

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/11/2026
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to develop a person-centered comprehensive care plan to address medical needs for 1 of 5 residents (Resident #4) reviewed for comprehensive care plans. The facility failed to ensure Resident #4's comprehensive care plan was revised to reflect current transfer status of requiring a mechanical lift. This failure could place residents at increased risk of falls, injuries, and a decreased quality of life. Findings included: Record review of Resident #4's facility face sheet, dated 2/10/2026, indicated Resident #4 was a [AGE] year-old male, admitted [DATE], with diagnoses of cerebral infarction (stroke) and diabetes (increased glucose in the blood). Record review of Resident #4's quarterly MDS assessment, dated 01/29/2026, indicated Resident #4 had a BIMS of 00 indicating severely impaired cognition, was dependent on staff for assistance with all ADLs, used a wheelchair, and had functional limitation of range of motion to both upper and lower extremities. Record review of Resident #4's comprehensive care plan, revision date 02/05/2026, indicated Resident #4's comprehensive care plan did not reflect the current transfer status of requiring a mechanical lift on admission [DATE] or on revision date 02/05/2025. Record review on 02/10/2026 of Resident #4's order summary report revealed Resident #4 had an order written on 10/24/2025 for out of bed twice daily and as tolerated two times a day for pain. There was no order related to Resident #4's use of mechanical lift. During an interview on 02/10/2026 at 12:16 PM, CNA B said she had worked at the facility for 9 years and she does not look at a Kardex to find out what kind of transfer requirements are ordered for the residents. She relies on verbal reports from the other CNAs and charge nurses for communication of correct lift requirements. CNA B said Resident #4 required a mechanical lift for transfers since he was dependent for all transfers. During an interview 02/11/2026 at 9:00 AM, MDS Nurse A said that there was no transfer status on Resident #4's admission care plan or his revised care plan and she would correct it to reflect two persons transfers with a mechanical lift. She said it appeared that the admission nurse clicked the transfer status but then deleted the transfer status, leaving it blank. She said not knowing proper transfer status could cause injuries if the correct transfer process was not followed. During an interview on 02/11/2026 at 9:15 AM, the DON said not having the correct transfer status on the care plan could cause injury if the staff were not aware of what was required for safety. During an interview on 02/11/2026 at 9:30 AM, the Administrator said not having the correct transfer status on the care plan could possibly cause injury to a resident if the staff was not aware of what transfer status was required. Record Review of a Facility policy dated 01/2025 titled: Care Plans, Comprehensive Person-Centered Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations; and (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
--	-------	-----------

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/11/2026
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(3) which professional services are responsible for each element of care.11.Asessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change.12.The interdisciplinary team reviews and updates the care plan		

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 02/11/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' environment remains as free of accident hazards as possible for 2 of 20 residents reviewed for quality of care. (Resident # 4 and Resident # 64) The facility failed to remove worn and damaged mechanical lift slings from service for Resident's # 4 and # 64. This failure could result in a loss of quality of life due to injuries. Findings included: 1. Record review of Resident # 4's face sheet, dated 2/10/2026, indicated Resident # 4 was a [AGE] year-old male, admitted [DATE], with diagnoses of cerebral infarction (stroke) and diabetes (increased glucose in the blood). Record review of Resident # 4's quarterly MDS assessment, dated 01/29/2026, indicated Resident # 4 had a BIMS of 00 indicating severely impaired cognition, was dependent on staff for assistance with all ADLs, used a wheelchair, and had functional limitation of range of motion to both upper and lower extremities. Record review of Resident # 4's comprehensive care plan, revision date 02/05/2026, indicated Resident #4's care plan did not reflect the current transfer status of requiring a mechanical lift. Record review on 02/10/2026 of Resident # 4's order summary report dated 02/10/2026 revealed Resident # 4 had an order written on 10/24/2025 for out of bed twice daily and as tolerated two times a day for pain. There was no order related to Resident # 4's transfer status or use of mechanical lift. During an observation