicated she did not have a BIMS score due to her rarely/never being understood. She rarely/never understood others. The assessment further indicated she took an anticoagulant medication. Record review of Resident #3's physician's orders, dated 08/25/25, indicated the following orders: *Aspirin Low Dose oral tablet chewable 81mg (an antiplatelet medication used to prevent cardiovascular events like heart attacks and strokes) Give 1 tablet by mouth one time a day. The start date was 07/11/24. * Clopidogrel Bisulfate oral tablet 75mg (an antiplatelet medication used to prevent heart attack, stroke, and other cardiovascular problems) Give 1 tablet by mouth one time a day for cerebrovascular disease. The start date was 07/11/24. There was not an order for an anticoagulant medication. Record review of Resident #3's care plan, indicated a focus dated 05/10/25 of Resident #3 was on anti-platelet medication related to cerebrovascular accident (stroke). Interventions included monitor/document/report to MD PRN signs and symptoms of anti-platelet complications. 2. Record review of Resident #12's face sheet, dated 08/26/25, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included heart failure (a condition where the heart muscle is weakened or stiffened, making it unable to pump blood effectively) and chronic kidney disease (a condition where the kidneys gradually lose their ability to filter waste products from the blood). Record review of Resident #12's quarterly MDS assessment, dated 07/17/25, indicated he had a BIMS score of 11, which indicated moderate cognitive impairment. He was able to make himself understood and he was able to understand others. The assessment further indicated he took an anticoagulant medication. Record review of Resident #12's physician's orders, dated 08/25/25, indicated the following orders: *Aspirin Low Dose oral tablet chewable 81mg Give 1 tablet by mouth one time a day. The start date was 09/15/24. * Clopidogrel Bisulfate oral tablet 75mg Give 1 tablet by mouth one time a day. The start date was 09/15/24. There was not an order for an anticoagulant medication. Record review of Resident #12's care plan, indicated a focus dated 09/21/24 of Resident #12 was on anti-platelet therapy related to disease process. Interventions included monitor/document/report to MD PRN signs and symptoms of anti-platelet complications. During an interview on 08/27/25 at 12:08PM, the MDS Coordinator said she would have to modify the MDS assessments for Resident #3 and Resident #12. She said she was not sure how the residents' assessments were marked for anticoagulants. She said anticoagulant should have been marked no on both residents' assessments. She said the residents were taking antiplatelet medications. She said there was no risk to the residents because of the inaccurate MDS. During an interview on 08/27/2025 at 12:17 PM, ADON A said she had been one of the ADONs for about 4 months. She said the current MDS Coordinator was new. She said her expectation was that the MDS assessments were completed accurately. She said she was going to in-service and make sure the MDS assessments for Resident #3 and Resident #12 were corrected. During an interview on 08/27/25 at 12:31PM, the DON said she expected the MDS for Resident #3 and Resident #12 to be accurate. She said there was no risk to the resident due to the MDS being marked wrong for anticoagulant. During an interview on 08/27/25 at 12:39PM, the Administrator said she expected the MDS to be accurate. She said she did not think there was a risk to the resident due to the MDS being marked for anticoagulant. Record review of the facility's policy, Minimum Data Set Policy, last revised 03/14/24, reflected: .Procedure1. IDT to utilize RAI for all processes pertaining to MDS.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, and dispensing of routine drugs and biologicals to meet the needs of each resident for 2 of 2 (Resident #1 and Resident #2) residents reviewed for gastrostomy tube. 1. The facility failed to ensure Resident #1 received potassium chloride (supplement), acidophilus (probiotic), Bactrim DS (antibiotic), and valproic acid (anticonvulsant) within the scheduled time frame on 08/26/25. 