STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675877	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Health Care Center	301 W Randol Mill Rd Arlington, TX 76011

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 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 interviews and record reviews, the facility failed to ensure 1 (Resident#1) out of 4 residents received adequate supervision and assistance devices to prevent incidents. The facility failed to provide Resident#1 with adequate supervision when transferring her on 10/09/25. This failure could result in falls, injuries and a decline in quality of life. Findings included:Record review of Resident#1's face sheet, dated 10/16/25 reflected, she was a [AGE] year-old female who was originally admitted on [DATE] and readmitted on [DATE], diagnosed with but not limited to: Alzheimer's disease (progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior) and is the with late onset, adult failure to thrive (a condition characterized by significant decline in physical and emotional well-being) , chronic embolism and thrombosis of left popliteal vein (Presence of blood clots located behind the knee) , generalized muscle weakness(Decreased muscle strength across multiple muscle groups), unsteadiness on feet, other abnormalities of gait and mobility, and unspecified lack of coordination. Record review of Resident#1's MDS, dated [DATE] reflected her BIMS score was blank which indicated Resident#1 could not recall. Resident#1 had a manual wheelchair. Resident#1 had an actively diagnosed with Hemiplegia (one-sided paralysis or weakness of the face, arm or leg) or Hemiparesis (Muscle weakness on one side of the body). Resident#1 functional status reflected: *Bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture) required Extensive assistance (resident involved in activity, staff provide weight-bearing support) with One-person physical assist.* Transfer (how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position.) required Total dependence (full staff performance every time during entire 7-day period) with Two- person physical assist. Record review of Resident#1 care plan, revised 07/15/25 reflected, Resident#1 had ADL self-care performance deficit r/t Limited Mobility and hemiplegia. Resident#1 goal was to maintain current level of function. Resident#1 intervention included bed mobility extensive with one person assist and transfer extensive with two-persons assist. Record review of Resident#1's hospice report reflected, Resident#1 started hospice on 07/29/25.Record review of Resident#1's SW general visit note, dated 10/09/25 reflected: [Resident#1] requires assistance with all ADL's and naps throughout the day. Record review of Resident#1's Hospice aide notes dated 09/29/25 reflected Resident#1 was a complete assist/total dependence for all ADL's including ambulation and transfers. During an interview on 10/16/25 at 9:10 pm CNA C stated he transferred Resident#1 from her wheelchair to the bed by himself. CNA C stated Resident#1 was transferred comfortably without an injury. CNA C stated Resident#1 was tiny and she would bear hug him, while he transferred her. He stated bear hug meant Resident #1 would either put her hands around his neck or stomach area for support. CNA C stated Reszident#1 was a one- person transfer now. CNA C stated Resident#1 could move very little side to side. During an interview on 10/21/25 at 9:30 am, Family member stated they were told by staff that Resident#1 was transferred by two staff with a mat. Family member stated while she was in the facility on 10/09/25 she observed Resident#1 being picked up by CNA C from her wheelchair and transferred to the bed by himself. During a phone interview on 10/21/25 at 5:12 pm, CNA J stated Resident#1 was a one-person transfer. CNA J stated Resident#1 would put her arms around her and she would lift her from the wheelchair to the bed. CNA J stated on 10/09/25 she transferred Resident#1 to her bed by herself with no injuries or concerns. CNA J stated Resident#1 was a one person transfer now. During an interview and observation on 10/21/25 starting at 6:50 pm., with the Admin and the Regional Nurse, the Admin stated Resident#1 used to be a mechanical lift when she first was admitted because she was combative and a heavier lady. The Admin stated Resident#1 use to be a two person assist but was now a one person assist. The Admin was asked why the care plan did not reflect Resident#1 being a one person assist, the Regional Nurse left the room and returned with a paper care plan, which now stated the resident was a one person assist. The Admin did not provide an explanation on why the MDS reflected the resident was a two person assist. The Admin stated a gait belt should have been used on Resident#1 for transfers. The Regional Nurse stated that was incorrect and the gait belt was not necessary for Resident #1. The Regional Nurse stated Resident#1 could have gotten bruises from the gait belt and that Resident #1 was a one person assist. Record review of facility policy titled Safe Lifting and Movement of Residents, last revised July 2017, reflected the following Policy Statement . In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move