and interview on 02/09/2026 at 12:48 pm, Resident # 4 was sitting in a high back wheelchair in the hallway outside his room. Resident # 4 had a lift sling with straps faded in color, light pink for red, strap green or blue is white with light green stitching. CNA C said she had training on mechanical lift transfers and watching for rips and tear threads coming unsewn on the slings used for transfers. CNA C was not sure about the faded colors on the straps. She said she would ask her nurse about taking the sling out of service. During an observation on 02/10/2026 at 08:00 am, the same bleached mechanical sling was on Resident # 4's wheelchair ready for use. 2. Record review of Resident # 64's face sheet revealed Resident # 64 was an [AGE] year-old female that admitted on [DATE] with a diagnosis of radiculopathy (pinched nerve in the spine). Record review of Resident # 64's admission MDS assessment dated [DATE] revealed Resident # 64 had a BIMS of 10 indicating moderate cognitive impairment and required maximum assistance with transfers. Record review of Resident # 64's comprehensive care plan dated 1/21/2026 revealed Resident # 64 had an ADL deficit and was dependent on staff for transfer. During an observation and interview on 2/9/2026 at 12:38 pm, Resident # 64 was observed in her room sitting in a wheelchair and had a lift sling under her. The sling's loops were frayed and torn. She said that she could stand but the facility must use a mechanical lift sometimes when she was weak. During an observation on 2/10/2026 at 9:15 am, Resident # 64 had a mechanical lift sling in her room that had frayed and torn loops. During an observation and interview on 2/10/2026 at 9:30 am, Resident # 64 was observed in the therapy room with no mechanical lift sling under her. She said she was strong this morning and they did not have to use the mechanical lift to get her up today. During an interview on 2/10/2026 at 9:48 am, CNA D said she was assigned to Resident # 64, and she required assistance x 1 for transfers. She said this morning she was good and stood up and transferred well but there were times in the afternoons that she was weaker, and a mechanical lift was used. She said before using a mechanical lift, the lift and sling were inspected for safety. The mechanical slings should be free of rips and tears and if they were not in good repair they should be given to the nurse and a new one obtained. She said using a frayed mechanical lift sling could cause a resident to fall and become injured. During an interview on 02/10/2026 at 8:15 am, Laundry Aide D said that she does not bleach the mechanical lift slings she washes them with colors and hangs them dry. She said she had received training to remove mechanical lift slings from service that were bleached. Laundry Aide D said she would remove lift slings that were ripped or torn. She said not removing damaged mechanical lift slings could cause (continued on next page)		

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 02/11/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injury to a resident if the lift sling broke.During an observation and interview on 02/10/2026 at 8:30 AM, the DON said she had worked at the facility for a couple of months. She said the staff are in-serviced on signs of wear and tear and to remove mechanical lift slings from service if they have rips, tears and coming unsewn. She said she was not aware of manufacturers' suggested practice of not bleaching. She said the lift sling used for Resident #4 would be removed from service and he would get a new lift sling. She said that using the faded lift sling could cause injury if it broke.During an interview on 02/10/2026 at 8:40 AM, the Administrator said the lift sling used for Resident #4 should be removed from service. She said they would have an in-service with staff. She said that using the faded lift sling could cause injury if it broke.During an interview on 02/10/2026 at 9:17 AM, the Housekeeping Supervisor said she would train all laundry staff on the care of the mechanical lift slings, including air dry and not use bleach. She said the lift sling that was used for Resident #4 could cause injury if it broke. Record Review of Facility policy dated 03/2025 Lifting Machine, using a Mechanical lift.The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting deviceGeneral Guidelines1.At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift.2.Mechanical Lifts may be used for tasks that require:a. Lifting a resident from the floor.transferring a resident from bed to chair.c. Lateral transfers.lifting limbs.c. Toileting or bathing; [NAME]. Repositioning.Steps in the Procedure1.Before using a lifting device, assess the resident's current transfer ability utilizing the Kardex located in the electronic health system.2.The Therapy Screen 2.0 form will be completed upon admission and readmission, with MDS changes including IPA's, quarterly or significant change MDS and PRN to assess and determine transfer/mobility