

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2024
NAME OF PROVIDER OR SUPPLIER  Greenhill Villas		STREET ADDRESS, CITY, STATE, ZIP CODE 2530 Greenhill Rd Mount Pleasant, TX 75455	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44596</p> <p>46929</p> <p>Based on interview and record review, the facility failed to ensure residents the right to be free from abuse and/or neglect for 1 (Resident #1) of 15 residents reviewed for abuse and/or neglect.</p> <p>The facility failed to prevent CNA A from committing verbal abuse by telling Resident #1 to hush while he was upset.</p> <p>This failure could place residents at risk of emotional harm.</p> <p>Findings included:</p> <p>1. Record review of Resident #1's face sheet, dated 05/08/24, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included spastic hemiplegia affecting right dominate side (a condition in which the part of the brain controlling movement is damaged), neuromuscular dysfunction of bladder (a dysfunction of the bladder caused by nervous system problems), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a disorder that causes intense, excessive and persistent worry and fear about everyday situations), paraplegia (inability to voluntarily move the lower parts of the body), and multiple sclerosis (an autoimmune condition that affects the brain and spinal cord).</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 02/23/24, indicated he was able to make himself understood and was able to understand others. He had a BIMS score of 15, which indicated intact cognition. He had impairment of all four of his extremities. He used a wheelchair for a mobility device. He was totally dependent on staff for his activities of daily living. He was always incontinent of both bowel and bladder.</p> <p>Record review of CNA A's undated Employee Disciplinary Report stated:</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/8 [CNA A] was suspended pending an investigation into allegations of abuse; those allegations were substantiated. [CNA A] has violated the Corporate Code of Conduct by having numerous violations of the rules of conduct not limited to one type of offense, but rather to multiple infractions. [CNA A] is aware of these policies and procedures as indicated by her signature on the Employee Handbook Acknowledgement form. [CNA A] meets criteria for immediate termination. [CNA A] will be terminated effective immediately.</p> <p>Record review of the Facility's Provider Investigation Report dated 04/11/24, stated in the Administrator's investigation summary section:</p> <p>. In an interview with [CNA A] by telephone she stated that she answered [Resident #1's] light that night and he told her to change him because he was wet. She said she told him he couldn't be wet because they just changed him. She said he started yelling at her and saying that she was hollering at him. She said she told him she was just a loud talker and was not hollering. She then told him that she would go get his aide and let her know he wanted to be changed. She said she then turned the call light off and told [CNA H] that he wanted changed. She stated that [CNA H] did change him. During an interview with aides working with [CNA A] that night, 4/4/24. [CNA H] stated that she heard loud talking from [Resident #1's] room from both [CNA A] and [Resident #1] but mostly it was from [Resident #1] yelling at [CNA A]. She said she heard [CNA A] say to [Resident #1] in a non-threatening way hush as if to attempt to calm him down and that she was going to find his aide and tell her he needs changed.</p> <p>During an interview on 05/08/24 at 8:35AM, Resident #1 said he remembered CNA A. He said in early April 2024 CNA A was taking care of him and he turned on his light and she came in, turned off the light and raised her voice at him. He said she told him I will come help you when I have time to help you. You do not need to turn on the light. He said she continued to yell at him and even told him to hush. He said she then turned off his call light and did not help him. He said after that incident he was afraid of CNA A and he was afraid that she may neglect his care.</p> <p>During an interview on 05/08/24 at 10:57AM, CNA H said she worked on April 5th with CNA A. She said she saw CNA A answer the call light for Resident #1. She said she heard CNA A tell Resident #1 to be quiet and she even heard CNA A tell Resident #1 to hush during the argument. She said it was never okay to tell a resident to hush.</p> <p>During an interview on 05/08/24 at 01:26PM, ADON K said she had worked at the facility since 04/11/24. She said if a resident was upset and a CNA came in the room and told a resident to hush, that would be verbal abuse, especially if it made the resident feel scared.</p> <p>During an interview on 05/08/24 at 1:30PM, the DON said she had worked in the facility about 2 weeks. She said if a resident was upset, and a CNA answered the light and told the resident to hush that would be verbal abuse.</p> <p>During an interview on 05/08/24 at 1:45PM, the Administrator in Training said that if a resident was upset and a CNA answered the call light and told the resident to hush, then that could be considered verbal abuse. She said she did not think the facility referred CNA A after she was terminated.</p> <p>Record review of the facility's policy, Abuse/Neglect, last revised 03/29/18, stated:</p> <p>(continued on next page)</p>		

