

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675666	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/21/2025
NAME OF PROVIDER OR SUPPLIER  Briarcliff Health Center of Greenville		STREET ADDRESS, CITY, STATE, ZIP CODE  4400 Walnut 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 0842  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.  (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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record reviews, the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented for 1 (Resident #1) of 3 resident reviewed for resident records. The facility failed to reflect that Resident # 1 presented with alterations in skin integrity on daily Skilled Evaluation forms. This failure placed residents at risk of having inaccurate assessments to include those with alterations in skin integrity, that could lead to residents not receiving care as needed due to inaccurate medical records. The findings included: Record review of Resident # 1's EMR and face sheet dated 10/08/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] and discharged on 09/05/2025. Her diagnoses included: Right femur (thigh bone) fracture, sacral region (area of the back and buttock) pressure ulcer, right buttock pressure ulcer, left buttock deep tissue injury, MRSA (Methicillin Resistant Staphylococcus Aureus, a type of bacteria that is resistant to many antibiotics), right lung cancer with lobectomy (removal of lobe of lung), post-operative anemia (blood loss after surgery), and Osteoporosis (a bone disorder where bones become thinner). Record review of Resident #1's admission MDS assessment dated [DATE] reflected that she was admitted from a short-term general hospital. The MDS report indicated she admitted with surgical wounds after hip replacement, an unstageable pressure ulcer to her right buttocks, a Stage 2 pressure ulcer to her sacrum and a deep tissue injury to her left buttock. She scored 15/15 on her BIMS which signified she was cognitively intact. Record review revealed resident required supervision in eating, maximum assistance in toileting, moderate assistance in upper body dressing and was dependent in lower body dressing, bathing, bed mobility and transfers. Record review of Resident #1's nurse's Skilled Evaluation assessments dated 08/12/2025 (completed by LVN A), 08/21/25 (completed by LVN A) and 08/25/25 (completed by LVN B) revealed that no skin issues or surgical wounds were identified, and no isolation-Active Infectious Disease or Contact Isolation precautions were identified. An interview on 10/08/2025 at 10:51 a.m. with LVN A revealed skilled charting is done on all new admissions and on residents receiving skilled services. LVN A stated that there is a section on the skilled evaluation form to check off any skin concerns. LVN A stated she tries to be accurate when completing the evaluation form. An interview on 10/08/2025 at 2:00 p.m. with LVN B revealed that the skilled evaluation form should reflect the current conditions of each resident. LVN B stated that she does not measure the wounds herself, but that active skin concerns and infections should be checked off on the skilled evaluation note. An interview on 10/08/2025 at 2:40 p.m. with Tx Ns confirmed that Resident #1 did admit with right hip surgical sites with sutures and staples, and a sacral, right buttock pressure ulcer and a left buttock deep tissue injury. An interview on 10/08/2025 at 3:30 p.m. with the DON revealed that she expects nursing staff to accurately identify and code current skin issues and infection control concerns on the daily skilled charting for all residents. The DON stated that the facility had recently changed assessment forms as the Skilled Evaluation form was complicated and too long. The DON stated the failure to ensure accuracy of documentation could place the residents at risk for missed assessment that could result in harm to residents. An interview on 10/08/2025 at 3:30 p.m. with the Administrator revealed that she expected nursing staff to follow all protocols and procedures for accurate documentation for all residents. The Administrator stated that poor documentation reflects on the credibility of nursing care and facility overall. Record review of policy and procedures titled Charting and Documentation, Revised October 2021 revealed medical records should be complete and accurately document residents' medical condition.</p>		

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

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 3 (Resident #1) resident reviewed for infection control. The facility failed to immediately implement Enhanced Barrier Precautions (EBP) for Resident #1 when she admitted on [DATE]. These deficient practices placed residents at risk for cross contamination and spread of infection. Findings included: Record review of Resident # 1's EMR and face sheet dated 10/08/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] and discharged on 09/05/2025. Her diagnoses included: Right femur (thigh bone) fracture, sacral region (area of the back and buttocks) pressure ulcer, right buttock pressure ulcer, left buttock deep tissue injury, MRSA (Methicillin Resistant Staphylococcus Aureus, a type of bacteria that is resistant to many antibiotics), right lung cancer with lobectomy (removal of lobe of lung), post-operative anemia (blood loss after surgery), and Osteoporosis (a bone disorder where bones become thinner). Record review of Resident #1's admission MDS assessment dated [DATE] reflected that she was admitted from a short-term general hospital. The MDS report indicated she admitted with surgical wounds after hip replacement, an unstageable pressure ulcer to her right buttocks, a Stage 2 pressure ulcer to her sacrum and a deep tissue injury to her left buttock. She scored 15/15 on her BIMS which signified she was cognitively intact. Record review revealed resident required supervision in eating, maximum assistance in toileting, moderate assistance in upper body dressing and was dependent in lower body dressing, bathing, bed mobility and transfers. Record review of Resident #1's EMR Medication Administration Record dated August 2025 reflected Enhanced Barrier Precautions (EBP) were implemented on 08/12/2025, six days after admission. Record review of Resident #1's Order Summary Report printed 10/07/2025 revealed active order for EBP with start date of 08/12/2025, six days after admission. An interview on 10/08/2025 at 10:51 a.m. with LVN A revealed she believed EBP should be implemented on all residents with wounds, catheters, feeding tubes and urinary or respiratory infections. LVN A stated she would notify the DON if a resident did not have the proper PPE and signs available that reflected EBP. LVN A stated she was not the nurse who admitted Resident #1 and does not recall if EBP was utilized by staff prior to 08/12/2025. An interview on 10/08/2025 at 10:58 a.m. with NA E revealed she would only know if someone required PPE to be worn if there was a sign posted on the door. NA E stated she knows to wear PPE with feeding tube and catheters. NA E stated if the resident had wounds, she would only know if the nurse told her at start of shift. An interview on 10/08/2025 at 11:00 a.m. with NA C revealed she would notify the charge nurse if PPE was not available for residents who needed it. NA C stated that residents with a catheter, feeding tube and infections need EBP when she works with them. NA C stated she knows which residents have EBP needs because they have a sign on their door. An interview on 10/08/2025 at 11:03 a.m. with NA D revealed that she would wear PPE for residents who have the EBP sign posted on their door. NA D stated that she would ask the charge nurse if she did not know what the EBP need was for a particular resident. NA D stated she would not know that a resident required EBP if there was not a sign on his/her door. An interview on 10/08/2025 at 2:00 p.m. with LVN B revealed that she believed EBP was implemented on all residents who required PPE be utilized to prevent infection, contain infection and prevent spread of infection. LVN B stated that residents who had wounds would require EBP use by all staff during interactions. An interview on 10/08/2025 at 3:30 p.m. with the DON revealed that she expects nursing staff to implement EBP for all residents who have open wounds to prevent spread of infection. The DON stated she expects the admitting nurse and/or wound treatment nurse to identify EBP needs when the resident is admitted and to ensure appropriate signs are posted on the resident's door, PPE container is available at room entrance and orders obtained for EBP as needed. The DON stated she does not know why Resident #1 did not receive orders for EBP until six days after admission and acknowledged that she should have been under EBP since admission due to her wound care needs. The DON stated failures to ensure EBP were in place would place the resident at greater risk for increased infection and spread of infection due to poor infection control procedures. An interview on 10/08/2025 at 3:30 p.m. with the Administrator revealed that she expected nursing staff to follow all protocols and procedures for infection control for all residents. The Administrator stated that poor infection control could result in harm or injury to identified resident and other residents and increase the chance of spreading infection throughout the facility. Record review of policy</p>		