status.3.Prepare the environment:5.Make sure that all necessary equipment (slings, hooks, chains, straps and supports) is on hand and in good condition. Sling Care:1. Disinfect slings between residents (unless disposable).2. Discard any worn, frayed or ripped slings.Record Review of Manufacturer's recommendations accessed www.medline.com 02/11/2026Indicated: Always inspect slings prior to each use Signs of rips. tears. or frays indicate sling wear which 1s unsafe and could result 1n injury Signs of fading. bleached areas. or permanent wrinkles on the straps indicate improper laundering which is unsafe and could result in injury Any slings with signs of wear or improper laundering should be immediately removed from use.Always confirm compatibility between the connection style of the patient sling and the patient lift before use.Do not remove sling labels. If sling labels are removed or no longer legible. sling must be immediately removed from use.Frequency of laundering should follow facility guidelines, or when the sling is soiled. Refer to the sling's tag for laundering instructions and follow all wash instructions.		

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 02/11/2026
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 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 that a resident who is incontinent of bladder receives appropriate treatment and services to prevent infections and to restore continence to the extent possible for 1 of 5 (Resident #72) residents observed for incontinent care. CNA D and CNA F did not provide proper incontinent care for Resident #72 and wiped from the anal area toward the urethral area (back to front) on 2/10/2026. This failure could place residents at risk for bacterial infections from improper incontinent care. Findings include: Record review of an admission Record for Resident #72 dated 2/10/2026 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnosis of colostomy status (surgically created opening (stoma) connecting the colon to the abdominal wall, allowing waste to bypass a damaged or diseased part of the bowel), anorexia nervosa (an eating disorder that involves severe calorie restriction low body weight), and hypertension (high blood pressure). Record review of a Quarterly MDS Assessment for Resident #72 dated 12/19/2025 indicated she had moderate impairment in thinking with a BIMS score of 8. She was dependent on staff for toileting hygiene. She was always incontinent of urine/bowel. Record review of a care plan for Resident #72 dated 2/8/2025 indicated she was on prophylactic medications for recurrent UTIs. During an observation on 2/10/2026 at 10:50 a.m., CNA D and CNA F were in the room of Resident #72. Both staff entered the room, sanitized their hands, and applied gloves. CNA F opened the resident's brief and pulled it down between her thighs. Both staff removed their gloves and placed them in the trash. Both sanitized their hands and donned gloves. CNA F removed wipes from the package and wiped the resident's right inner thigh and placed the wipe in the trash; and then removed another wipe and wiped down the left inner thigh and placed it in the trash. CNA F removed a wipe and wiped down the middle of the vagina from front to back, removed her gloves, placed them in the trash, and sanitized her hands. CNA F donned gloves and the resident was rolled onto her right side. CNA F removed the soiled brief and placed them in the trash along with her gloves. CNA F sanitized her hands and donned gloves. CNA F removed wipes and wiped the residents left and right buttocks from front to back (from the resident's rectal area toward her back). CNA F then wiped the resident's rectal area down the middle from back to front toward the resident's urethra. She removed her gloves and placed them in the trash and sanitized her hands. She placed a clean brief under the resident's buttocks and secured it. Resident was repositioned in bed. Both staff removed their gloves and placed them in the trash and sanitized their hands. During an interview on 2/10/2026 at 10:59 am, CNA F said she had been employed at the facility since 2014. She said she worked D Hall where Resident #72 resided. When asked about the care she provided to Resident #72 if she should have done anything differently, she said she wiped her rectal area from back to front and was not thinking that she had wiped her incorrectly at that time. She said she had a skills check off about a month ago and had been trained on how to perform incontinent care to a female resident and knew to wipe from front to back. She said there was a risk for infections if staff did not wipe the correct way when care was provided to a female resident. Record review of a competency skills check off on 10/25/2025 indicated CNA F was successful with donning PPE or contact precautions and incontinent care with a female resident. During an interview on 2/10/2026 at 1:22 pm, CNA D said she had been employed at the facility for 5 years. She said her last competency skills check-off was November 2025. She said during the care provided to Resident #72; CNA F did not wipe the resident from front to back when she wiped her rectal area. She said there was a risk of UTI's and infections if staff did not wipe the correct way when care was provided. Record review of a competency skills check off on 10/2/2025 indicated CNA D was successful with donning ppe for contact precautions and incontinent care with a female resident. During an interview on 2/11/2026 at 10:34 am, the ADON said she was responsible for training staff on infection control on hire and yearly thereafter and as (continued on next page)		

