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	03/04/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident was treated with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 5 residents (Residents #1) reviewed for Resident Rights. The facility failed to ensure CNA A did not use profanity while completing incontinent care for Resident #1.This failure could place residents at risk of emotional distress and diminished quality of life.Findings include: Record review of Resident #1's admission Record, dated 3/4/26, indicated an [AGE] year-old female who was readmitted to the facility on [DATE]. Resident #1 had diagnoses which included COPD (lung disease that obstructs airflow), dementia (altered cognition), and congestive heart failure (heart condition which causes fluid buildup). Record review of Resident #1's quarterly MDS, dated [DATE], indicated Resident #1 had severely impaired cognition with a BIMS of 5. She required setup/cleanup assistance with oral hygiene; she required supervision with eating. She required moderate assistance with toileting hygiene and upper body dressing. She required maximal assistance with shower/bathing self, lower body dressing, and putting on/taking off footwear. Record review of Resident #1's comprehensive care plan, dated 6/25/25, indicated the resident had a communication deficit related to being hard of hearing. Interventions were in place which included anticipate and meet resident needs. During an observation on 3/4/26 at 10:52 a.m., revealed CNA A was providing incontinent care for Resident #1 with CNA B assisting. While CNA A was changing her gloves, she dropped a glove onto the ground and blurted out God damn it. CNA A put on a new glove and continued with incontinent care. Resident #1 did not appear to have heard the utterance of profanity and did not show any emotional reaction. During an interview on 3/4/26 at 11:00 a.m., CNA B said she did not hear CNA A use profanity during incontinence care for Resident #1. CNA B said she had not heard any staff using profanity in or around resident care areas. During an interview on 3/4/26 at 11:02 a.m., CNA A said she did not realize she used profanity while conducting incontinent care for Resident #1. CNA A said she should not have used profanity in any resident care area. CNA A said she had not used profanity around residents in the past. CNA A said she had recently attended in-service training which covered abuse and neglect and resident rights. CNA A said profanity should not be used around residents because it could be offensive even when not directed directly at a resident. During an interview on 3/4/26 at 1:25 p.m., Resident #1 said she did not hear CNA A use profanity in her room during incontinent care today, but that happens all the time. Resident #1 said she couldn't recall a staff member using profanity in her room before, but staff had frequent personal conversations. Resident #1 said she heard staff use profanity out in the hallway near her room but couldn't provide staff names or details. Resident #1 said it bothered her to hear profanity, but not a lot because everyone cusses sometimes. During an interview on 3/4/26 at 4:15 p.m., the DON said she was responsible for supervision or the nursing department. The DON said it was her expectation that staff remained professional in resident care areas and that included not using profanity or inappropriate language. The DON said going forward she planned to complete training and 1-on-1 coaching with staff as needed covering residents' rights 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

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	03/04/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	customer service skills. During an interview on 3/4/26 at 4:30 p.m., the ADM said she was ultimately responsible for all departments in the facility. The ADM said it was her expectation that no employee would use profanity or foul language around a resident or in resident care areas. The ADM said she had conducted frequent in-services which covered resident rights and would continue to train staff as needed through in-services and coaching. Record review of the facility's Coaching Form, dated 9/23/25, indicated [CNA A] wanted to put off wound care and when I said I wanted to do it now she said GD cursing in front of resident in his own room. Specific coaching/education given to employee indicated please be mindful of others in their rooms especially don't curse god. Record review of the facility's in-service training attendance roster titled Customer Service, dated 2/12/26, indicated CNA A attended 1-on-1 coaching related to customer service skills. Record review the facility's, undated, policy titled Resident Rights indicated .The resident has a right to a dignified existence.A facility must treat each resident with respect and dignity and care for reach resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life.

