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	11/20/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 45053 Based on observations, interviews, and record review, the facility failed to ensure that each resident had a right to personal privacy and confidentiality of residents' personal and medical information for 1 of 4 medication carts reviewed for clinical records on Station 3. MA E failed to lock and secure the laptop on medication cart on Station 3. This failure could affect 48 residents by placing them at risk of resident-identifiable information being accessed by the public. Findings included: An observation on 11/20/24 at 3:11 PM revealed a laptop medication cart on the hallway of Station 3 that was unattended, unlocked, and unsecured. HHSC surveyor observed resident information (name, date of birth, photo etc.) on the screen from the laptop on the medication cart that was unlocked, unattended and unsecured. There were not any staff in the hall and a resident was observed walking in the hallway past the medication cart on Station 3. MA E was observed inside a resident ' s room. In an interview on 11/20/24 at 3:19 PM, MA E said she was the only Medication Aide for the facility. She stated that she was responsible for ensuring that the laptop on the medication cart was locked and always secured. She said that she thought that she locked the laptop on the medication cart prior to entering the resident ' s room. She stated that the laptop on the medication cart should remain locked and always secured to ensure that no one could look at the screen on the laptop and have access to resident ' s confidential medical records. MA E stated that the risk of the laptop on the medication cart being unlocked and not properly secured was that anyone could have access to the resident ' s information. She stated that if someone gained access to any resident ' s private information, they could use it against them and could cause harm to a resident. MA E stated that she has been employed at the facility for a couple of months and received In-Service Trainings relating to medication administration, storage, and HIPPA since being employed at the facility. (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: 675877	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/20/24 at 3:35 PM, LVN F stated that she was unaware that MA E did not properly lock and secure the laptop on her medication cart on Station 3. LVN F stated that if she observed a medication cart that was unlocked, she would lock the medication cart. She stated that she has been trained via In-Service Trainings that the medication carts were to remain locked and always secured when they were unattended. She stated that she has been employed at the facility for 6 years and she and other staff were regularly retrained and reeducated on medication storage and securing the medication carts. She stated that the risk of a resident or anyone else having access to an unlocked laptop medication cart could cause the potential for someone to obtain residents confidential information and medical records. She stated that harm could be caused to a resident if someone gained unauthorized access to their medical records and could use the information against them. In an interview on 11/20/24 at 3:42 PM, the DON stated that she was unaware the MA E left the laptop on her medication cart unlocked in the hallway of Station 3. She stated that her expectation was that her staff were to lock and secure any computer or laptop they used when they were not in use. She stated that the laptop on each medication cart was to be always locked and secured. She stated residents, visitors, and guests could look at and obtain confidential and private information from the open laptop. She stated that harm could be caused to residents if anyone looked at their information on the laptop, which should be accessed only by staff. She stated that a resident or someone in a wheelchair would not be able to look at the information on the laptop on the medication cart due to the medication cart being too high for a person in a wheelchair to have eye level access to the information on the laptop. The DON stated that she will retrain and educate MA E and staff on medication administration and storage because they all have access to the medication carts. In an interview on 11/20/24 at 4:18 PM, the Administrator stated that she was not aware that MA E left the laptop on her medication cart unlocked on the hallway of Station 3. She stated that all staff have been trained via In-Service Training relating to how to properly secure the laptops on the medication carts. She stated that harm could be caused to a resident if a laptop on a medication cart was unlocked, which was a HIPPA violation, which meant that access to personal and confidential records and information should not be available for anyone to access. She stated that staff at the facility are In-Serviced on HIPPA at least on a quarterly basis. She reported that MA E was a new hire and received HIPPA training as part of her New Hire Orientation. Record review of MA E ' s CEU Certificate revealed that she completed 1 hour of development and/or training for HIPPA and You on 11-04-24. Record review of the facility's policy titled, Medication Storage - in the Home, dated 12/2018 reflected no information regarding securing clinical records. An email from the Administrator received on 11/22/24 at 1:42 PM revealed the facility did not have a policy related to HIPPA policies, procedures, and guidelines. She stated that the facility follows the HIPPA Guidelines in relation to the Health Insurance Portability and Accountability Act of 1966.

