

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Legend Healthcare and Rehabilitation - Greenville		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 Jack Finney Blvd Greenville, TX 75402	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637</p> <p>Based on interview and record review, the facility failed to ensure the resident had the right to be free from abuse for 1 of 16 (Resident #1) residents reviewed for abuse.</p> <p>The facility failed to protect Resident #1 from verbal and physical abuse from Resident #2 on [DATE].</p> <p>The noncompliance was identified as PNC. The noncompliance began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk for physical and verbal abuse, psychosocial harm, and decreased quality of life.</p> <p>Findings Include:</p> <p>1. Record review of the face sheet dated [DATE] indicated Resident #1 was readmitted to the facility on [DATE] with diagnoses including dementia, muscle weakness, and cognitive communication deficit.</p> <p>Record review of the quarterly MDS dated [DATE] indicated Resident # 1 understood others and was understood by others. The MDS indicated Resident #1 had a BIMS of 03 and was severely cognitively impaired. The MDS indicated during the 7-day look back period Resident #1 did not have any physical behaviors towards others. The MDS indicated during the 7-day look back period Resident #1 did not have any verbal behaviors directed towards others.</p> <p>Record review of the care plan last updated [DATE] indicated Resident #1 had actual impairment to skin integrity r/t bruise to left upper arm [DATE]. The care plan indicated Resident #1 had a skin tear to the left upper arm [DATE].</p> <p>Record review of an incident report dated [DATE] indicated, [Resident #1 was] noted to have [a] skin tear and bruise to [the] left upper arm. Another resident was witnessed grabbing [Resident #1's] arm. MD and RP notified. Wound care provided per facility protocol. Resident were separated immediately.</p> <p>(continued on next page)</p>

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the progress note dated [DATE] at 8:54 p.m. indicated, CNA reported to this nurse that while she was charting, she overheard another resident aggressive with this resident and when she turned around other resident had grabbed this resident left arm causing bruising and skin tear. Area was assessed, skin tear was cleaned and covered with steri-strips. When interviewed resident states that he was not sure what happened that other resident had just grabbed him. Two residents were immediately separated .</p> <p>Record review of the progress note dated [DATE] at 1:13 a.m. indicated [Resident #1] in another room, sleeping well, no acute distress noted .</p> <p>Record review of the progress note dated [DATE] at 3:13 p.m. indicated Resident #1 expired in the facility with family at bedside.</p> <p>2. Record review of the face sheet dated [DATE] indicated Resident #2 was admitted to the facility on [DATE] with diagnoses including Alzheimer's, psychotic disorder with delusions (mental disorder that causes abnormal thinking and perceptions), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and muscle weakness.</p> <p>Record review of the quarterly MDS dated [DATE] indicated Resident #2 understood other and was understood by others. The MDS indicated Resident #2 had a BIMS of 00 and was severely cognitively impaired. The MDS indicated during the 7-day look back period Resident #2 did not have any physical behaviors towards others. The MDS indicated during the 7-day look back period Resident #2 did not have any verbal behaviors directed towards others.</p> <p>Record review of the care plan last updated on [DATE] indicated Resident #2 had demonstrated physical behaviors toward other residents related to anger and dementia.</p> <p>Record review of the incident report dated [DATE] indicated, [Resident #2] reportedly grabbed another resident's arm and left a bruise and skin tear. [Resident #2] was heard saying give me the fucking toilet paper before grabbing [the] other resident's arm. [Resident #2] was noted to have a UTI and is now being treated .</p> <p>Record review of the progress note dated [DATE] at 8:48 p.m. indicated CNA reported to this nurse that [Resident #2] had grabbed another resident's arm causing bruise and small skin tear. Interviewed [Resident #2] who is unable to tell what happened. CNA reported that she was charting and heard resident make a statement about toilet paper and she turned around to see resident grabbing [another resident's] left arm. CNA told this resident to let go and he did and then CNA separated [the] two residents .Resident to move rooms.</p> <p>Record review of the PIR dated [DATE] indicated Resident #2 was witnessed by CNA A saying give me that fucking toilet paper to Resident #1 and was witnessed by CNA A with his hand on Resident #1's left arm. The PIR indicated Resident #1 was noted with a skin tear and bruise to his left arm. The PIR indicated after Resident #2 was asked to let go of Resident #1 that he complied. The PIR indicated the residents were separated immediately.</p> <p>During an interview on [DATE] at 12:36 p.m., Resident #1 said he had not had issue with too many of the other residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 1:01 p.m., CNA A said she did not remember the specifics of the incident between Resident #1 and Resident #2 except that Resident #2 reached out and grabbed Resident #1.