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	03/04/2026

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 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 ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 2 of 5 residents (Resident #2 and #3) reviewed for ADL care.The facility failed to ensure Residents #2 and #3 were provided appropriate incontinent care.This failure could place residents at risk of loss of dignity, skin breakdown, infection, and hospitalization.Findings include: 1. Record review of Resident #2's admission Record, dated 3/3/26, indicated an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included Type 2 Diabetes, Parkinson's Disease (affects movement), and dementia (altered cognition).Record review of Resident #2's comprehensive care plan, dated 12/27/24, indicated Resident #2 had bowel and bladder incontinence. Interventions were in place which included provide incontinent care frequently and apply moisture barrier after each episode, and check resident every 2 hours and assist with toileting as needed.During an interview on 3/3/26 at 9:40 a.m., Resident #2 said she had frequently been left in soiled/wet briefs for hours. Resident #2 said she woke up around 5:30 a.m. and staff didn't usually check on her for incontinence until 10:00 a.m. or later. Resident #2 said she was wet at that time and had not been changed.During an observation on 3/3/26 at 9:50 a.m., CNA C and CNA B assisted Resident #2 with incontinent care. Resident #2 was visibly soiled with both urine and feces when her brief was changed at 9:59 a.m.During an interview on 3/3/26 at 10:05 a.m., CNA C said she arrived at work that day at 7:00 a.m. CNA C said she did not check on or change Resident #2 until 10:00 a.m. CNA C said she did not check on Resident #2 because she typically let staff know when she was wet/soiled.During an interview on 3/4/26 at 1:05 p.m., LVN D said she expected CNAs to round on residents at least every 2 hours and assist with incontinent care as needed. LVN D said she didn't routinely provide supervision to CNAs to ensure tasks were completed as assigned. LVN D said it wasn't her job to supervise CNAs.2. Record review of Resident #3's admission Record, dated 3/3/26, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included fracture of right humerus, Type 2 Diabetes, weakness, and disorientation.Record review of Resident #3's MDS dated [DATE], indicated Resident #3 had intact cognition with a BIMS of 13. She required supervision with eating and oral hygiene. She required substantial assistance with all other ADLs. She was frequently incontinent of bowel and bladder.Record review of Resident #3's comprehensive care plan, dated 2/12/26, indicated Resident #3 had an ADL self-care performance deficit. Interventions were in place which included assist with personal hygiene as required, bathing assistance, and toileting assistance.During an interview on 3/4/26 at 1:40 p.m., RP #4, RP for Resident #3, said on 2/17/26 she was visiting Resident #3 and activated the call light. RP #4 said they waited 25 minutes, timed on her cell phone. RP #4 said after waiting 25 minutes she went to the nurse's station and asked for assistance. RP #4 said it was an additional 6 minutes before assistance arrived and Resident #3 had an incontinent episode. RP #4 said it was a consistent pattern of not providing timely incontinent care, not a single episode.During an interview on 3/4/26 at 2:00 p.m., RP #5 , RP for Resident #3, said on an unknown date at an unknown time, while visiting Resident #3, they activated the call light for assistance. RP #5 said she timed the response time of 25 minutes and no staff responded. RP #5 said she assisted Resident #5 to the restroom herself. RP #5 said she witnessed similar incidents but could not provide further examples.During an interview on 3/4/26 at 4:15 p.m., the DON said she was responsible for supervision of the nursing department. The DON said she expected CNAs to round on residents at a minimum of every 2 hours and to provide incontinent care as needed to residents. The DON said the charge nurses were responsible for ensuring CNAs performed their job duties as assigned. The DON said she monitored staff compliance through leadership rounding and monitoring skin reports specifically for skin integrity concerns. The DON said she began in-service training to (continued on next page)

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	03/04/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff covering incontinent care and would continue the training.During an interview on 3/4/26 at 4:40 p.m., the ADM said she was ultimately responsible for supervision of all departments. The ADM said it was her expectation that CNA staff were rounding on residents at least every 2 hours and providing incontinent care as needed. The ADM said the risks to residents who were not provided with prompt incontinent care could include skin breakdown. The ADM said the facility had already begun in-servicing staff to address concerns with incontinent care.Record review of the facility's policy titled Perineal Care, dated 4/27/22, indicated .An incontinent resident of urine and/or bowel should be identified, assessed, and provided appropriate treatment and services.