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	06/17/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of hazards as was possible for three of ten residents (Resident #14, Resident#57 and Resident #74) reviewed for accident hazard. The facility failed to ensure a pair of scissors was not on Resident #14's bed on 06/15/2026. The facility failed to ensure a pair of scissors was not on Resident #57's bed on 06/15/2026. The facility failed to ensure a fingernail clipper was not on Resident #74's bedside table on 06/15/2026. These failures could prevent the residents from having an environment that was free from accidents and potential injury. Findings included: 1. Record review of Resident #14's Face Sheet, dated 06/17/2026, reflected a [AGE] year-old female, admitted on [DATE]. The resident was diagnosed with Type 2 Diabetes (a chronic condition where the body either resists insulin or do not produce enough of it, leading to high blood sugar), Psychotic disorder (severe mental illnesses characterized by a disconnection from reality, primarily involving hallucinations and delusions), and Anxiety disorder (mental health conditions characterized by excessive, persistent, and disproportionate fear or worry about everyday situations). Record review of Resident #14's Quarterly MDS Assessment, dated 06/04/2026, reflected a BIMS score of 10 indicating moderate cognitive impairment. Record review of Resident #14's Comprehensive Care Plan, dated 03/14/2022, reflected the resident was at risk for side effects of anti-anxiety medication with interventions including to monitor for confusion, dizziness and drowsiness. During an observation and interview on 06/15/2026 at 8:30 AM. Resident #14 was in her bed, awake and watching television. Her room was clean and homelike. It was observed that on top of the resident's bed was a pair of scissors unattended and within reach. Resident #14 stated the scissors were her own and she used them when she wanted. During an interview on 06/15/2026 at 8:40 a.m., LVN A stated she was not aware Resident #14 had scissors and that it should not be inside Resident #14's room because it could cause harm or injury to Resident #14 or to others. 2. Record review of Resident #57's Face Sheet, dated 06/17/2026, reflected a [AGE] year-old male admitted [DATE]. The resident was diagnosed with Dementia (an umbrella term for a decline in mental ability-such as memory, thinking, and reasoning-severe enough to interfere with daily life), Psychotic disorder (severe mental illnesses characterized by a disconnection from reality, primarily involving hallucinations and delusions), Anxiety disorder (mental health conditions characterized by excessive, persistent, and disproportionate fear or worry about everyday situations.) and Parkinson's disease (a progressive neurological disorder that damages dopamine-producing brain cells. It primarily affects movement, leading to hallmark signs like resting tremors, muscle stiffness, slowed physical actions) Record review of Resident #57's Quarterly MDS Assessment, dated 03/17/2026, reflected a BIMS score of 15 indicating intact cognition. Record review of Resident #57's Comprehensive Care Plan, dated 03/14/2022, reflected the Resident #57 had an ADL self-care performance deficit r/t Parkinson's with intervention including assistance by one staff as necessary and, The resident has impaired thought processes r/t Dementia with the listed goal, The resident will develop skills to cope with cognitive decline and maintain safety. During an observation and interview on 06/15/2026 at 9:23AM, Resident #57 was in his bed and awake. His (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	living area was clean and homelike. It was observed on top of Resident #57's bed was a pair of scissors unattended, and within reach. Resident #57 stated the scissors were his own and he used them to trim his beard. During an interview on 06/15/2026 at 8:40 a.m., LVN B stated she was not aware Resident #57 had scissors on his bed. LVN B stated the risk of having the scissors was injury as Resident #57 may cut himself or others. 3. Record review of Resident #74's Face Sheet, dated 06/17/2026, reflected an [AGE] year-old female admitted [DATE]. The resident was diagnosed with Type 2 Diabetes (a chronic condition where your body doesn't use insulin properly or can't make enough of it, leading to high blood sugar), and Dementia (an umbrella term for a decline in mental ability-such as memory, thinking, and reasoning-severe enough to interfere with daily life). Record review of Resident #74's Quarterly MDS Assessment, dated 03/23/2026, reflected a BIMS score of 01 indicating severe cognitive impairment. Record review of Resident #74's Comprehensive Care Plan, dated 09/05/2024, reflected the Resident #74 had impaired cognitive function/dementia or impaired thought processes r/t Dementia with the goal: The resident will develop skills to cope with cognitive decline and maintain safety. Comprehensive Care Plan, dated 09/05/2024, also reflected, The resident is resistive to care r/t Dementia with interventions: Give clear explanation of all care activities prior to and as they occur during each contact. If possible, negotiate a time for ADLs so that the resident participates in the decision-making process. Return at the agreed time. If resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again. During an observation and interview on 06/15/2026 at 9:30AM, Resident #74 was in her bed and awake. Observed on top of Resident #74's bedside table was a fingernail clipper unattended, and within reach. Resident #74 stated the fingernail clippers were