

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: 675774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
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)		
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. **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 for 100 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 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675774
		If continuation sheet Page 1 of 9

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 08/28/2025
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 prescribed anticonvulsant therapy. Intervention included Pain management as needed. See MD orders. Provide alternative comfort measures 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 for Hydrocodone-Acetaminophen Tablet 10-325 MG - Give 2 tablet by mouth every 8 hours as needed for Pain. It did not reflect medication was administered on 08/23/25 at 9:45 PM by LVN E, 08/25/25 at 5:15 AM by RN B, 08/25/25 at 3:45 PM by ADON A, 08/26/25 at 10:30 PM by RN F, 08/27/25 at 6:45 AM by LVN C and 08/27/25 at 3:30 PM by RN F. Interview on 08/27/2025 at 3:25 PM with LVN C revealed on 08/21/25 Resident #100 complained of pain level of 7 or 8. LVN C stated she thought she called the pharmacy to get Resident #100's pain medication of Hydrocodone-Acetaminophen Tablet 10-325 MG out of the emergency e-kit since Resident #100 medication had not arrived yet from the pharmacy. She stated Resident #100 did have a current prn pain medication order and they had to contact the pharmacy to access narcotic medication out of the E-kit. She stated she was given an access code from pharmacy once the physician order was verified with the pharmacist. She stated she followed up with Resident #100 to ensure Resident #100's pain medication was effective. Interview on 08/27/2025 at 3:56 PM with the Pharmacist revealed on 08/21/25 at 2:41 PM LVN C contacted pharmacy to get pain medication for Resident #100 out of the emergency kit. The Pharmacist stated nurse from facility had to contact pharmacy to get a narcotic medication out of the emergency kit to get a code to access to put in the system so it will be dispensed. The Pharmacist stated this was the only time facility contacted pharmacy to get Resident #100 narcotic medication of Hydrocodone-Acetaminophen 10-325 mg 2 tablets out of emergency e-kit. She stated pharmacy was available 24 hours/365 days a year. She stated the nurse had to call the pharmacy to get a code to access the narcotic medication out of the emergency kit. Interview on 08/28/2025 at 10:00 AM with ADON A revealed prn pain medications should be documented on resident's MAR/TAR including the pain level. She stated she was pulled to work the floor as a charge nurse due to nurse having to leave shift early. [SP1] She stated she should have documented on the MAR for Resident #100's prn pain medication including pain level. Interview on 08/28/2025 at 12:21 PM with LVN D revealed she should document on Resident #100's MAR for the prn pain medication. She stated she did review Resident #100's physician order but could not recall if she documented on the MAR she had given the prn pain medication when she worked on 08/22/25. Interview on 08/28/25 at 10:47 AM with LVN E revealed he typically documented on the resident's MAR when giving resident a prn pain medication. He stated Resident #100 had complained of pain level of 5 or 6 so he administered Resident #100's prn pain medication as ordered. He stated it was important to document the prn pain medication so it would show how often they are getting the pain medication, to document the pain levels at time of administration and follow up to ensure effectiveness of pain medication. Interview on 08/28/2025 at 11:01 AM with the DON revealed she expected the charge nurse to document Resident #100's pain level, administer medication as ordered, document it on the MAR along (continued on next page)		

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 08/28/2025
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the narcotic count sheet. She stated not documenting on the MAR when giving a prn pain narcotic medication could place residents at risk of medication given outside of physician orders and possible drug diversion if not documented accurately. She stated the charge nurse should document if getting the narcotic pain medication out of emergency kit in resident's chart. Surveyor attempted to contact RN F on 08/28/2025 at 12:08 PM, but was unable to reach RN F. Interview on 08/28/2025 at 12:09 PM with RN B revealed she could not recall what night she worked with Resident #100 but Resident #100 requested her prn pain medication for pain. She stated she did give the hydrocodone-acetaminophen 10-3325 2 tablets to her as ordered and documented on the narcotic count sheet. She stated she must have forgotten to document it on Resident #100's MAR to show the pain level and signing it was given. She stated she usually did document in the MAR when giving prn scheduling pain medication. Review of facility's policy Administration of Drugs revised May 2021 reflected .3. All current drugs and dosage schedules must be recorded on the resident's electronic administration record (eMAR).6. When PRN medications are administered, the nurse must record: A. Justification/reason the medication is given B. The date and time administered via eMAR C. Any results achieved from administering the drug and the time each results were observed.Right documentation - Document administration or refusal of the medication after the administration or attempt and note any concerns. Review of the facility's policy Controlled Medications - Storage and Reconciliation revised January 2022, reflected, . A reconciliation or physical inventory of all controlled medications is conducted by two licensed nurses and is documented on an audit record at each shift change.		