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 02/11/2026
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed if issues arise. She said if staff provided incontinent care to a female resident, they should wipe from front to back. She said residents could be at risk for infections if staff did not follow infection control practices or did not wipe the resident properly. During an interview on 2/11/2026 at 10:38 am, the DON said she had been in the position since December 1, 2025. She said she along with the ADON was responsible for conducting in-services with the staff and competency evaluations. She said she was made aware of CNA D and CNA F who provided care to Resident #72 when they did not follow infection control measures. She said when incontinent care was provided to a female resident, they should wipe from front to back. She said she planned to provide 1:1 training with CNA D and CNA F. She said if staff did not follow infection control measures residents could be at risk for spreading infections. She said if staff did not wipe female residents correctly, they could cause the resident to develop UTI's or worsening infections. During an interview on 2/11/2026 at 10:42 am, the Administrator said the DON and ADON was responsible for training staff on infection control procedures and policies. She said if the staff provided incontinent care to a female resident, they should wipe from front to back. She said if staff did not follow infection control measures, then residents could be at risk for infections. She said they planned to do more monitoring on pericare along with more frequent in-servicing. Record review of a facility policy titled Perineal Care revised October 2010 indicated, .The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. 9. For a female resident: b. Wash perineal area, wiping from front to back .		

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 02/11/2026
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that ensure accurate acquiring, receiving, dispensing and administering of medications for 2 of 6 residents (Residents # 27 and # 62) reviewed for pharmacy services. The facility failed to remove Resident # 27's expired lorazepam concentrate (anxiety medication) from the medication room refrigerator. The facility failed to remove Resident #62's expired ondansetron (nausea medication) from the medication cart. These failures could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications, decreased quality of life, and hospitalization. Findings included: 1. Record review of Resident #27's face sheet revealed Resident #27 was an [AGE] year-old female that admitted on [DATE] with a diagnosis of polyneuropathies (damage to multiple peripheral nerves). Record review of Resident #27's comprehensive care plan dated 2/20/2025 revealed Resident #27 used anti-anxiety medications and to administer medications as ordered. Record review of Resident #27's discontinued order report dated 8/11/2025 revealed Resident #27's lorazepam was discontinued. Record review of Resident #27's Quarterly MDS assessment dated [DATE] revealed Resident #27 had a BIMS of 07 indicating severe cognitive impairment. During an observation 2/10/2026 at 11:35 am, the lock box located in the main medication room refrigerator had a bottle for Lorazepam 2 milligrams/milliliter for Resident #27 that was opened on 4/03/2025 and per label was to be discarded after 90 days of opening. Record review of Resident #27's narcotic log sheet for lorazepam 2 milligrams/milliliter revealed the last dose was given 8/11/2025. 2. Record review of Resident #62's face sheet revealed Resident #62 was a [AGE] year-old female that admitted on [DATE] with a diagnosis of traumatic subdural hemorrhage (collection of blood in the brain). Record review of Resident #62's comprehensive care plan dated 2/20/2025 revealed no problem with nausea addressed on current care plan. Record review of Resident #62's Quarterly MDS assessment dated [DATE] revealed Resident #62 had a BIMS of 04 indicating severe cognitive impairment. Record review of Resident #62's order summary report dated 2/10/2026 revealed Resident #62 had an active order for ondansetron 4 milligrams by mouth every 4 hours as needed for nausea or vomiting. Record review of Resident #62's medication administration reports for January 2026 