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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 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. 45053 Based on observations, interviews, and record review the facility failed to properly secure medications in locked compartments for 1 (Station 3) of 4 medication carts reviewed for drug storage. MA E failed to lock and secure the medication cart on Station 3. This failure placed 48 residents at risk for their identifiable information accessed by anyone who had unauthorized access to the medication cart and consumption of harmful medications. Findings included: An observation on 11/20/24 at 3:11 PM revealed a medication cart parked on the hallway of Station 3 that was not locked and secured. There were not any staff in the hall and a resident was observed walking in the hallway past the medication cart on Station 3. MA E was observed inside a resident ' s room. HHSC surveyor observed the cart to be open and accessible. In an interview on 11/20/24 at 3:19 PM, MA E said she was the only Medication Aide for the facility. She stated that she was responsible for ensuring that the medication cart was locked and always secured. She said that she thought that she locked the medication cart prior to entering the resident ' s room. She stated that the medication cart should remain locked and always secured to ensure the medications were not ingested by anyone. MA E stated that the risk of the medication cart being unlocked and not properly secured was that anyone could have access to the medication cart and take anything from the cart. She stated that if someone had access to the medication, they could ingest the medication and it could cause harm if they had an allergic reaction to the medication. She stated that if someone had blood pressure issues and they ingest a medication, the unauthorized use of the medication could make it worse, and possibly send them to the hospital. MA E stated that she has been employed at the facility for a couple of months and received In-Service Trainings related to medication administration and storage since being employed at the facility. In an interview on 11/20/24 at 3:35 PM, LVN F stated that she was unaware that MA E did not properly lock and secure her medication cart that was parked on Station 3. LVN F stated that if she observed a medication cart that was unlocked, she would lock the medication cart. She stated that she had been trained via In-Service Trainings that the medication carts were to remain locked and always secured when they were unattended. She stated that she has been employed at the facility for 6 years and she and other staff were regularly retrained and reeducated on medication storage and securing the medication carts. She stated that the risk of a resident or anyone else having access to an unlocked medication cart could cause the potential for someone who was not prescribed the medication, access to the medication, and ingest the medication. LVN F stated that if someone ingests medication that was not prescribed to him/her it could cause harm and lead to an overdose, illness, and a possibly hospitalization . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/20/24 at 3:42 PM, the DON stated that she was unaware that MA E left her medication cart unlocked in the hallway of Station 3. She stated that her expectation was that the medication cart was to be always locked when it was not in use. She stated that if a medication cart was not properly locked and secured anyone including a resident could walk up to the medication cart and take anything from the medication cart. She stated that someone could only ingest the medication if they could pop the pills from the package. She stated that harm could be caused to anyone who ingested a medication that was not prescribed to them. She stated that she would hope that staff would be able to hear the door or drawer being opened from the medication cart and they would be able to stop anyone from taking anything from the medication cart. The DON stated that she will retrain and educate MA E and staff on medication administration and storage because they all have access to the medication carts. In an interview on 11/20/24 at 4:18 PM, the Administrator stated that she was not aware that MA E left her medication cart unlocked on the hallway of Station 3. She stated that all staff have been trained via In-Service Training relating to how to properly secure the medication carts. She stated that if a medication cart was unlocked, there was a risk or potential for someone to get access to the medication stored in the medication cart. The Administrator stated that she was not clinical, therefore she did not want to give any information regarding any potential harm if someone had access to an unlocked medication cart. She stated that there was a possibility of no harm or there was a possibility that there could be some adverse effects. Record review of the facility's policy titled, Medication Storage - in the Home, dated 12/2018 reflected: Policy: It is the policy of this home that medications will be stored appropriately as to be secure from tampering, exposure, or misuse. Procedure 2. Only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medications (i.e., medication aides, etc.) are allowed access to medications. Medication rooms, carts, and medications supplies are locked or attended by persons with authorized access .9. Schedule III and IV controlled medications are stored .in a locked drawer or compartment .