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 08/28/2025
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 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 2 of 12 residents (Resident #95, and Resident #24) observed for infection control. 1. The facility failed to ensure Hospice Aide G used the required PPE and perform hygiene for Resident #95, who was on enhanced barrier precautions due to her Foley catheter and wound while providing the resident a bath and failed to place soiled linen in a plastic bag and not in the roommate's wheelchair on 08/27/25. 2. The facility failed to ensure CNA N changed gloves during incontinent care for Resident #24 on 08/27/2025. These failures could place the residents at risk of cross-contamination and development of infection. Findings included: 1. Record review of Resident #95's Face sheet dated 08/25/25 reflected an [AGE] year-old female with an admission date of 05/13/24 and a re-admission date of 08/14/25. Diagnosis included dementia. Record review of Resident #95's care plan with a revision date of 08/14/25 and 08/17/25 reflected, has indwelling catheter: Neurogenic bladder (injury or disease that interrupts the electrical signals between the nervous system and bladder function) .Has pressure ulcer development right sacrum (base of the spine) related to immobility. Interventions. Use Enhanced Barrier Precautions. In an observation on 08/27/25 at 09:35 a.m. Hospice Aide G was observed providing a bed bath to Resident #95. Hospice Aide G had on gloves but no gown. After completion of bed bath, Hospice aide removed the top sheet and blanket and placed them in the resident's roommate wheelchair. The Treatment Nurse entered Resident #95's room to perform a skin assessment. The Treatment Nurse washed her hands, donned gown and gloves and she and Hospice Aide G repositioned the Foley drainage bag and turned the resident to observe her skin. The Treatment Nurse uncovered the sacral wound to reveal it was about the size of pea with no drainage noted. The Treatment Nurse removed her PPE, washed her hand and left the room. Hospice Aide G then retrieved the top sheet and blanket from the wheelchair and placed them on top of the resident's night stand next to her bed. She then removed her gloves and without performing hand hygiene retrieved a clean top sheet and pillowcases and replaced the pillowcases on the 2 pillows. She then placed pillow under the resident's head and one under her feet to offload her heels and then covered her with a clean sheet. She then put the soiled top sheet in a plastic and bag and folded the blanket and laid it on top of the resident's nightstand. Hospice Aide G took the pan of bath water to the bathroom sink and discarded the water, rinsed out the bath basin and washed her hands. In an interview with Hospice Aide G on 08/27/2025 at 09:50 a.m. she stated Resident #95 was not in isolation and she did not have to wear a gown and mask when providing her care, only gloves. Hospice Aide G was not aware of what Enhanced Barrier Precautions meant and was not aware the resident was on Enhanced Barrier Precautions. She stated her company had reviewed isolation protocol with her for residents with COVID but was not familiar with what type of resident's required Enhanced Barrier Precautions. She stated she had not noticed the signage posted outside of the resident's door. She stated she realized when she placed the soiled linen on the wheelchair, that it was not the resident's wheelchair, which was why she moved it to the nightstand. She stated she knew she was not to place it on the floor, but stated she should have placed the sheet in a plastic bag. She stated she did not realize she needed to wash her hands after removing her gloves. In an interview with LVN I on 08/27/2025 at 10:20 a.m. she stated most of the residents she had on hospice had the same aide come every day. She stated when a new aide comes in she will make sure they know if a resident is on Enhanced Barrier Precautions. She stated she was not aware Resident #95's hospice aide was not familiar with Enhanced Barrier Precautions. She stated Resident #95 was on Enhanced Barrier Precautions due to her wound and her Foley catheter. She stated the risk of not wearing the proper PPE during care was the spread of drug-resistant germs to other residents. In an interview with the (continued on next page)		