and February 2026 revealed Resident #62 had not received ondansetron after expiration date. During an observation on 2/10/2026 at 11:30 am Resident #62 had a card of ondansetron 4 milligrams 1 tablet by mouth every 4 hours as needed that expired on 1/14/2026. During an interview on 2/10/2026 at 11:40 am, LVN E said that all the nurses were responsible for checking the medication carts and locked boxes as needed and should always check each medication before administering to ensure it was for the correct resident, not expired, and labeled correctly. She said that medications that were expired and discontinued should be removed for disposal. She said residents that receive expired medications could have poor effects because of decreased potency. She said she was not aware lorazepam concentrate was only good for 90 days after opening. During an interview on 2/10/2026 at 11:44 am, the DON said that she and the ADON checked the medication carts and lock boxes periodically for expired medications but there was not a set schedule. She said the pharmacist checked all the carts monthly and removed any medications that were expired. She said she was not aware lorazepam concentrate was only good for 90 days after opening and would educate all nurses on lorazepam concentrate. She said that expired medications could have decreased effectiveness. During an interview on 2/11/2026 at 10:47 am, the Administrator said that the nurses and pharmacists were responsible for ensuring all medications were discarded after expiration. She said the nurses should be checking the medication carts and other storage areas regularly and especially before administering any medication. She said any medication that was expired should be removed and discarded. She said medications that were expired could be (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/11/2026
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ineffective. She said she expected the facility policies for medication storage, labeling and administration was always followed. Record review of a facility policy titled Administering Medications dated 2001 indicated, .11. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi dose container, a date will be put on the container, 12. Vials labeled as single dose or single use are not used on multiple residents. Such vials are used only for one resident in a single procedure . Record review of a facility policy titled Storage of Medications dated 2001 indicated, .5.Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed .		

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 02/11/2026
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure drugs and biological's used in the facility were labeled in accordance with currently accepted professional principles and the expiration date when applicable for 1 of 4 medication carts (A hall nurse medication cart) reviewed for labeling and storage, in that: The facility failed to label over the counter (OTC) eye drops with the name of the specific resident it was ordered for on [DATE]. This failure could place residents who receive medications to have adverse reactions or cross contamination. Findings included: During an observation on [DATE] at 11:30 am, the medication cart for hall A had an OTC bottle of Sodium Chloride Hypertonicity ophthalmic solution 5% that was opened and unlabeled. During an interview on [DATE] at 11:40 am, LVN E said she was not sure what resident the eye drops belonged to. She said the nurses were responsible for labeling the OTC eyes drops with the residents name and date opened to ensure they were not used on multiple residents. She said the nurses should be checking their carts each shift and before administering any medication to ensure the medication was for the correct resident, not expired and labeled correctly. She said that labeling was to prevent cross contamination. During an interview on [DATE] at 11:44 am, the DON said that she and the ADON checked the medication carts periodically for unlabeled medications but there was not a set schedule. She said the pharmacist checked all the carts monthly and removed any medications that were unlabeled. She said that unlabeled eye drops could cause cross contamination and infections. During an interview on [DATE] at 10:47 am, the Administrator said that the nurses and pharmacists were responsible for ensuring all medications were labeled and stored correctly. She said the nurses should be checking the medication carts and other storage areas regularly and especially before administering any medication. She said that eye drops should be labeled with resident name and date opened to ensure single resident use to prevent chance of spreading infections. She said she expected the facility policies for medication storage, labeling and administration was always followed. Record review of a facility policy titled Labeling of Medication Containers dated 2001 indicated, . medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations .		