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F 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	.Verbal Abuse: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability .Abuse as defined in 40 TAC 19.101(1) .		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44596</p> <p>48958</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 12 residents (Resident #2) reviewed for accidents and hazards in that:</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure the back door on the memory care unit was monitored and secured while there was a malfunction with the doors locking. During this time Resident #2 eloped.</li> <li>2. The facility failed to monitor and supervise resident in the memory care unit who was an elopement risk.</li> <li>3. The facility failed to in-service staff on elopement response.</li> </ol> <p>These failures could place residents at risk for inadequate supervision and accidents.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #2's face sheet, dated 05/07/24, indicated she was a [AGE] year-old female, admitted on [DATE]. Her diagnoses included dementia with agitation(a term used to describe a group of symptoms affecting memory, thinking and social abilities), diabetes mellitus type 2 with diabetic neuropathy (a long-term medical condition in which your body doesn't use insulin properly, resulting in unusual blood sugar levels), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and alzheimer's disease (a progressive disease that destroys memory and other important mental functions).</li> </ol> <p>Record review of the annual MDS assessment, dated 02/21/24, indicated Resident #2 did not have a BIMS score conducted, which indicated severe cognitive impairment. The MDS indicated she exhibited behaviors of wandering at least 1-3 of 7 days of the assessment. Resident #2 required limited assistance with bed mobility, transfers, walking in room and the corridor, locomotion on and off unit, and eating. She required extensive assistance with dressing, toileting, and personal hygiene. She required insulin injections 7 of 7 days of the assessment.</p> <p>Record review of Resident #2's care plan, last edited 02/28/24, indicated a problem of resident is at risk for wandering around facility with/without purpose. Interventions included:</p> <ul style="list-style-type: none"> <li>*disguise exits.</li> <li>*distract resident from wandering by offering pleasant diversion.</li> <li>*identify wandering patterns.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the weather on 11/26/2023 at 3:53 PM the temperature was 51 degrees outside .</p> <p><a href="https://www.wunderground.com/history/daily/us/tx/[facility city]/KGGG/date/2023-11-26">https://www.wunderground.com/history/daily/us/tx/[facility city]/KGGG/date/2023-11-26</a></p> <p>Record review of Resident #2's elopement risk assessment, completed on 11/26/23, indicated Resident #2 was at risk for elopement. The assessment indicated Resident #2 had a history of wandering.</p> <p>Record review of Resident #2's provider investigation report completed by previous Administrator for her elopement incident indicated memory care unit doors were not locking at 3:00 PM on 11/27/2023 and staff in unit notified of findings. Resident was found outside of memory care unit on grass walking towards the smoke section. Resident was unable to give description. Previous Administrator wrote a statement on 12/1/2023 indicated . Resident # 2 lives in on the secure unit. On 11/26/2023 she was found in the parking area behind the kitchen by laundry aide C. The smoking area is also by the kitchen where laundry aide C was sitting with other residents. Laundry aide C approached her and kept her with her while she allowed the other residents to smoke. Laundry aide C called someone from inside the facility to come and take her back to the unit. She arrived back in the unit around 4:00 PM. Resident #2 was assessed by LVN B. There were adverse effects or issues from skin assessments for Resident #2. Staff on unit CNA E and CNA F reported that they had just seen her about 10 minutes prior to her being returned. Maintenance was informed who came immediately to check the secured doors. He conducted an in-service to staff on how to reset the mag locks on the unit. An elopement in-service was conducted and a local fire safety company was informed to check the secured doors. The Maintenance Supervisor has been monitoring the secured doors to ensure safety to the residents. The doors are working correctly at this time.</p> <p>Record review of in-service on Elopement Assessment and Risk Assessment, completed on 11/27/2023.</p> <p>Record review of in-service on Abuse and Neglect Policy, completed on 11/27/2023.</p> <p>During an interview on 05/07/2024 at 1:29 PM Medication Aide G said Resident #2 walks and roam the halls all the time.</p> <p>During an interview and observation on 05/07/2024 at 1:34 PM Resident #2 was sitting on the couch watching television with other residents. Surveyor introduced herself to resident and asked Resident #2 could we talk; she responded with a smile and continued to watch television.