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 08/28/2025
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hospice Patient Care Manger on 08/28/2025 at 09:23 a.m. she stated Hospice Aide G was new. She stated she had her going out with another aide to makes sure she was familiar with all the residents she sees but stated she was not sure if she had been out with her to this facility. She stated they do go over infection control and thinks it included Enhanced Barrier Precautions but was not certain. She stated she would make sure she received additional training. In an interview with the DON on 08/28/2025 at 11:05 a.m. she stated any resident with an implanted medical device and or open wound had to be on Enhanced Barrier Precautions to prevent the risk of spreading multi-drug-resistant infections. She stated dirty lines should always be bagged and not placed on the floor or furniture and especially not on other resident's wheelchairs. She stated all staff were to perform hand hygiene after glove removal. She stated failure to follow their infection protocol placed all residents at risk of cross contamination. She stated she expected the hospice companies to train their staff but stated she would also make sure any hospice staff providing care in their facility followed their infection control protocol while providing care to their residents. 2.Record review of Resident #24's Quarterly MDS assessment dated [DATE] reflected Resident #24 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses included cerebral infarction (a condition where blood flow to the brain is interrupted, leading to tissue damage), diabetes mellitus, and elevated blood pressure. Resident #24 had a BIMS score of 07, which indicated Resident #24's cognition was severely impaired. The MDS assessment indicated Resident #24 was frequently incontinent of urine and required maximal assistance with toileting hygiene. Observation on 08/27/25 at 9:55 AM revealed CNA N was in Resident #24's room to provide incontinence care. CNA N had gloves on, she unfastened Resident #24's brief, she then provided peri-care to the resident, wiping across the resident's pubis bone and then down each groin. She rolled resident on his side. CNA N wiped the resident's buttock area with peri-wipes, front to back, she then removed the soiled brief and with soiled gloves, placed the clean brief under the resident. She rolled the resident on his back onto the clean brief. Once finished, she fastened the resident's brief. She removed and discarded her gloves and washed her hands In an interview on 08/27/25 at 10:25 AM, CNA N stated she should change her gloves and perform hand hygiene when she went from dirty to clean. CNA N stated failing to provide proper care exposed the resident to infections. In an interview on 08/28/25 at 12:15 PM, the DON stated she expected the staff to remove their gloves and sanitize their hands when going from dirty to clean. She stated CNAs were trained to change gloves and perform hand hygiene when going from dirty to clean. She stated failure to do so would potentially lead to cross-contamination and possible spread of infection. She stated the ADONs would do random rounds for monitoring. Record review of the Facility's policy titled, Enhanced Barrier Precautions, revised August 2022, reflected, Enhanced Barrier Precautions (EBP's) are utilized to prevent the spread of multidrug-resistant organisms (MDROs).EBP's employ targeted gown and glove use during high contact resident care activities when contact precautions do no otherwise apply.Examples of high-contact resident care activities.Bathing/showering.changing linens.EBP's are indicated .for residents with wounds and/or indwelling devices regardless of MDRO colonization.Staff are trained prior to care for residents on EBP's. Record review of the facility's policy titled, Handwashing/ Hand Hygiene, revised August 2019, reflected, The facility considers hand hygiene the primary means to prevent the spread of infections.All personnel shall.Wash hands with soap.and water.when hands are visibly soiled.Use an alcohol-based hand rub.or.soap.and water for the following situations.Before and after direct contact with residents.before moving from a contaminated body site to a clean body site during resident care.After removing personal protective equipment PPE and before moving to another body part .After removing gloves. Hand hygiene is always the final step after removing and disposing of personal protective equipment.The use of gloves does not replace handwashing/hand hygiene. Record review of the facility's policy titled, Laundry and Bedding, Soiled, dated September 2022, reflected, Soiled laundry/bedding shall be handled, transported and process according to best practices for infection prevention and control.All used laundry is handled as potentially contaminated (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: 675774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	using standard precautions. Contaminated laundry is bagged or contained at the point of collection (i.e., location where it was used) .		

