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 03/27/2026
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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from significant medication errors for 1 of 6 residents (Resident #1) reviewed for significant medication errors, in that: The facility administered the incorrect insulin on 03/12/2026 based on a failed medication reconciliation upon Resident #1's readmission resulting in a low blood glucose reading of 35. The facility should have administered Insulin Glargine (a long acting medication use to treat diabetes mellitus and help regulate blood glucose levels) 12 units daily and incorrectly administered Tresiba (an ultra-long-acting insulin). The facility failed to ensure nursing staff were able to locate the emergency kit with glucagon medication (an emergency medication to treat severe hypoglycemia or low blood glucose level) to treat Resident #1's blood glucose level of 35 until the EMS team arrived to provide emergency intervention. An IJ was identified on 03/26/2026. The IJ Template was provided to the facility on [DATE] at 2:40 p.m. The IJ was removed on 03/27/2026 at 11:45 a.m. The facility remained out of compliance at a potential for more than minimal harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure placed resident at risk for adverse side effects to include decrease in blood glucose levels resulting in increased confusion, loss of consciousness or life-threatening complications such as brain or organ damage or even death. Findings include: Record review of Resident #1's face sheet, dated 03/26/2026, revealed an [AGE] year-old male originally admitted [DATE] and discharged on 03/13/26 due to hypoglycemic episode with a blood glucose level of 35 and re-admitted on [DATE] after being treated for a hypoglycemia episode. Resident #1 was re-hospitalized on [DATE] after a fall and remained in the hospital during this survey. Diagnoses included Diabetes Type II (a chronic metabolic disorder where the body develops insulin resistance and cannot properly regulate blood sugar level), Chronic Obstructive Pulmonary Disease (a progressive lung disease that restricts airflow), dysphagia (difficulty swallowing), chronic kidney disease (an irreversible loss of kidney function, preventing the kidneys from properly filtering the blood), atherosclerotic heart disease (heart disease involving the buildup of plaque, fat and cholesterol which narrows the blood vessels and restricts blood flow), atrial fibrillation (a heart rhythm disorder), gout (a painful form if inflammatory arthritis). Record review of Resident #1's Baseline Care Plan, revised 02/04/2026, revealed Resident #1 had diabetes mellitus and was receiving insulin. Record review of Resident #1's re-admission MDS, dated [DATE], revealed a BIMS score of 11 which indicated moderate cognitive impairment. Further of review of the readmission MDS dated [DATE] revealed Resident #1 presented with lower extremity range of motion impairment, required supervision with eating; maximum assistance with upper body dressing and bathing; and was dependent in bed mobility, transfers and lower body dressing. Record review of Resident #1's hospital discharge instructions, dated [DATE] revealed an order for 12 units Insulin Glargine (a long-acting insulin) one time a day and Insulin regular (a short acting insulin) to be administered via sliding scale before meals. Additional discharge instructions were to stop taking Insulin degludec (trade name Tresiba, an ultra-long-acting insulin) 40 units one time a day. Record review of Resident #1's March 2026 Medication Administration Record revealed the facility did not transcribe an order for 12 units (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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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Insulin Glargine (long-acting insulin) one time a day and Insulin Regular (short acting) to be administered via sliding scale. Record review of Resident #1's medication administration record for 03/01/2026-03/31/2026 revealed the facility failed to accurately reconcile Resident #1's hospital discharge instructions on readmission and continued with orders for Tresiba (Insulin) 40 units at the hours of sleep. On 03/12/2026 at the hour of sleep, Resident #1 had a blood glucose level of 135 and received 40 units of Tresiba (Insulin). At 5:10 a.m. on 03/13/2026, Resident #1 had a blood glucose level of 35. Record review of Resident #1's nursing progress noted dated 03/13/2026 revealed Resident #1 received nursing intervention for hypoglycemia (low blood sugar) to include dissolved sugar packets in water and juice until EMS arrived and administered Dextrose 50 (a concentrated carbohydrate solution used to treat severe hypoglycemia / low blood sugar) and transferred Resident #1 to the hospital. An interview with the responsible party was attempted on 03/26/26 at 11:45 a.m. and was unsuccessful. In an interview on 03/26/2026 at 11:45 a.m., LVN A stated she completed all of the admission assessments on 03/12/2026 on the re-admission of Resident #1 but did not review the hospital discharge medication list. LVN A stated that as time permits, two nurses split the admission process for new and re-admissions and the medication review for Resident #1's re-admission on [DATE] was completed by the charge nurse. In an interview on 03/26/26 at 12:05 p.m., LVN B revealed that he was the charge nurse when Resident #1 re-admitted on [DATE] and that he completed the medication reconciliation. LVN B acknowledged that he failed to accurately reconcile the medications and accurately transcribe the correct insulin orders. LVN #B stated he was notified of this transcription error on 03/17/2026 at 2:20 p.m. by the DON, at which time he received a written counseling related to transcription. LVN #B stated that this error could result in harm to the resident by lowering her blood sugar causing a hypoglycemic episode. In an interview on 03/26/26 at 12:23 p.m., RN C stated that she followed the physicians orders on 03/12/2026 when she checked Resident #1's blood sugar at the hours of sleep and administered 40 units of Tresiba (insulin). RN C stated she was aware that Resident #1 has re-admitted that day, but the re-admission and medication reconciliation was completed by the previous shift nurse. RN C stated that when she checked Resident #1's blood glucose level at 5:10 a.m., blood glucose level was at a low level of 35. RN C stated that Resident #1 was alert, about to sit upright and had no difficulty swallowing. RN C stated she administered sugar dissolved in peach juice and water until EMS arrived. RN C stated she was unable