

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: 675816	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Greenbrier Nursing & Rehabilitation Center of Pale		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 establish and 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 3 of 5 residents (Residents #8, #21 and #57) and of 4 of 6 staff (CNA A, CNA B, CNA C and CNA D) reviewed for infection control. 1.The facility failed to ensure CNA B and CNA D washed or sanitized their hands and failed to remove the dirty brief prior to place a new brief during incontinent care provided to Resident #8 on 1/28/2026.2. The facility failed to ensure CNA A and CNA B followed enhanced barrier precautions and wore a gown and gloves when providing direct care to Resident #57 on 01/28/2026.3. The facility failed to ensure CNA C performed hand hygiene between glove changes on 1/28/2026 during perineal care for Resident #21. These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings include: 1. Record review of Resident #57's facility face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #57 had a diagnosis of diabetes (high blood sugar levels in the body). Record review of Resident #57's baseline care plan, dated 1/25/2026 revealed Resident #57 was on enhanced barrier precautions and gloves and gown should be donned if any of the following activities were to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity. Record review of Resident #57's MDS list revealed an MDS had not been completed and was not yet due. Record review of Resident #57's order summary report, dated 1/28/2026, revealed Resident #57 required enteral feedings (feeding through a tube to the stomach) but did not reveal an order for EBP. During an observation and interview on 01/27/2026 at 3:38 PM revealed Resident #57 had an EBP sign at the door and PPE outside the room in a cart. The resident could not recall if the staff wore PPE when providing care to her. During an observation on 01/28/2026 at 8:15 AM revealed Resident #57 was provided incontinent care by CNA A and CNA B. Neither CNA applied a gown prior to providing care to Resident #57. During an interview on 01/28/2026 at 8:25 AM, CNA A said she had been trained on EBP and EBP was used for residents who had wounds and feeding tubes. She said PPE was to protect the residents and other residents and by not wearing PPE infections could spread. During an interview on 01/28/2026 at 8:27 AM, CNA B said she had been trained on EBP and EBP was used for residents who had devices like a catheter or feeding tube or wounds. She said PPE was to protect the residents as well as other residents and by not wearing PPE infections could spread. 2. Record review of Resident #8's admission Record, dated 1/28/2026, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #8 had diagnoses which included cerebral infarction (stroke), expressive language disorder (difficulty speaking), hypertension (high blood pressure), and gastrostomy status (tube inserted into the stomach for nutrition). Record review of Resident #8's Quarterly MDS Assessment, dated 10/30/2025, indicated he was rarely/never understood with a BIMS score of 0 which was severe cognitive impact. He required substantial/maximal assistance with personal hygiene. He was always incontinent of urine/bowel. Record review of Resident #8's care plan, dated 4/1/2024, indicated he was on enhanced (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	barrier precautions. Interventions included to perform hand sanitation before entering the room and prior to leaving the room. During an observation on 01/28/2026 at 9:01 AM, revealed CNA B and CNA D were present in the hallway and gathered supplies to perform incontinent care and placed them in a plastic bag. Both donned (put on) a gown in the hallway at the door of Resident #8. Staff entered the room, and CNA D placed a draw sheet on the over bed table as a barrier and placed the plastic bag on top of it. Both placed gloves on their hands without washing or sanitizing them. CNA D opened Resident #8's brief and placed it between his thighs. CNA D removed a wipe from the bag and wiped his penis in a circular motion and placed the wipe in the trash. CNA B removed her gown and gloves and exited the room to get more wipes because they did not have enough to complete care. CNA B brought back in supplies and donned a gown and placed gloves on her hands without washing or sanitizing them. CNA D removed wipes from the bag and wiped his inner thighs and placed the wipe in the trash x2. Resident #8 was rolled onto his right side and CNA D removed a wipe from the plastic bag and wiped his rectal area from front to back x2 and placed the wipes in the trash. CNA D rolled the brief underneath his buttocks and placed a clean brief under the brief and rolled the resident onto his left side over the dirty brief and CNA B removed the brief and placed it in the trash. CNA D secured the brief and repositioned the resident in bed. CNA D removed her gloves and placed them in the trash and placed gloves on her hand without washing or sanitizing them. CNA B removed her gloves and placed them in the trash and sanitized her hands and placed gloves on her hands. The resident was pulled up in bed and repositioned again in bed. Both staff removed their gloves and gowns and placed them in the trash. Both sanitized their hands. During an interview on 1/28/2026 at 9:13 AM, CNA D said she had been employed at the facility for 4 months. She said during care that was provided to Resident #8 she did not wash or sanitize her hands before care was started. She said she was nervous and forgot. She said she did not wash or sanitize her hands between glove changes either. She said she should have removed her gloves when she changed from dirty to clean when the brief was removed and she touched the clean brief and placed it underneath the resident and the brief should have been removed before the clean brief was placed. She said she had a skills check-off when she was hired. She said there was a risk for residents to get bacteria, germs and cross contamination if staff did not perform hand hygiene. During an interview on 1/28/2026 at 2:05 PM, CNA B said she had been employed at the facility for 5 years. She said during the care that was provided to Resident #8 she should have removed the dirty brief before CNA D placed the clean brief. She said she should have washed or sanitized her hands before the care was started. She said she forgot. She said residents could be at risk of infections if staff did not wash or sanitize their hands before and after care. 3. Record review of Resident #21's facility face sheet, dated 1/28/26, a [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis which included cystitis (inflammation of the bladder). Record review of Resident #21's quarterly MDS assessment, dated 1/1/26, indicated a BIMS score of 15, which indicated she was cognitively intact. She required substantial/maximum assistance for toileting and personal hygiene. Record review of Resident #21's comprehensive care plan, dated 12/29/25, indicated she had an ADL self-care performance deficit and required staff assistance times one person for toileting. During an observation on 1/28/26 at 9:35 AM revealed CNA C performed perineal care on Resident #21. She was observed to wash her hands upon entrance to the room. During care, she was observed changing her gloves three times during care without performing hand hygiene. During an interview on 1/28/26 at 9:50 AM, CNA C said I normally don't do this with y'all. I have not been watched by state before When asked if she knew why hand hygiene should be performed between glove changes, she replied No. During an interview on 1/29/2026 at 8:40 AM, the DON said she was the IP for the facility and was responsible for training staff on infection control on hire and annually thereafter. She said hand hygiene should be done before care, after care, and before gloves were donned. She said staff should never touch clean items with dirty gloves as it was a risk for contamination. She said EBP was for residents who had MDROs, foley catheters, PICC lines, wounds, and gastric tubes. She said if a resident was on EBP staff should wear (continued on next page)		

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