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observations, interviews, and record review, the facility failed to accommodate residents' food intolerances and preferences for 1 of 5 residents (Residents #43) reviewed for food preferences. The facility failed to provide daily oatmeal as requested for Resident #43. This failure could place residents at risk for not having their choices and food preferences accommodated, possible weight loss and a diminished quality of life. Findings included: Record review of Resident #43's Face Sheet dated 11/19/24 reflected a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #43's Admission MDS assessment dated [DATE] reflected she had moderately impaired cognition and her diagnoses included gastroesophageal reflux disease (a disease where stomach acid flows into and irritates the esophagus); diabetes (disease that results in too much sugar in the blood); and end stage renal disease (condition in which the kidneys stop functioning. She was receiving dialysis (treatment to remove toxins from the blood of patients with kidney failure). During an interview on 11/18/24 at 11:06 AM, Resident #43 stated she did not like the breakfast served at the facility and preferred they just bring her oatmeal every day. She stated she did not like the bacon or eggs she was given. She stated the bacon was too salty for her. She stated she had asked the nurse and the lady that brings me medicine about it more than once but they still brought her the other breakfast and sometimes a small bowl of oatmeal. Resident #43 stated she just wanted a large bowl of oatmeal every day. During an interview on 11/19/24 at 7:25 AM, LVN C stated resident meal preferences were communicated with the dietary staff. She stated, if a resident did not eat their meal, they offered them an alternate meal. She stated, if a resident made a request such as oatmeal, that would be a one-time request and would not replace their regular meal. She stated residents sometimes made requests then forgot they made the request and would be upset the next day when they received the same thing. When asked how a resident would know ahead of time what was planned to be served for lunch or dinner that day, LVN C replied, If they ask us, we can let them know . An observation and interview on 11/19/24 at 8:01 AM revealed the DON was standing near the entrance of the dining room near the menu postings. The DON stated residents were not receiving daily menus in their rooms, but nursing staff could inform any resident what was planned for the day. She stated she did not believe the deadlines of 9 AM and 2 PM were completely accurate. She stated, if a CNA noticed a resident was not eating or did not like the food, they could request an alternate meal for the residents at any time during the meal service and it would be provided . (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 11/19/24 at 8:25 AM revealed Resident #43 was sitting up in bed eating breakfast. Her tray consisted of eggs, toast, grits, and sausage. She stated she was eating the grits and sausage but still preferred oatmeal. She stated she would like to talk to the DON about her concerns. The DON was observed in the hallway nearby and was asked to speak to Resident #43. Resident #43 informed the DON she had previously requested she only wanted oatmeal for breakfast and continued to receive eggs on her plate. She pointed to the grits and eggs. The DON asked the resident if it was possible staff believed it was a request for that particular day only and Resident #43 told her it was not. In an interview on 11/19/24 at 12:20 PM, CNA D stated she had not taken any meal orders from any of the residents. She stated she normally worked on the weekends and was working an extra shift that day. CNA D stated, if a resident complained about the food, they could offer an alternate meal during mealtime. She stated she had not received any special requests from residents. She stated, if a resident wanted a diet change, she should tell the Charge Nurse. In an interview on 11/20/24 at 7:27 AM, LVN C stated Resident #43 had previously told her she liked hot cereal, but she had no idea she meant for every breakfast meal. She stated she thought the request was for that particular meal only. LVN C stated they monitored residents meal intake to ensure they were getting what they wanted, and she had misunderstood the resident's request. She stated the risk of not honoring resident's food preferences included residents not eating, malnutrition, and weight loss. In an interview on 11/20/24 at 12:32 PM, the Dietary Manager stated what had occurred was the menus were posted on the wall outside the dining room and the dietary staff were following whatever diet order was on the ticket. She stated she just started the position the previous week. She stated, What I started today was printing the 'always available' menu and daily menu and I took them to the charge nurses. She stated the nurse should request the menu item or other item and let the dietary staff know. The Dietary Manager stated she preferred to get the lunch requests by 9:00 AM or 10:00 AM so the resident's trays were not delayed, but the residents could order an alternate any time during the meal service. She stated the nurses could enter special request orders at any time to be included on the resident's tickets. The Dietary Manager stated, since she started, she had been walking around the dining room and visiting resident rooms during meals to ask residents how their meals were. She stated she had not received any complaints. She stated the risk of not honoring resident preferences included the residents would be unhappy, not eating, and have potential weight loss . During an interview on 11/20/24 at 1:04 PM, MA E stated Resident #43 had told her about 2 weeks prior that she only wanted oatmeal for breakfast and that she had already told other people, including the previous Dietary Manager, the same thing. MA E stated she recalled telling the previous Dietary Manager herself about the request. She stated she thought she recalled telling the Charge Nurse the same but was unable to recall who she spoke with. MA E stated she did not know her diet order had not been switched. She stated residents sometimes ask her for food items while she was passing medications and she typically told the charge nurse. She stated the risk for residents not receiving their meal preferences were they may stop eating. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/20/24 at 4:00 PM, the Administrator stated she had not received any complaints related to food preferences or meal service. She stated she tested the trays three times a week herself for quality. The Administrator stated, since she started, food service had been their strongest area and they had never had any complaints. She stated there had been staff turnover within dietary services over the past two weeks and there may have been a drop in communications. She stated the risk to residents was they had the right to check the menu and make requests . An email from the Administrator received on 11/20/24 at 3:03 PM revealed the facility did not have a policy related to dietary services and resident preferences.

