STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675816	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Nursing & Rehabilitation Center of Pale	2404 Hwy 155 Palestine, TX 75803

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. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services for 1 of 8 residents (Resident #1) reviewed for incontinence. 1. The facility failed to provide appropriate incontinent care to Resident #1 when he was observed sitting in a wheelchair in his room with visibly wet clothing on and a strong odor of ammonia was detected from his room on 9/8/25 from 11:28 a.m. until 1:58 p.m. 2. The facility failed to provide appropriate incontinent care to Resident #1 when he was observed lying on sheets visibly soiled with yellow and brown stains and a strong odor of ammonia was detected from his room and his pants were visibly wet around his left hip on 9/9/25 from 2:54 p.m. until 5:06 p.m. These failures could place residents at risk of skin break down, urinary tract infection, and diminished quality of life.Findings included:1.Review of an admission Record for Resident #1 dated 9/8/2025 indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses of dementia (altered cognition), type 2 diabetes, and psychotic disorder with delusions. Review of the quarterly MDS for Resident #1 dated 8/6/2025 indicated he had severely impaired thinking with a BIMS score of 04. He required total assistance for putting on/taking off footwear; he required partial assistance with personal hygiene and showering/bathing; he required supervision with putting on/taking off footwear, lower body dressing, upper body dressing, and toileting hygiene; he required setup/cleanup assistance with oral hygiene and eating. He was occasionally incontinent of bladder, and he was always continent of bowel. Record review of the care plan for Resident #1 dated 12/2/24 indicated he had an ADL self-care performance deficit, appropriate interventions were in place including supervise as needed with bathing, walking, and bed mobility. During an observation on 9/8/25 at 11:28 a.m., Resident #1 was observed in his room. He was seated in a wheelchair watching television. His pants and shirt were visibly wet around his left hip and thigh. There was a strong odor of ammonia emanating from his person and room. During an interview on 9/8/25 at 1:30 p.m., CNA A said she was working Resident #1's hall that day. CNA A said she rounded on residents usually every 30 minutes to 1 hour, and every 2 hours at a minimum. CNA A said she rounded on residents more frequently if they were heavy wetters to ensure every resident was dry.During an observation on 9/8/25 at 1:56 p.m. Resident #1 was observed in his room sitting in a wheelchair watching television. He was visibly wet from his left knee to approximately halfway up his torso and a strong odor of ammonia was emanating from his person and room.During an observation on 9/8/25 at 2:00 p.m., CNA A entered Resident #1's room and assisted him with incontinent care.During an observation and interview on 9/9/25 at 2:54 p.m., Resident #1 was observed in his room. He was lying on his bed; his sheets were visibly wet with a brown outer ring approximately the width of half of the sheet and a smaller yellow ring approximately half the size. A strong odor of ammonia was detected from his person and room. His pants were visibly wet around the left hip area. Resident #1 said he thought he was dry. He said he was not wet all day like yesterday. He said he could not remember when a staff member last checked on him. During an observation on 9/9/25 at 5:06 p.m., Resident #1 was observed in his room. He was lying on his bed; his sheets were visibly wet with a brown outer ring approximately the width of half of the sheet and a smaller yellow ring approximately half the size. A strong odor of ammonia was detected from his person and room. His pants were visibly wet around the right hip area. Resident #1 appeared to be sleeping.During an interview on 9/9/25 at 5:08, CNA B said she worked the 2:00 p.m. to 10:00 p.m. shift and was working on Resident #1's hall that day. She said she did not round on residents until 3:30 p.m. or 4:00 p.m. because she had to assist residents with showers first. She said she checked on Resident #1 around 3:00 p.m. and checked his briefs and noted them to be dry. She said she did see something on his sheets but Resident #1 did not want her to do anything about it.During an interview on 9/10/25 at 9:00 a.m., LVN C said CNAs were expected to round on residents every 2 hours and part of that rounding should include checking for any incontinent care needs. He said CNAs should go into every room and ask the resident if they need any assistance. During an interview on 9/10/25 at 9:10 a.m., LVN D said CNAs were expected to check on every resident at least every 2 hours. She said CNAs should be checking to see if residents need peri care and providing it. She said CNAs should be checking for wet or soiled linens and changing them. She said if a resident refused care the CNA should report it to the nurse so they can assist. During an interview on 9/10/25 at 9:30 a.m., the DON said she was ultimately responsible for supervising nursing staff. The DON said CNAs were expected to round every 2 hours and should be checking for and addressing any resident