to locate the facility emergency kit with glucagon injection or gel. RN C stated she notified the physician, responsible party and DON of change of condition and subsequent hospital transfer. In an interview on 03/26/2026 at 1:10 p.m., the DON stated she was notified by RN C of the low blood sugar for Resident #1 and hospital transfer on 03/13/26 at approximately 5:30 a.m. The DON stated that glucagon gel and injection are available in the emergency kit which is located in the medication room, and that she was not sure why the floor staff were unable to locate it to administer to Resident #1. The DON was able to locate the emergency kit after searching for 45 minutes and surveyor confirmed that there was a tube of glucagon gel and one injection of glucagon in the emergency kit. The DON stated that while Resident #1 was hospitalized , they reviewed the hospital records, and it was confirmed that the LVN B failed to complete an accurate medication reconciliation when Resident #1 re-admitted on [DATE] which resulted in the low blood glucose level on the morning of 03/13/2026. The DON stated she met with LVN B and issued a written disciplinary action and provided Inservice and training on the importance of accurate transcription and medication reconciliation. The DON stated that she expects all nurses to complete the medication reconciliation for all admissions accurately and to ensure that transcription is done correctly. The DON stated that she expects all nursing staff to confirm the readmission orders with the physician and transcribe them to the EMR to ensure accurate medication administration. In an interview on 03/27/2026 at 11:08 a.m., the attending physician stated he did not recall exactly what Resident #1's admitting orders were but recalled he did ask the facility to continue / follow hospital orders and would evaluate the resident at next visit to the facility. The physician stated that he was the facility medical director and there were standing (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	orders in place for the use of glucagon in the event of a low blood sugar reading as indicated. The physician stated he expects the nurses to accurately review the hospital discharge instructions and call him with accurate information when the orders are verified. The physician stated failure to accurately administer insulins could result in hyperglycemia (high blood glucose levels) or hypoglycemia (low blood glucose levels) that could cause harm to the residents. Record review of the facility policy named, Reconciliation of Medications on Admission, revised July 2025, revealed, Purpose: The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. and, General Guidelines, 1. Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating a list.to ensure that medications, routes and dosages have been communicated to the Attending Physician and care team. Record review of the facility policy named, Adverse Consequences and Medication Errors, revised April 2014, revealed, 5. A medication error is defined as .the administration of drugs which is not in accordance with professional standards and 6. Examples of medication errors include: a. Omission - a drug is ordered but not administered; and f. Wrong drug (e.g. vibramycin ordered, vancomycin given). This was determined to be an Immediate Jeopardy (IJ) on 03/26/2026 at 2:10 p.m. The Administrator and the DON were notified and provided the IJ Template on 03/26/2026 at 2:42 p.m., and a Plan of Removal was requested. The following Plan of Removal submitted by the facility was accepted on 03/27/2026 at 11:30 a.m. Tag Cited: F760 Alleged Issues:The facility failed to ensure Resident #1 was free from significant medication errors when the facility failed to administer Insulin Glargine medication according to hospital discharge instructions as ordered by the physician and failed to administer emergency medicine for low blood sugar due to staff not being able to locate the emergency medicine kit. Plan of Removal 1. Immediate ActionsThe Medical Director was notified by the DON on 03/26/2026 of the Immediate Jeopardy. Resident #1 was hospitalized at time of this survey and facility interventions were completed based on this identified concern. The DON completed a chart audit on all residents with a diagnosis of diabetes mellitus on 03/26/2026 to ensure all residents had orders in place for glucagon injection or gel as needed for low blood sugar and signs of hypoglycemia. A Glucagon Audit Sheet was implemented to be completed daily by charge nurse to ensure glucagon is available in the emergency kit. The tracker will be monitored by the DON or ADON daily in the clinical meeting Monday thru Friday. On Saturday and Sunday, the audit sheet will be monitored by the weekend supervisor or designee. The DON completed an audit on 03/27/2026 at 9:15 a.m. to confirm emergency glucagon orders were in place for all residents with a diagnosis of Diabetes Mellitus. The DON located the glucagon medication in the emergency kit in the medication room and re-labeled it with a large red paper to allow for it to be easily located. The DON implemented a policy that two nurses will review the medication reconciliation for all new admissions and readmissions. 2. Education An in-service was conducted with DON and ADON by the Regional Nurse director on 03/26/2026 at 2:00 p.m. in regard to the Diabetes protocol and the reconciliation of medications on all admissions. An in-service was conducted on 03/26/2026 from 2:45 p.m. - 4:00 p.m. by the DON for all full time and part time nurses on the importance of accuracy for medication reconciliation for new admissions and readmissions, the location of the emergency kit supply of glucagon and hypoglycemia / diabetes protocols. The DON/ADON will educate all new nursing staff of these same trainings before they are allowed to work. An in-service was conducted on 03/27/2026 at 5:50 a.m. by the DON for the Weekend Supervisor on reviewing the medication reconciliation for all new and re-admissions and the location of the emergency kit supply of glucagon. 3. Monitoring The DON or designee will monitor each new admissions physicians orders to ensure accurate transcription at the daily clinical meeting Monday thru Friday. The weekend supervisor or designee will monitor the physicians orders on Saturday and Sunday. The Regional Clinical Nurse will monitor to ensure the plan of removal education remains in place on the weekly Quality Improvement reviews. The Administrator will ensure the clinical meeting IDT members review the physician's orders for all new and re-admissions at the (continued on next page)

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