STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676241	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhill Villas	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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interview and record review, the facility failed to provide residents with personal privacy and confidentiality of his or her personal and medical records for 1 of 1 (Resident #1) resident reviewed for resident rights. The facility did not ensure the treatment nurse used a secure telephonic device to communicate with the wound nurse NP. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth. Findings included: Record review of Resident #1's face sheet, dated 09/09/24, indicated Resident #1 was originally admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus without complications (chronic condition that affects the way the body processes blood sugar), and laceration without foreign body (an object originating outside the body if an organism), right lower leg. Record review of the quarterly MDS assessment, dated 07/08/24, indicated Resident #1 made herself understood and usually understood others. Resident #1's BIMS score was 5, which indicted her cognition was severely impaired. Resident #1 required substantial/maximal assistance with upper and lower body dressing and taking off footwear. Resident #1 required setup or clean-up assistance with eating, supervision with oral hygiene and partial/moderate assistance with personal hygiene. Resident #1 was at risk for developing pressure ulcers/injuries and did not have any skin problems. Record review of Resident #1's comprehensive care plan dated 07/23/2024 did not reveal a care plan for the laceration to her right lower leg. Record review of Resident #1 event nurses' note dated 08/22/24 completed by RN A indicated Resident was sitting in her wheelchair a doorway. Resident has a laceration to right lower leg, shin, with horizontal laceration noted with gross amount of blood puddled at feet and around the room, pressure applied with towel. Resident unable to provide description of accident. EMS called and resident transferred to a local hospital for further evaluation and treatment. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1 after-visit summary dated 08/22/2024 discharge instructions indicated to keep wound clean and dry, apply pressure dressings as needed for bleeding. Keep the bandage and ace wrap (wound care supplies) on the wound for the next 24 hours before changing. Follow up with PCP or return to the ER in 10-14 days for suture removal. Record review of a text message dated 08/23/24 beginning at 3:18 p.m. between the treatment nurse and wound care NP indicated a picture of the laceration to Resident #1's right shin was sent to the wound care NP informing of the wound and requesting treatment orders. The wound care NP sent back an order for medi-honey, collagen powder, and gauze island border QD. During an interview on 09/07/24 at 12:33 p.m., the treatment nurse stated it was reported to her that Resident #1 had an incident that required her to be sent to the local hospital for treatment and evaluation. The treatment nurse stated when Resident #1 returned from theER on [DATE] she had orders to leave the dressing in place for 24 hrs. The treatment nurse stated on 08/23/24 she removed the dressing and assessed the laceration but failed to take measurements or document the laceration. The treatment nurse stated after she removed the bandage, she took her personal cell phone and sent a picture of the laceration to the wound care NP. In the text message it also included the resident name. The treatment nurse stated he replied with an order for medi-honey, collagen powder, and gauze island border QD. The treatment nurse stated normally if there was something new such as a wound she would normally call or send a text requesting orders. The treatment nurse stated she normally did not send pictures, but she needed the NP to see her wound. The treatment nurse stated there was no other way to send pictures except through her personal phone. The treatment nurse stated this failure was a HIPPA violation and put Resident #1 at risk for confidentiality of her personal medical records. During an interview on 09/09/24 at 3:37 p.m., the Administrator stated she learned that the treatment nurse had Resident #1's wound picture and name in her name after the state surveyor intervention. The Administrator stated there was not a system in place for overseeing and monitoring HIPPA violations. The Administrator stated the risk of having residents' personal information in an unsecured telephonic device was disclosing Resident #1 medical records to some that might not need to know. Record review of facility undated policy titled, Resident Rights,, indicated, A facility must trat each resident with respect, dignity, and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. The facility must protect and promote the rights of the resident . Privacy and confidentiality. 3. The resident has a right to secure and confidential personal and medical records .