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(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 records, 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 disease and infection for 1 of 8 residents (Resident #1) reviewed for infection control. The facility failed to maintain an infection control program on 9/8/25 at 2:00 p. m. when CNA A assisted Resident #1 with incontinent care without changing her gloves, washing/sanitizing her hands, or cleaning from clean (urethral) to dirty (rectal) areas in the correct order. These failures could place residents at risk of diminished quality of life, urinary tract infection, or hospitalization.Findings included: 1.Review of an admission Record for Resident #1 dated 9/8/2025 indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses of dementia (altered cognition), type 2 diabetes, and psychotic disorder with delusions. A review of the quarterly MDS assessment for Resident #1 dated 8/6/2025 indicated he had severely impaired thinking with a BIMS score of 04. He required total assistance for putting on/taking off footwear; he required partial assistance with personal hygiene and showering/bathing; he required supervision with putting on/taking off footwear, lower body dressing, upper body dressing, and toileting hygiene; he required setup/cleanup assistance with oral hygiene and eating. He was occasionally incontinent of bladder, and he was always continent of bowel. Record review of a care plan for Resident #1 dated 12/2/24 indicated he had an ADL self-care performance deficit, appropriate interventions were in place including supervise as needed with bathing, walking, and bed mobility. During an observation on 9/8/25 at 1:58 p.m., CNA A assisted Resident #1 with incontinent care. CNA A did not wash or sanitize her hands prior to beginning incontinent care. CNA A donned gloves and cleaned Resident #1 from dirty to clean areas starting with his rectal area to clean fecal incontinence and moving to his urethral area. CNA A assisted Resident #1 with dressing including pants, shirt, shorts, and shoes. CNA A did not change her gloves or wash/sanitize her hands while providing care. During an interview on 9/8/25 at 2:15 p.m., CNA A said she had been trained in incontinent care and infection control and had recently had 1-on-1 coaching concerning resident care. CNA A said she did sanitize her hands before entering the room, but she should have changed her gloves and cleaned going from clean to dirty areas.During an interview on 9/8/25 at 5:20 p.m., the DON said CNAs were expected to follow infection control guidelines when providing resident care. The DON said CNAs were expected to wash or sanitize their hands and to change gloves when soiled. The DON said she planned to conduct in-services with direct care staff covering appropriate infection control and incontinent care technique. During an interview on 9/10/25 at 9:00 a.m., LVN C said CNAs were expected to wash/sanitize their hands when entering a room to provide resident care. He said CNAs were expected to follow infection control policies when providing incontinent care including appropriately donning/doffing PPE. LVN C said he monitored CNAs compliance with policy by rounding on residents and following behind them to ensure tasks were completed appropriately. Review of in-service dated 7/28/25 at 2:30 p.m. indicated CNA A attended an in-service which included computer-based training on customer service skills. Review of in-service dated 7/28/25 at 2:30 p.m. indicated CNA A attended an in-service which included computer-based training on bed mobility and repositioning residents. Review of coaching form dated 7/28/25 indicated CNA A received coaching on customer service skills and repositioning residents. Review of the facility's policy titled Perineal Care dated 5/11/22 revealed the following .Perform hand hygiene.Gently perform perineal care, wiping from clean, urethral area, to dirty, rectal area, to avoid contaminating the urethral area - CLEAN to DIRTY! .Gently perform care to the buttocks and anal area, working from front to back without contaminating the perineal area.Doff gloves and PPE.