STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675774	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Healthcare and Rehabilitation - Greenville	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**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, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 3 (100 Hall Med Aide Cart, 100 Hall Nurses Cart, and 400 Hall Nurses Cart) of 4 carts and 1 resident (Resident #100) of 8 residents reviewed for pharmacy services. The facility failed to ensure:- LVN K responsible for100 Hall Med Aide Cart, counted controlled drugs every shift change.- RN B responsible for 100 Hall Nurses Cart, counted controlled drugs every shift change.- RN L responsible for 400 Hall Nurses Cart, counted controlled drugs every shift change. - ADON A, RN B, RN F, LVN C, LVN D and LVN E documented on Resident #100's MAR for administering prn hydrocodone-acetaminophen 10-325 mg tablets. - LVN C failed to document on 08/21/25 when she administered hydrocodone-acetaminophen 10-325 mg 2 tablets from emergency kit. These failures could place residents at risk of not having the medication available due to possible drug diversion and medications not administered according to physician orders. Findings Included:- Record review on 08/26/25 at 10:12 AM of 100 Hall Med Aide Cart, with MA J revealed missing signatures for Off duty for 08/26/2025 (10:00 PM to 6:00 AM shift) of the narcotic count sheet. - Record review on 08/26/25 at 10:21 AM of 100 Hall Nurses Cart, with LVN I revealed missing signatures for Off duty for 08/20/2025 (2:00 PM to 10:00 PM shift) of the narcotic count sheet. - Record review on 08/26/25 at 10:41 AM of 400 Hall Med Nurses Cart, with LVN K revealed missing signatures for On duty and Off duty for 08/21/2025 (2:00 PM to 10:00 PM shift) of the narcotic count sheet. Interview on 08/28/2025 at 11:54 AM, LVN K stated she should have signed the narcotic sheet after counting the narcotics, on 8/26/25 at the beginning and at the end of the shift 10 PM to 6 AM. She stated she got busy because she was called to go to the dining room, and she forgot to go back and sign the count sheet. She stated she knew that she supposed to sign immediately after the count was done. She stated the risk would be potential for drug diversion. Interview on 08/28/25 at 2:05 PM, RN L stated she should have signed the narcotic sheet after counting the narcotics on 8/21/25 at the beginning and at the end of the shift 2 PM to 10 PM. RN L stated, I counted the narcotics, but I don't remember what happened why I did not sign. RN L stated this failure could potentially cause a drug diversion. She stated she was trained and learned that she was supposed to sign the narcotic count sheet immediately after counting with the other nurse. On 08/28/25 at 2:14 PM attempted to call RN B, she did not answer. Interview on 08/28/25 at 12:15 PM, the DON stated she expected nurses to sign the narcotic count sheet at the beginning and at the end of their shift after they completed count with the incoming and off-going nurse. The DON stated if the staff was not signing the narcotic count sheets, she was unable to prove they were counting. The DON stated it was important to ensure a drug diversion did not occur. The DON stated the ADONs would daily check the cart on the weekdays and the weekend supervisor during the weekends for monitoring. 2. Review of Resident #100's face sheet undated reflected she was a [AGE] year-old female admitted to the facility on [DATE] for diagnoses of acute osteomyelitis of the left foot and ankle (infection of the bone), type 2 diabetes mellitus with diabetic neuropathy (chronic condition where the body does not produce enough insulin to regulate blood sugar levels and damage to nerves), chronic pain syndrome, peripheral vascular disease (condition that affect the blood vessels outside of the heart) and osteoarthritis (joint disease that causes pain, stiffness and swelling). Review of Resident #100's comprehensive care plan dated 08/24/25 reflected she had neuropathic pain and is prescribedanticonvulsant therapy. Intervention included Pain management as needed. See MD orders. Provide alternative comfortmeasures PRN. Review of Resident #100's physician order dated 08/20/25 of Hydrocodone-Acetaminophen Tablet 10-325 MG Give 2 tablet by mouth every 8 hours as needed for Pain. Review of Resident #100's Narcotic Record for Hydrocodone-Acetaminophen Tablet 10-325 MG reflected Resident #100 was administered the following:-2 tablets administered on 08/21/25 at 8:30 PM by LVN C-2 tablets administered on 08/22/25 at 5:30 AM by LVN D-2 tablets administered on 08/22/25 at 1:30 PM by ADON A-2 tablets administered on 08/22/25 at 9:30 PM by ADON A-2 tablets administered on 08/23/25 at 9:45 PM by LVN E-2 tablets administered on 08/25/25 at 5:15 AM by RN B-2 tablets administered on 08/25/25 at 3:45 PM by ADON A-2 tablets administered on 08/26/25 at 10:30 PM by RN F-2 tablets administered on 08/27/25 at 6:45 AM by LVN C-2 tablets administered on 08/27/25 at 3:30 PM by RN F Review of Resident #100's August 2025 MAR/TAR printed on 08/28/25 reflected no medication administration was documented for Resident #100 on 08/20/25, 08/21/25, 08/22/25 and 08/27/25

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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. Based on observations, interviews, and record review, the facility failed to ensure that drugs and biologicals were stored properly in locked compartments for one of five medication carts (medication cart for hall 300) reviewed for storage of Drugs and Biologicals. The facility failed to ensure RN F locked his medication cart for hall 300 on 08/27/2025. This failure could place the residents at risk of accessing/opening the cart causing accidental overdose or misuse of medications and not receiving the full benefit of the medication. Findings included: Observation on 08/27/2025 at 03:44 p.m. revealed a medication cart was parked against the wall with the drawers facing out toward the hallway. The cart was not locked because the centralized, metal, round lock, was protruding and the metal lock needed to be pushed in to lock the drawers of the cart. The cart was facing the hallway, and the drawers could easily be opened. The drawers of the cart contained various over-the-counter medications, blister packs of medications, and insulins. Several staff and residents were passing by the unlocked cart. Approximately 5 minutes passed when RN F walked out of a Resident #100's room and returned to the medication cart. In an interview with RN F on 08/27/25 at 03:50 p.m. he stated he forgot to push the button on the cart to lock it before he answered the Resident #100's call light. He stated the risk of leaving the cart unlocked was anyone could have accessed the medications in the cart. He said the cart should be locked every time it was left unattended because anybody, residents, staff, and visitors, could open it and could get anything from the cart. In an interview with the DON on 08/28/2025 at 11:10 a.m., she stated medication carts should be always locked to prevent unauthorized access to the medications. She stated the risk were to resident's obtaining medications that was not intended for them as well as diversion of medications. She stated RN F was an as needed employee, but stated she had never seen him leave the cart unlocked. She stated they would re-educate him on the importance of keeping the medication cart secured. Record review of facility policy Medication Storage , revised May 2021 reflected, It is the policy of this facility to ensure the proper and safe storage of drugs and biologicals.Drugs and/or biologicals should not be left unsecured/unattended.Medication and treatment carts will be kept locked when unattended.