</p> <p>During an observation on 05/07/2024 at 1:37 PM Surveyor tried to Exit the door on the long hallway of the memory care unit and was unsuccessful. The doorbell did go off on the door when exit was attempted.</p> <p>During observation on 05/07/2024 at 1:40 PM Surveyor tried to exit the door close to the front desk and was unsuccessful. The door beeped when exit was attempted.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/07/2024 at 1:47 PM LVN B said sometimes the lights flickers, because the lights go off. LVN B said on 11/26/2023, the day of the incident she called the previous Administrator to notify her that the doors were unlocked throughout the building . LVN B said Resident #2 went out of the back door at the end of the hallway on the memory care unit when the doors were unlocked. LVN B said laundry aide C found Resident #2 outside on the grass behind the kitchen area. LVN B said when Resident #2 was returned to the memory care unit; then her and LVN D performed a head-to-toe skin assessment on Resident #2. LVN B said Resident #2 did not have any injuries. LVN B said the CNA's that were working that day were CNA F and CNA E. LVN B said after she performed the assessment on Resident #2 she had CNA F and CNA E to sit at the exit doors until the doors started back locking. LVN B said the administrator called Maintenance Supervisor to fix the door system. LVN B said there was a reset button at the nurses' station if the doors lose power due to the light flickering, that button will reset the doors to be locked. LVN B said she was not sure if the button was there prior to that incident or it was installed after the incident occurred.</p> <p>During an interview on 05/07/2024 at 1:56 PM laundry aide C said when she first saw Resident #2 she was walking up to the back door of the kitchen from behind some cars. Laundry aide C said she left the smoking area and brought Resident #2 back to the smoking area. Laundry aide C said she sat Resident #2 down, then got someone from the kitchen to go get a CNA to assist Resident #2 back to the unit. Laundry aide C said she does not remember what Resident # 2 wore that day, but she remembers it was not warm and she does not remember the temper being cold.</p> <p>During an interview on 05/07/2024 at 2:23 PM CNA E said she just knew the lock system was not down when she came into work. CNA E said she thought the system was down about 5 hours. CNA E said when the door system was down there should be someone sitting where they can see the front and back door. CNA E said there should have been a staff member watching the doors before Resident #2 got out of the facility. CNA E said she was passing medications at the time of the Resident #2 elopement. CNA E said CNA F was supposed to be watching the doors while assisting other residents on the unit.</p> <p>During an interview on 05/07/2024 at 2:30 PM Maintenance Supervisor said anytime the fire alarms goes off or the facility lose power the system goes offline and the doors unlock. He said the there are also intermittent times when the system goes offline. He said there was a green reset button at each nursing station . He said he if he remembered correctly he believed one of the memory care unit residents pulled the fire alarm. He said he did not have system inspected after the system malfunctioned with the doors, because he knew what cause the issue. He said once the fire alarms went off the doors are supposed to be unlocked, but this time they did not relock. He said he called a staff member at and he explained to him that he needed to push the green button to reset and activate the doors to lock. He said there had been different repairs made since the incident with the memory care unit door system.</p> <p>Attempted to call CNA F on 05/08/2024 at 10:34 AM, phone number was disconnected.</p> <p>During an interview on 05/08/2024 at 1:55 PM the Director of Nursing said she was going to have to look up the facility policy of elopement, because she has only been working at the facility a week. She said if there was a resident to elopement while she was in charge she would notify the Administrator first on the situation, then have all staff members to check all the rooms for the resident. She said after checking all the rooms in the facility; she would notify the local police. She said she would notify the resident responsible party and primary care physician of the situation.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Attempted to call previous Administrator on 05/08/2024 at 2:15 PM, no answer .</p> <p>Record review of a facility Elopement Response Policy revised dated 01/2023 indicated .nursing personnel must report and investigate all reports of missing residents. When and elopement has occurred or is suspected, our elopement response plan will be immediately implanted.</p> <p>Record review of a facility Abuse and Neglect Policy revised dated 05/09/2017 indicated .the facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreat of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility.</p>		