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 02/11/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, 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 7 residents (Resident #72) reviewed for infection control. The facility failed to ensure CNA D and CNA F followed contact precautions when incontinent care was provided to Resident #72 on 2/10/2026. These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings included: Record review of an admission Record for Resident #72 dated 2/10/2026 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnosis of colostomy status (surgically created opening (stoma) connecting the colon to the abdominal wall, allowing waste to bypass a damaged or diseased part of the bowel), anorexia nervosa (an eating disorder that involves severe calorie restriction low body weight), and hypertension (high blood pressure). Record review of a Quarterly MDS Assessment for Resident #72 dated 12/19/2025 indicated she had moderate impairment in thinking with a BIMS score of 8. She was dependent on staff for toileting hygiene. She was always incontinent of urine/bowel. Record review of a care plan for Resident #72 dated 2/8/2025 indicated she was on isolation-contact isolation-based precaution MRSA with interventions included PPE defined by the CDC required before entering a contact precautions designated room is always gloves and a gown. Record review of active physician orders for Resident #72 dated 2/10/2026 indicated an order for contact isolation for MRSA in urine until antibiotic is finished, every shift with a start date of 2/8/2026. During an observation on 2/10/2026 at 10:50 AM, CNA D and CNA F were in the room of Resident #72. The resident's door had a sign for contact precautions and PPE in the hallway in a container that had gowns and gloves. Both staff entered the room, sanitized their hands, and applied gloves. Neither staff donned a gown during incontinent care that was provided. During an interview on 2/10/2026 at 10:59 am, CNA F said she had been employed at the facility since 2014. She said she worked D Hall where Resident #72 resided. When asked about the care she provided to Resident #72 if she should have done anything differently, she said the resident was on contact precautions and should have worn a gown. She said she had been off the past couple of days and when she last worked Resident #72 was not on contact precautions. She said she did not pay attention that the resident had a sign on her door along with PPE in a container in the hallway. She said there was a risk of infections if staff did not wear gowns if on contact precautions when care was provided. Record review of a competency skills check off on 10/25/2025 indicated CNA F was successful with donning PPE for contact precautions and incontinent care with a female resident. During an interview on 2/10/2026 at 1:22 pm, CNA D said she had been employed at the facility for 5 years. She said during the care provided to Resident #72 they should have worn a gown during care because the resident was on contact precautions and did not notice at the time the sign or PPE in the hallway. She said there was a risk of infections if staff did not wear gowns for residents who were on contact precautions. Record review of a competency skills check off on 10/2/2025 indicated CNA D was successful with donning PPE for contact precautions and incontinent care with a female resident. During an interview on 2/11/2026 at 10:34 am, the ADON said she was responsible for training staff on infection control on hire and yearly thereafter and as needed if issues arise. She said if a resident was on contact precautions the staff should wear a gown and gloves. She said residents could be at risk of infections if staff did not follow infection control practices. During an interview on 2/11/2026 at 10:38 am, the DON said she had been in the position since December 1, 2025. She said she along with the ADON was responsible for conducting in-services with the staff and competency evaluations. She said she was made aware of CNA D and CNA F who provided care to Resident #72 when they did not follow infection control measures. She said Resident #72 was on contact isolation for an infection in her urine and when staff provided care, (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/11/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they should wear a gown and gloves. She said she planned to provide 1:1 training with CNA D and CNA F. She said if staff did not follow infection control measures residents could be at risk for spreading infections. During an interview on 2/11/2026 at 10:42 am, the Administrator said the DON and ADON was responsible for training staff on infection control procedures and policies. She said residents who were on contact precautions staff should wear gowns and gloves when care was provided. She said if staff did not follow infection control measures, then residents could be at risk for infections. She said they planned to do more monitoring on pericare along with more frequent in-servicing. Record review of a facility policy titled Isolation-Categories of Transmission-Based Precautions revised March 20, 2025 indicated, .Contact Precautions 8. Staff and visitors wear disposable gown upon entering the room and remove before leaving the room		