</p> <p>During an interview on [DATE] at 1:49 p.m., the DON said in the event of a resident-to-resident altercation she expected staff to separate the residents and notify the abuse coordinator. The DON said the importance of preventing resident-to-resident altercations was for safety.</p> <p>During an interview on [DATE] at 2:01 p.m., the Administrator said she was the abuse coordinator. The Administrator said she expected staff to report all allegations or witnessed abuse and neglect to her immediately. The Administrator said the importance of preventing all types of abuse including resident-to-resident altercations was for resident safety.</p> <p>Record review of the facility's Freedom from Abuse, Neglect, Exploitation policy last revised ,d+[DATE] indicated, It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment. It is the policy of this facility to recognize the resident right to personal privacy and confidentiality of their physical body, personal care, and personal space or accommodations .The facility act to protect and prevent abuse and neglect from occurring in the facility by: .Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur, to include validating that the facility has deployed the correct number of competent staff on each shift to meet the needs of residents .</p> <p>The facility had corrected the noncompliance prior to surveyor entrance by the following:</p> <p>Separating Resident #1 and Resident #2</p> <p>In-servicing staff regarding abuse and neglect and how to handle residents with dementia.</p> <p>The surveyor confirmed the facility had corrected the non-compliance prior to survey starting by:</p> <p>Record review of Resident #1 and Resident #2's progress notes and census record to ensure the residents were separated and there was a room change for Resident #1 following the incident.</p> <p>Record review of an in-services dated [DATE] indicated staff were in-serviced regarding abuse and neglect and how to handle residents with dementia.</p> <p>Staff interviewed (NA B, CNA C, CNA D, Treatment Nurse, CNA A, CNA E, SW, LVN F, LVN G, and LVN H) on [DATE], [DATE], and [DATE] between 9:16 a.m. and 1:23 p.m. were able to name all types of abuse including physical, verbal, sexual, emotional, and misappropriation of property. Staff interviewed said if they witnessed abuse, they would intervene and then report it immediately. Staff interviewed said the Administrator was the Abuse Coordinator of the facility. Staff interviewed said when handling residents with dementia and de-escalating resident-to-resident altercations, they would stay calm, attempt to redirect the resident, not argue with the resident, use reassuring tones, sit with the resident, and stay positive.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637</p> <p>Based on observation, interview, and record review the facility failed to ensure that the resident environment remained free of accident hazards and each resident was provided adequate supervision to prevent injuries for 1 of 3 residents (Resident #3) reviewed for accident hazards.</p> <p>The facility failed to ensure Resident #3 did not fall during a mechanical lift transfer on 12/17/24 when NA B performed a mechanical lift transfer (uses a specialized device to safely move individuals with limited mobility from one place to another) by herself.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 12/17/24 and ended on 12/23/24. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk for injury during mechanical lift transfers.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Record review of the face sheet dated 4/9/25 indicated Resident #3 was admitted to the facility on [DATE] with diagnoses including contracture (a permanent or temporary tightening of soft tissues, muscles, tendons, ligaments, or skin that restricts movements) of the left knee, contracture of the right knee, lack of coordination, Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), muscle weakness, and need for assistance with personal care. <p>Record review of the quarterly MDS dated [DATE] indicated Resident #3 understood others and was understood by others. The MDS indicated Resident #3 had a BIMS of 13 and was cognitively intact. The MDS indicated Resident #3 was dependent with transfers.</p> <p>Record review of the care plan last updated 1/14/25 indicated Resident #3 had an actual fall without injury related to poor balance and unsteady gait. The care plan indicated Resident #3 had an ADL self-care performance deficit related to generalized weakness with interventions including transfer: mechanical lift with 2 persons assists.</p> <p>Record review of the incident report dated 12/17/24 indicated the nurse was notified by a CNA that after transferring Resident #3 to her wheelchair with the mechanical lift Resident #3 was sliding out of the wheelchair. The incident report indicated the CNA assisted Resident #3 to the floor. The incident report indicated when the nurse entered the room Resident #3 was lying on her back in the floor, on top of the mechanical lift pad. The incident report indicated Resident #3 reported her chest hurt and she wanted to go to the hospital. The incident report indicated the nurse assessed Resident #3 for injuries and no injuries were noted. The incident report indicated Resident #3 complained of hurting all over her body. The incident report indicated Resident #3 was sent to the hospital for evaluation. The incident report indicated Resident #3 was lowered to the floor by the CNA while transferring due to Resident #3 slipping out of the mechanical lift pad/sling.