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 08/28/2025
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)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #10) of 6 residents reviewed for ADLs. The facility failed to ensure Resident #10 had her fingernails cleaned and trimmed on 8/26/25. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Record review of Resident #10's Quarterly MDS assessment dated [DATE] reflected Resident #10 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included type 2 diabetes mellitus, cognitive communication deficit, and need for assistance with personal care. Resident #10 had a BIMS score of 0, which indicated Resident #10' cognition was severely impaired. The MDS assessment indicated Resident #10 required maximal assistance with personal hygiene. Record review of Resident #10's Care Plan revised 04/06/25, reflected the following: Focus: [Resident#10] has an ADL self-care performance deficit . Goal: will current level of function through the review date . Interventions: . Personal hygiene .Staff to assist with ADLs as needed.In an observation on 08/26/25 at 10:56 AM revealed Resident #10 was laying in her bed. The nails on both hands were approximately 0.3cm in length extending from the tip of his fingers. The nails were discolored tan and had brownish colored residue underside. Resident #10 was confused and the answer to question did not make sense.In an interview on 08/26/25 at 11:57 AM, CNA M stated CNAs and nurses were responsible to clean and cut the residents' nails. CNA A stated she did not notice Resident #10's nails. She stated she would do it right then. She stated the risk would be infection control and injury. In an Interview on 08/28/25 at 12:15 PM, the DON stated nail care should be completed as needed and every time aides wash the residents' hands. The DON stated nails should be observed daily. The DON stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The DON stated he expected CNAs to offer to cut and clean nails if they were long and dirty. The DON stated the ADONs would do the routine rounds to monitor. The DON stated residents having long and dirty nails could be an infection control issue and skin break down if scratching. Record review of the facility's policy Nails Care revised January 2022, reflected the following: . Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. Routine nail care, to include trimming and filing, will be provided on an as needed basis.		

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 08/28/2025
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)		
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 a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for one (Resident #55) of two residents reviewed for foley catheter (a thin, flexible tube inserted into the bladder to drain urine) care. The facility failed to ensure CNA N and CNA P maintained the foley catheter drainage bag below Resident #55's bladder during a mechanical lift transfer on 08/27/25. This failure placed residents at risk for the development and/or worsening of urinary tract infections and dislodgement of the foley catheter. Record review of Resident #55's Quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included dementia (a group of conditions that cause a decline in cognitive abilities, such as memory, thinking, reasoning, and judgment), overactive bladder (a chronic condition characterized by a sudden, uncontrollable urge to urinate), and need for assistance with personal care. She had a BIMS of 13 which indicted she was cognitively intact. She required extensive to total assistance with transfer, and she had a foley catheter. Record review of the Resident #55's care plan initiated on 01/31/25 reflected, Has an indwelling catheter related to overactive bladder. Interventions included .Monitor/record/report to Medical Doctor for signs and symptoms of urinary tract infection . Observation on 08/27/25 at 10:49 AM revealed CNA N and CNA P entered Resident #55's room to transfer Resident from wheelchair to bed. CNA P unhooked the catheter bag from the wheelchair side and hooked it to the top bar of the mechanical lift, above resident's bladder. The staff raised the resident from the wheelchair with the Foley catheter bag hanging above the resident's head. Urine was observed flowing back toward the resident's bladder. The staff then positioned her over her bed and lowered her into her bed and unhooked the catheter bag from the mechanical lift and onto the side of her bed. In an interview with CNA P on 08/27/25 at 11:10 AM, she stated she was trained to make sure the catheter bag was always in a privacy bag, make sure the tubing was not kinked and make sure they emptied the drainage bag each shift. The CNA was not sure where the catheter bag should have been positioned during the transfer. She stated having it above the bladder could possibility cause the urine to run backwards, which could cause an infection. In an interview with CNA N on 08/27/25 at 11:12 AM, she stated they should have held the drainage bag below the resident bladder level while they transferred her. She stated failing to do this could cause the urine to back up and might cause an infection. In an interview with the DON on 08/28/25 at 12:15 PM, she stated not keeping the foley catheter bag below the resident's bladder, placed them at risk of a urinary tract infection and cross contamination. She stated she would provide training to nursing staff on positioning of the drainage bag during transfers. She stated she would do skills check on foley catheter care to monitor nursing staff. Review of the facility's policy titled, Indwelling Urinary Catheter Care, reflected, . Maintain the drainage tubing below the level of the bladder.		

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 08/28/2025
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)		
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.		