her own and she used it to trim her fingernails as needed. During an interview on 06/15/2026 at 9:35 a.m., LVN B stated she was not aware Resident #74 had fingernail clippers in her room. LVN B stated the risk of having fingernail clippers was injury as Resident #74 may cut herself. During an interview on 06/16/2026 at 1:58 pm, the DON stated it could be family members that brought the scissors and fingernail clippers to the facility. She stated her expectation was that all staff removed sharp and dangerous items from resident rooms and stored them for supervised use. The DON stated staff were educated and trained in the proper use and safety of sharp objects like scissors and fingernail clippers. She stated the risk to residents could be cutting themselves or others. Record review of the facility's policy titled, Safety and supervision of Residents, revised December 2007, indicated policy statement, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Facility-Oriented Approach to Safety included:1. Our facility-oriented approach to safety addresses risks for groups of residents.2. Safety risks and environmental hazards are identified on an ongoing basis through acombination of employee training, employee monitoring, and reporting processes.4. Employees shall be trained and serviced in potential accident hazards and how toidentify and report accident hazards and try to prevent avoidable accidents.Resident-Oriented Approach to Safety included: 1. Our resident-oriented approach to safety addresses safety and accident hazards forindividual residents.2. Staff shall use various sources to identify risk factors for residents, including theinformation obtained from the medical history, physical exam, observation of theresident, and the MDS.3. The interdisciplinary care team shall analyze information obtained from assessmentsand observations to identify any specific accident hazards or risks for that resident.The care team shall target interventions to reduce the potential for accidents.4. Implementing interventions to reduce accident risks and hazards shall include thefollowing:a. communicating specific interventions to all relevant staff.b. assigning responsibility for carrying out interventions.c. providing training, as necessary.d. ensuring that interventions are implemented; ande. documenting interventions.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature control for 3 residents (Resident #22, Resident #75 and Resident #105) medication on 1 of 3 medication carts (100 Hall nurse cart) reviewed for pharmacy services.1. The facility failed to ensure proper disposal of Resident #22's Tramadol 50mg tab when the blister pack was damaged. 2. The facility failed to ensure proper disposal of Resident #75's Acetaminophen-Codeine #3 tab when the blister pack was damaged. 3. The facility failed to ensure proper disposal of Resident #105's Lorazepam 0.5mg tab when the blister pack was damaged. 4. The facility failed to ensure CMA A ensured that Resident #11 swallowed her medication before leaving the resident's room. These failures could place residents at risk for compromised medication efficacy, unsafe administration, and increased harm to residents.Findings included: 1. Record review of Resident #22's Comprehensive MDS Assessment, dated 05/05/2026, reflected the Resident #22 was an [AGE] year-old female, admitted [DATE]. She had a BIMS score of 08, indicating moderate cognitive impairment. The resident had diagnoses including Respiratory failure (a life-threatening condition where the lungs cannot adequately supply oxygen to the blood), anxiety disorder (a mental health condition characterized by excessive, persistent, and Depression (a common, serious mood disorder that causes persistent sadness, loss of interest, and physical or emotional fatigue). Record review of Resident #22's Comprehensive Care Plan, dated 02/19/2026, reflected Resident #22 was on pain medication therapy Hydrocodone and Tramadol r/t right hip fracture. Interventions included administer medication as ordered by physician. Monitor/document side effects and effectiveness Q-Shift. Record review of Resident 22's active physician orders, dated 06/16/2026, reflected tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 6 hours as needed for Pain and with PT/OT. During an observation on 06/16/26 at 9:45 a.m., with LVN B, of the 100 Hall nurse cart, revealed Resident #22's Tramadol 50mg tab had a damaged blister bubble and the tablet still inside, at the time the medication cart was reviewed. 2. Record review of Resident #75's Comprehensive MDS Assessment, dated 03/03/2026, reflected the Resident #75 was a [AGE] year-old female, admitted [DATE]. She had a BIMS score of 03, indicating severe cognitive impairment. The resident had diagnoses including anxiety disorder (mental health conditions characterized by excessive, persistent, and disproportionate fear or worry about everyday situations) and depression (a common, serious mood disorder that causes persistent sadness, loss of interest, and physical or emotional fatigue). Record review of Resident #75's active physician orders, dated 06/16/2026, reflected, Acetaminophen-Codeine Tablet 300-30mg Give 1 tablet by mouth every 6 hours as needed for Pain. During an observation on 06/16/26 at 9:45 a.m. with LVN B of the 100 Hall nurse cart, revealed Resident #75's Acetaminophen-Codeine Tablet 300-30 mg tab had a damaged blister bubble and the tablet still inside, at the time medication cart was reviewed. 