2. The facility failed to ensure Resident #2 received apixaban (anticoagulant), ferrous sulfate (iron supplement), furosemide (diuretic), and valproic acid (anticonvulsant) within the scheduled time from on 08/26/25. These failures could place residents at risk for medication errors and adverse effects from medication. The findings included: Record review of face sheet, dated 08/27/25, reflected Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis of mild cognitive impairment and dysphagia (difficulty swallowing). Record review of the admission MDS assessment, dated 08/11/25, reflected Resident #1 had unclear speech, was sometimes understood by others, and was sometimes able to understand others. Resident #1 had a BIMS score of 4, which indicated severe cognitive impairment. The MDS reflected Resident #1 had no behaviors or refusal of care during the look-back period. The MDS reflected Resident #1 used a feeding tube while a resident. Record review of the comprehensive care plan, revised 08/08/25, reflected Resident #1 required a feeding tube related to dysphagia. Record review of the order summary report, dated 08/27/25, reflected Resident #1 had the following orders: 1. acidophilus probiotic - give 1 capsule via gastrostomy tube two times a day for probiotic support x 7 days with antibiotics. 2. Bactrim DS 800-160 mg - give 1 tablet via gastrostomy tube two times a day for UTI x 7 days. 3. potassium chloride solution - give 40 mEq via gastrostomy tube one time a day for supplement. 4. valproic acid oral solution 250 mg/5 mL - give 5 mL via gastrostomy tube one time a day for mood disorder. Record review of Resident #1's MAR, dated August 2025, reflected the following: 1. potassium chloride solution - give 40 mEq via gastrostomy tube one time a day for supplement was scheduled for 8 AM. 2. acidophilus probiotic - give 1 capsule via gastrostomy tube two times a day for probiotic support x 7 days with antibiotics was scheduled for 8 AM. 3. Bactrim DS 800-160 mg - give 1 tablet via gastrostomy tube two times a day for UTI x 7 days was scheduled for 8 AM. 4. valproic acid oral solution 250 mg/5 mL - give 5 mL via gastrostomy tube one time a day for mood disorder was scheduled for 8 AM. 2. Record review of the face sheet, dated 08/27/25, reflected Resident #2 was a [AGE] year-old female who initially admitted on [DATE] with diagnoses of history of stroke, dysphagia (difficulty swallowing), and gastrostomy status (opening into the stomach from the abdominal wall, made surgically for the introduction of food). Record review of the quarterly MDS assessment, dated 08/06/25, reflected Resident #2 had no speech, was sometimes understood by others, and was sometimes able to understand others. Resident #2's staff assessment for mental status reflected a short-term memory problem, long-term memory problem, and severely impaired decision making skills. Resident #2 was unable to recall current season, location of own room, staff names and faces, and that they are in a nursing home. The MDS reflected no behaviors or refusal of care during the look-back period. Resident #2 had a feeding tube while a resident at the facility. Record review of the comprehensive care plan, revised 04/04/25, reflected Resident #2 required a feeding tube related to dysphagia secondary to stroke. Record review of the order summary report, dated 08/27/25, reflected the following: 1. apixaban 2.5 mg - give 1 tablet via gastrostomy tube every morning and at bedtime for atrial fibrillation (irregular heart rhythm). 2. ferrous sulfate oral solution 5 mg/20 mL - give 30 mL via gastrostomy tube two times a day for supplement. 3. furosemide 40 mg - give 1 tablet via gastrostomy tube two times a day for edema and atrial fibrillation. 4. valproic acid oral solution 250 mg/5 mL - give 2.5 mL via gastrostomy tube two times a day for tremors. Record review of Resident #2's MAR, reflected the following: 1. apixaban 2.5 mg - give 1 tablet via gastrostomy tube every morning and at bedtime for atrial fibrillation was scheduled for 8 AM. 2. ferrous sulfate oral solution 5 mg /20 mL - give 30 mL via gastrostomy tube two times a day for supplement was scheduled for 8 AM. 3. furosemide 40 mg - give 1 tablet via gastrostomy tube two times a day for edema and atrial fibrillation was scheduled for 8 AM. 4. valproic acid oral solution 250 mg/ 5 mL - give 2.5 mL via gastrostomy tube two times a day for tremors was scheduled for 8 AM. During an interview on 08/26/25 beginning at 6:45 AM, the Regional Nurse Consultant stated LVN C had already given Resident #1 and Resident #2 all the scheduled morning medications through the gastrostomy tube. The Regional Nurse</p>		