STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676161	A. Building B. Wing	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Healthcare and Rehabilitation Center	6850 Rufe Snow Dr Fort Worth, TX 76148

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a comprehensive assessment within 14 calendar days after admission as required for 1 (Resident #3) of 3 resident records reviewed.The facility failed to ensure Resident#1's Admission/Comprehensive MDS assessment was completed within 14 days following her admission to the facility.This failure could result in newly admitted residents not receiving the proper care required to attain or maintain the highest practicable physical, mental and psychosocial well-being. Findings included:Review of Resident #1's MDS assessment dated [DATE] revealed she was a [AGE] year-old female who admitted to the facility on [DATE]. Her BIMS was a 15 indicating she was cognitively intact. Her diagnoses included: HTN, DVT, GERD .Record review of Resident #1's MDS Summary screen in the Electronic Health Record on 05/04/26 revealed the resident's MDS had an ARD date of 04/10/26 and was completed on 04/21/26 (11 days after the ARD date). In an interview on 05/04/26 at 12:50 PM, the DON stated that MDS Nurse was responsible for MDS's. She stated that she was not aware of MDS being incomplete and late. The DON stated that she is sent a list of MDS and signs them . She stated she was not an MDS nurse and never was an MDS nurse. In an interview on 05/04/26 at 1:04 PM, the MDS Nurse stated that she had been the MDS Nurse at the facility for about 12 years. The MDS Nurse stated that she knew that the SW had been behind on her sections of the MDS but had completed her part on 04/17/26, a Friday, so the MDS Nurse was not able to complete the MDS until 04/21/26. She stated that it was important for the MDS to be completed on time to ensure accurate billing.In an interview on 05/04/26 at 1:15 PM, the Administrator stated that the facility did not have a policy on MDS but use the RAI manual.Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.20.1, dated October 2025, reflected 14th calendar day of the resident's admission (admission date + 13 calendar days). The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status.

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from significant medication errors for 1 (Resident #1) of 3 residents reviewed for medication errors in that:The facility failed to administer Resident #1's Metoprolol Succinate ER Tablet Extended Release 24 Hour 50 MG as ordered by the physician on 04/27/26, 04/28/26, 04/29/26.This failure could place residents at risk of medical complications and a decrease in therapeutic dosages of their medications as ordered by the physician.Findings included:Review of Resident #1's MDS assessment dated [DATE] revealed she was a [AGE] year-old female who admitted to the facility on [DATE]. Her BIMS was a 15 indicating she was cognitively intact. Her diagnoses included: HTN.Record review of Resident #1's care plan with a competition date of 04/22/26 reflected: Focus: The resident has hypertension.Date Initiated: 04/06/2026.Goal: The resident will remain free from s/sx of hypertension through the review date.Interventions: Give anti hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate.Review of Resident #1's consolidated physician orders for the month of April 2026 reflected:- Metoprolol Succinate ER Tablet Extended Release 24 Hour 50 MG Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold for SBP less than 110 or HR less than 60. Do not crushReview of Resident #1's MAR for April 2026 reflected Resident #1 received her Metoprolol Succinate ER Tablet outside of parameters on the following dates by the following staff:- 04/27/26 Resident #1's SBP was 101 and Medication Aide A administered the medication outside of parameters- 04/28/26 Resident #1's SBP was 108 and Medication Aide A administered the medication outside of parameters- 04/29/26 Resident #1's SBP was 108 and Medication Aide A administered the medication outside of parametersReview of Resident #1's nurses' notes for the dates of 04/01/26 through 05/04/26 revealed there was 1 note on 04/27/26 that reflected: 4/27/2026 09:00 [9:00 AM] Orders - Administration Note Note Text: Metoprolol Succinate ER Tablet Extended Release 24 Hour 50 MG Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold for SBP less than 110 or HR less than 60. Do not crush LOW/BP In an interview on 06/30/22 9:41AM, Medication Aide A stated she had administered the medication outside of parameters on 04/27/26, 04/28/26 and 04/29/26 for Resident #1. She stated she was to hold the blood pressure medication since it was below parameters and notify her nurse. She stated that if the blood pressure medication was administered below parameters, the resident blood pressure could lower more. In an interview on 05/04/26 at 12:15 PM, LVN B stated that the medication aides pass all routine medications and that he passed PRN medications. LVN B stated that if a medication aide received a blood pressure reading outside of parameters they were to recheck the blood pressure and if the blood pressure was still outside of parameters to notify him. He stated Medication Aide A had not notified him of any blood pressures being out of parameters for Resident #1. LVN B stated it was important to not give medication outside of parameters as it could cause a resident to bottom out resulting in adverse effects causing the resident to feel worse. In an interview on 05/04/26 at 12:50 PM, the DON stated she was not aware of blood pressure medications being administered outside of parameters. The DON stated that if a blood pressure was outside of parameters, she expected the nurse to notify the physician and hold the medication and indicate the hold on the MAR. The DON stated administrating the medication outside of parameters could cause the residents blood pressure and heart rate to drop significantlyReview of the facility policy titled Medication Administration revised 03/05/2026 reflected: 4. Medications are administered according to the prescriber orders.

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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. Based on observation, interviews, and record review the facility failed to ensure all drugs and biologicals were stored securely for one (treatment cart #1) of 4 reviewed for storage of medications.The facility failed to ensure treatment cart #1 was locked while unattended on 05/04/26This failure could place residents at risk of having access to unauthorized medications and/or lead to possible harm or drug diversions. Findings included:An observation on 05/04/26 at 8:50 AM revealed treatment cart #1 was unlocked and unattended with no staff within eyesight of the medication cart. All drawers could be opened, and medication and supplies (needles, gauze, ointments, etc.) could be easily accessed. In an interview on 05/04/26 at 8:54 AM, with LVN B stated treatment cart #1 belonged to the wound care nurse who was not at work. In an observation and interview on 05/04/26 at 8:55 AM, ADON C locked treatment cart #1. ADON C stated that her expectation was the treatment cart was locked when not in use. She stated it was the responsibility of the nurse who used the cart last to lock the cart. She said she did not know who had used the cart last. ADON C stated that it was important the cart was locked when unattended so people don't have access to what is inside. In an interview on 05/04/26 at 9:02 PM, ADON D revealed that the treatment cart should be locked when not in use, as there could be dangerous items in the cart that residents do not need access to. ADON D stated it was the responsibility of the nurse who last used the treatment cart to ensure it was locked. ADON D did not state if she knew who had used the cart last. In an interview on 05/04/26 at 12:50 PM, the DON stated that her expectation was the treatment cart was always locked unless it was in use. The DON stated that any staff member could lock the cart if they observed it unlocked. The DON stated it was important for the treatment cart to be locked when not in use as there were items for wound care that people don't need and if you searched hard enough scissors.Review of the facility policy titled Storage of Medications dated 06/24/2025 reflected: 3. The nursing staff is responsible for maintaining medication storage and prep areas in a clean, safe and sanitary manner.8. Compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts and boxes) containing drugs and biologicals are locked when not in use.