3. Record review of Resident #105's Quarterly MDS Assessment, dated 03/21/2026, reflected that Resident #105 was an [AGE] year-old female, admitted [DATE]. She had a BIMS score of 08, indicating moderate cognitive impairment. The resident had diagnoses including Respiratory failure (a life-threatening condition where the lungs cannot adequately supply oxygen to the blood), Chronic obstructive pulmonary disease (a progressive lung disease that damages the airways and air sacs, making it difficult to breathe) and Depression (a common, serious mood disorder that causes persistent sadness, loss of interest, and physical or emotional fatigue). Record review of Resident #105's Comprehensive Care Plan, dated 01/19/2026, reflected, The resident uses anti-anxiety medications Lorazepam r/t end of life care. Interventions included: Administer ANTI-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Record review of Resident #105's active (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician orders, dated 06/16/2026, reflected, Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 6 hours as needed for Terminal restlessness and Moderate anxiety. During an observation on 06/16/26 at 9:45 a.m. with LVN B of the 100 Hall nurse cart, revealed Resident #105's Lorazepam Oral Tablet 0.5 MG had a damaged blister bubble and the tablet still inside, at the time the medication cart was reviewed.During an interview with LVN B on 06/16/2026 at 10:00 a.m., she stated she did not notice the blisters were damaged before it was brought to her attention. She stated the nurses were responsible for inspecting the blister packs at every shift change when they did the narcotic count. LVN B stated if a narcotic blister seal was broken, the medication should be discarded and witnessed by two nurses. She stated that the risk of a damaged blister would be the potential for drug diversion and contamination of medication. She stated the risk to the resident was medication not being effective if it was compromised. She stated that she had been in-serviced on medication storage. 4. Record review of Resident #11's Quarterly MDS Assessment, dated 05/12/2026, reflected Resident #11 was admitted on [DATE]. She was a [AGE] year-old female and had a BIMS score of 11 which indicated moderate cognitive impairment. The resident had diagnoses which included bipolar disorder (a mental health condition that causes extreme, uncontrollable shifts in a person's mood, energy, and activity levels), Muscle weakness and Chronic Obstructive Pulmonary Disease (a progressive, irreversible disease that blocks airflow, making it difficult to breathe). Record review of Resident #11's Comprehensive Care Plan, initiated 05/12/2026, reflected no areas indicating she could have medication at bedside or self-medicate. Record review of Resident #11's active physician orders, dated 06/16/2026, reflected no orders indicating she could have medication at beside or self-medicate. During an observation and interview on 06/15/20226 at 9:00 a.m., during initial tour, revealed 1 white oval pill and 2 white round pills in a medication cup on Resident #11's beside table. Resident #11 stated CMA A left it for her and that she would take it later. During an interview on 06/15/2026 at 9:02 a.m., LVN A revealed CMA A administered Resident #11's morning medication. She stated she always ensured the residents swallowed their medication before leaving the room but did not know why CMA A left medication in a cup for Resident #11. She stated Resident #11 did not have physician orders to self-medicate or have medication at bedside. She stated the risk to the resident was over medicating or missing to take medication. She stated she had been in-serviced on medication administration and medication storage and labelling. During an interview on 06/16/2026 at 1:00 pm, CMA A stated that Resident #11 asked her to leave the medications on her bedside table. CMA A stated she was supposed to watch the resident take her medication before leaving the room or bring it later to Resident #11 when she was ready to take her medication but failed to do that. CMA A stated the risk was Resident #11 missing the medication or another resident taking the medication. She stated she had been in-serviced on medication administration and medication storage and labelling. During an interview on 06/16/26 at 1:58pm, the DON stated if a blister pack seal was broken on any controlled medications, the pill should be discarded and witnessed by two nurses. The DON stated it was not acceptable to keep a pill in a blister pack that was opened. The DON stated the risk would be losing the medication because the seal was broken. She stated nurses and medication aides were responsible for checking the medication blister packs for broken seals during medication count on the change of shifts. The DON stated the ADON audited the medication carts bi-weekly, then the pharmacy consultant audited the medication room, and the medication carts every month. She stated the nurses and the medication aides had been in-serviced on medication storage and administration.During an interview on 06/16/26 at 1:58 pm, the DON stated if the medication aides and nurses were doing the medications rights, they should be able to ensure they gave the right medication to the right patient. She stated the medication aides and nurses were expected to stand and watch residents swallow their medications before exiting the room. Record review of the facility's policy titled, Storage of Medication, dated 6/24/2025 reflected the following: Drugs and biologicals are stored in the packaging containers or other dispensing systems they are received. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or destroyed. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.