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F 0919

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Make sure that a working call system is available in each resident's bathroom and bathing area.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 28637

Based on observations, interviews, and record review, the facility failed to be adequately equipped to allow for staff assistance through a communication system which relayed the call directly to a staff member or to a centralized staff work area for 1 of 7 residents (Resident #28) reviewed for physical environment.

The facility failed to ensure the call system in Resident #28's room was functioning properly.

This could place the residents at risk of not receiving the care and services to maintain their highest level of well-being.

Findings included:

Record review of Resident #28's Face Sheet, dated 11/20/24, reflected an [AGE] year-old female admitted to the facility on [DATE].

Record review of Resident #28's Quarterly MDS Assessment, dated 9/10/24, reflected she had moderately impaired cognition and required supervision with dressing and partial assistance with transfers. Her diagnoses included unspecified dementia and need for assistance with personal care.

An observation on 11/18/24 at 1:14 PM revealed Resident #28 was in her room, sitting on the side of the lower end of her bed facing her wheelchair. She stated she was going to get dressed and pointed at clothing laying on her wheelchair. When asked if she called for assistance, she pointed toward the call light button clipped to her pillow and stated, you can push that. When the call light button was pressed, the light above her door was not functioning, no sound was heard at the nurses' station, and the panel near the nurses' station was not lit to indicate the call was placed. Resident #28's call light was plugged into the wall in her room using a cord that was split with another cord and the call light for the other half of her room [unoccupied]. The second call light was checked and found to be functioning appropriately. Further interview with Resident #28 revealed she could not recall whether she had previous problems with her call light and she stated her memory was not very good.

In an observation on 11/18/24 at 1:37 PM revealed LVN A entered Resident #28's room and asked her if she needed assistance. LVN A stated she was not Resident #28's Charge Nurse but was responding to her call light. CNA B arrived in the room and stated she was unaware her call light was not working. She checked the second call light, found it was functioning and replaced Resident #28's button with the functional one located on the other side of her room. CNA B stated she would report the malfunction to maintenance and request a replacement cord.

In an interview on 11/19/24 at 2:51 PM with the Maintenance Supervisor revealed he tested the call light function daily and rotated through a different set of rooms every day. The Maintenance Supervisor stated he was unaware the call light in Resident #28's room was not functioning and would ensure the cord was replaced. He stated call light malfunctions placed residents at risk of being unable to call for assistance when needed.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 11/20/24 at 7:45 AM revealed the call light in Resident #28's room had been replaced and was functioning properly. In an interview on 11/20/24 at 11:23 AM, LVN C stated she was Resident #28's Charge Nurse that week and was unaware her call light was not working. She stated call lights should be checked periodically and reported to maintenance if they were not working properly. She stated she would have called the Maintenance Supervisor and also entered the information into the maintenance logbook at the nurses' station if she knew a call light wasn't working. LVN C stated Resident #28 had confusion and she had never known her to use her call light much as she liked to try and do things for herself. She stated they checked on her frequently. LVN C stated the risk of nonfunctioning call lights included residents not getting the care they needed and injuries. In an interview on 11/20/24 at 4:00 PM, the Administrator stated she was unable to locate a policy for call light testing. She stated the Maintenance Supervisor was responsible for ensuring the call lights functioned and had a variety of things he tested daily. The Administrator stated Resident #28 was very verbal and was able to communicate with the nursing staff. She stated the risk of call lights not functioning included resident's possibly being unable to call for assistance. Record review of the Maintenance Log Book entries dated between 8/11/24 and 10/5/24 revealed there were no entries related to call light malfunctions. There were no entries dated after 10/5/24. Record review of the facility's policy titled, Call Light-Use of, dated 12/2018 reflected: Policy: It is the policy of this home to ensure residents have a call light within reach that they are physically able to access and that they have been instructed on its use. Equipment 1/ Bedside call light in functioning order .Procedure 1. All nursing personnel must be aware of call lights at all times .10. Report any defective call lights to the charge nurse immediately. 11. Log defective call lights, with exact location, in maintenance log .