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/2/25 at 1:09 p.m., Resident #3 said she remember falling back in December. Resident #3 said she fell out of the mechanical lift and went to the hospital. Resident #3 said when she went to the hospital she was diagnosed with a UTI. Resident #3 said NA B had been operating the mechanical lift when she fell .</p> <p>During an interview on 4/2/25 at 1:23 p.m., NA B said she was a nurse aide at the facility and had worked at the facility for 6-7 months. NA B said she had taken the CNA class but had not taken her state test. NA B said she remember the incident with Resident #3 on 12/17/24. NA B said there was no one in the facility available to assist her with a mechanical lift transfer and she did not realize it was a requirement to have more than one person for a mechanical lift transfer. NA B said she was transferring Resident #3 by herself via mechanical lift from the bed to the chair. NA B said after she had Resident #3 in the air over the floor, she realized Resident #3 was at an angle due to not having the mechanical lift pad positioned under her properly. NA B said Resident #3 was freaking out and she lowered Resident #3 to the floor. NA B said she immediately ran to get assistance. NA B said Resident #3 complained of pain (she could not remember to where) but Resident #3 said the pain had been there prior to the transfer. NA B said Resident #3 was sent to the ER for evaluation.</p> <p>During an interview on 4/9/25 at 1:49 p.m., the DON said she expected 2 staff members to be present when performing a mechanical lift transfer. The DON said the importance of ensuring 2 staff members were present was for the safety of the residents. The DON said an NA should not perform any transfer by themselves including a mechanical lift transfer. The DON said an NA should not perform a transfer by themselves because they are not certified, and mechanical lift transfer should always have two staff members present.</p> <p>Record review of the facility's Safe Transfers policy revised 9/2023 indicated, It is the policy of this facility to transfer a resident in a safe manner. A transfer is the safe movement of a resident from one surface to another. Safe and efficient transfers are combination of the resident's ability and perceptual capacity, proper equipment, appropriate techniques, and good planning. Residents may transfer independently or be assisted by one or more caregivers. Transfers may involve assisted devices and/or involve a mechanical lift . Mechanical lift transfers are usually used for residents who are total dependent .Safe and secure mechanical lift transfers may require the help of minimum two, caregivers depending on the resident's conditions. The following basic principles apply to performing all mechanical lift transfers safely and effectively .7. Ensure that the resident's body is in alignment. 8. Make sure the placement of the sling is low enough to fully support the resident's thighs and buttocks so that the resident will not slip out of the bottom of the sling during the transfer .10. Always reevaluate the resident's position, the location of the slings, and the security of the attachments before moving away from the bed or chair .</p> <p>The facility had corrected the noncompliance by the following:</p> <p>Retraining NA B in mechanical lift transfers</p> <p>In-servicing staff regarding fall prevention and mechanical lift transfer</p> <p>The surveyor confirmed the facility had corrected the non-compliance prior to survey starting by:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of NA B's employee file indicated she was hired at the facility on 9/13/24 for a Nursing Assistant. The employee file indicated NA B had completed a Nurse Aide Competency Course approved by Texas HHS on 9/13/24. The employee file indicated on 12/17/24 NA B had been checked of by the OT regarding safe use of mechanical lift with 2 people. The employee file indicated NA B was given a final written warning on 12/17/24 regarding failure to perform job duties directly related to or engaging in conduct that in anyway compromises the safety, health, and/or physical comfort and well-being of a resident.</p> <p>On 4/3/25 observed CNA A, CNA E, CNA C and CNA D perform mechanical lift transfers safely using 2 staff members to assist in the transfer, ensuring the mechanical lift sling was properly placed under the residents prior to transfer, and ensuring each residents' body was aligned properly prior to transfer.</p> <p>Record review of in-services dated 12/23/25 indicated staff had been in-serviced regarding fall prevention and safe transfers.</p> <p>Staff interviewed (NA B, CNA C, CNA D, CNA A, and CNA E) on 4/2/25 and 4/3/25 between 9:16 a.m. and 1:23 p.m. were able to answer all question regarding in-services including fall precautions including beds in low position, call light in reach, and fall mats at bedside. Staff interviewed said mechanical lift transfers always required 2 persons assist, ensure the mechanical lift sling was properly placed under the resident, and ensure each resident's body was properly aligned prior to transfer.</p>		