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observation, interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, for 1 of 3 (Resident #1) residents reviewed for abuse. 1. The facility failed to implement the abuse and neglect policy and procedure regarding reporting an injury of unknown origin. 2.The facility did not implement their policy on reporting neglect for laceration of unknown origin for Resident #1 to the abuse coordinator (Administrator) or HHSC. These failures could place the residents at increased risk for abuse and neglect. Findings included: Record review of the facility policy for Abuse/Neglect revised 03/29/2018, indicated, The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation as defined in this subpart. This includes but was not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms E. Reporting .Facility employees must report allegations of abuse, neglect, exploitation, mistreatments of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 07/10/2019 . a. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation . Record review of Resident #1's face sheet, dated 09/09/24, indicated Resident #1 was originally admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus without complications (chronic condition that affects the way the body processes blood sugar), and laceration without foreign body (an object originating outside the body if an organism), right lower leg. Record review of the quarterly MDS assessment, dated 07/08/24, indicated Resident #1 made herself understood and usually understood others. Resident #1's BIMS score was 5, which indicated her cognition was severely impaired. Resident #1 required substantial/maximal assistance with upper and lower body dressing and taking off footwear. Resident #1 required setup or clean-up assistance with eating, supervision with oral hygiene and partial/moderate assistance with personal hygiene. Resident #1 was at risk for developing pressure ulcers/injuries and did not have any skin problems. Record review of Resident #1's comprehensive care plan dated 07/23/2024 did not reveal a care plan for the laceration to her right lower leg. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1 event nurses' note dated 08/22/24 completed by RN A indicated Resident was sitting in her wheelchair a doorway. Resident has a laceration to right lower leg, shin, with horizontal laceration noted with gross amount of blood puddled at feet and around the room, pressure applied with towel. Resident unable to provide description of accident. EMS called and resident transferred to a local hospital for further evaluation and treatment. Record review of Resident #1's electronic medical records dated 09/07/24 did not address how Resident #1 obtained her injury to her right lower leg. Record review of a statement dated 08/22/24 completed by the ADON indicated Upon resident return to facility. Resident was interviewed by the ADON. Family members, LVN E, and wound nurse present. Resident states she bumped leg on bed. Family is present and is aware of interventions to pad bed with pool noodles to prevent injury. Record review of a statement dated 08/22/24 completed by the Administrator indicated I was asked to come to Resident #1 room by the ADON. Resident #1 had bumped her leg on her bed. Family members, LVN E and treatment nurse in room. Family is aware of interventions that we will pad bed with pool noodles to prevent any further injury. During an observation and interview on 09/07/24 at 10:57 a.m., Resident #1 was currently at a local hospital. Resident #1 was lying in bed with family at bedside. An attempted interview with Resident #1, indicated she was non-interview able. During an interview on 09/09/24 at 12:01 p.m., CNA M stated she was at the nursing station charting when she heard someone yelled Help, Help on 08/22/24. CNA M stated she got up and went down the hall and saw Resident #1 sticking her head out of her room doorway. CNA M stated when she got to her room, she noticed there was blood on her right lower leg and floor. CNA M stated there was puddles of blood all in her room. CNA M stated she immediately called out for RN A. CNA M stated RN A came down and assessed her. CNA M stated Resident #1 was unable to tell her and RN A what happened. CNA M stated her, and RN A searched the room to see how the injury occurred but was unable to confirm the incident. During a telephone interview on 09/09/24 at 1:22 p.m., RN A stated she was called to the room by CNA M on 08/22/24, when she got there Resident #1 was sitting in her wheelchair wearing a bra and pull up. RN A stated she kept asking Resident #1 what happened, but she could not remember what occurred. RN A stated she assessed Resident #1 and called EMS for further evaluation and treatment. RN A stated she tried to contact the DON/ADON and Administrator via phone to report the incident, but they did not answer the call. RN A stated reporting timely was important to ensure the safety of the residents and staff. RN A stated the risk of not reporting timely was abuse and neglect. During an interview on 09/09/24 at 9:25 a.m., the DON stated she was notified by RN A via text the night of the incident on 08/22/24, but she was asleep and did not see it until the next morning. The DON stated she followed up on the incident. The DON stated since the incident was unwitnessed and Resident #1 was unable to tell how the incident occurred, the incident should have been reported to state within two hours. The DON stated it was important to report allegations to ensure resident safety. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/09/24 at 3:26 p.m. Resident #1's family member stated she recall the ADON and Administrator coming into Resident #1's room after she returned to the facility to discuss interventions that would be implemented. Resident #1's family member stated when Resident #1 was asked by the ADON and Administrator about how the injury occurred Resident #1 was unable to recall the incident. During an interview on 09/09/24 at 2:16 p.m., The Administrator stated she was the Abuse Coordinator for the facility. The Administrator stated she learned of the incident re: the laceration to Resident #1 right lower leg the following morning on 08/22/24 during morning meeting. The Administrator stated RN A should have notified her when the resident could not recall the incident during her assessment. The Administrator stated if she would have known of the incident, she would have reported it within 2 hours. The Administrator stated her and the ADON obtained statements from Resident #1, but no thorough investigation was completed. The Administrator stated she was responsible for overseeing by daily morning meetings and in-services to ensure changes of condition was addressed and reported to appropriate entities in a timely manner. The Administrator stated it was important to report an allegation of abuse to verify if anyone was connected to the abuse. The Administrator stated this failure could potentially put Resident #1 at risk for infection, abuse, or neglect.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observation, interview, and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source were reported immediately, but no later than 2 hours after the allegation was made, for 1 of 3 (Resident #1) residents reviewed for abuse and neglect. The facility failed to report Resident #1's laceration to right lower leg, an injury of unknown origin, timely to HHSC. This failure to report could place the residents at risk for abuse. Findings included: Record review of Resident #1's face sheet, dated 09/09/24, indicated Resident #1 was originally admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus without complications (chronic condition that affects the way the body processes blood sugar), and laceration without foreign body (an object originating outside the body if an organism), right lower leg. Record review of the quarterly MDS assessment, dated 07/08/24, indicated Resident #1 made herself understood and usually understood others. Resident #1's BIMS score was 5, which indicated her cognition was severely impaired. Resident #1 required substantial/maximal assistance with upper and lower body dressing and taking off footwear. Resident #1 required setup or clean-up assistance with eating, supervision with oral hygiene and partial/moderate assistance with personal hygiene. Resident #1 was at risk for developing pressure ulcers/injuries and did not have any skin problems. Record review of Resident #1's comprehensive care plan dated 07/23/2024 did not reveal a care plan for the laceration to her right lower leg. Record review of Resident #1 event nurses' note dated 08/22/24 completed by RN A indicated Resident was sitting in her wheelchair a doorway. Resident has a laceration to right lower leg, shin, with horizontal laceration noted with gross amount of blood puddled at feet and around the room, pressure applied with towel. Resident unable to provide description of accident. EMS called and resident transferred to a local hospital for further evaluation and treatment. Record review of Resident #1's electronic medical records dated 09/07/24 did not address how Resident #1 obtained her injury to her right lower leg. Record review of a statement dated 08/22/24 completed by the ADON indicated Upon resident return to facility. Resident was interviewed by the ADON. Family members, LVN E, and wound nurse present. Resident states she bumped leg on bed. Family is present and is aware of interventions to pad bed with pool noodles to prevent injury. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a statement dated 08/22/24 completed by the Administrator indicated I was asked to come to Resident #1 room by the ADON. Resident #1 had bumped her leg on her bed. Family members, LVN E and treatment nurse in room. Family is aware of interventions that we will pad bed with pool noodles to prevent any further injury. During an observation and interview on 09/07/24 at 10:57 a.m., Resident #1 was currently at a local hospital. Resident #1 was lying in bed with family at bedside. An attempted interview with Resident #1, indicated she was non-interview able. During an interview on 09/09/24 at 12:01 p.m., CNA M stated she was at the nursing station charting when she heard someone yelled Help, Help on 08/22/24. CNA M stated she got up and went down the hall and saw Resident #1 sticking her head out of her room doorway. CNA M stated when she got to her room, she noticed there was blood on her right lower leg and floor. CNA M stated there was puddles of blood all in her room. CNA M stated she immediately called out for RN A. CNA M stated RN A came down and assessed her. CNA M stated Resident #1 was unable to tell her and RN A what happened. CNA M stated her, and RN A searched the room to see how the injury occurred but was unable to confirm the incident. During a telephone interview on 09/09/24 at 1:22 p.m., RN A stated she was called to the room by CNA M on 08/22/24, when she got there Resident #1 was sitting in her wheelchair wearing a bra and pull up. RN A stated she kept asking Resident #1 what happened, but she could not remember what occurred. RN A stated she assessed Resident #1 and called EMS for further evaluation and treatment. RN A stated she tried to contact the DON/ADON and Administrator via phone to report the incident, but they did not answer the call. RN A stated reporting timely was important to ensure the safety of the residents and staff. RN A stated the risk of not reporting timely was abuse and neglect. During an interview on 09/09/24 at 9:25 a.m., the DON stated she was notified by RN A via text the night of the incident on 08/22/24, but she was asleep and did not see it until the next morning. The DON stated she followed up on the incident. The DON stated since the incident was unwitnessed and Resident #1 was unable to tell how the incident occurred, the incident should have been reported to state within two hours. The DON stated it was important to report allegations to ensure resident safety. During an interview on 09/09/24 at 3:26 p.m. Resident #1's family member stated she recall the ADON and Administrator coming into Resident #1's room after she returned to the facility to discuss interventions that would be implemented. Resident #1's family member stated when Resident #1 was asked by the ADON and Administrator about how the injury occurred Resident #1 was unable to recall the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/09/24 at 2:16 p.m., The Administrator stated she was the Abuse Coordinator for the facility. The Administrator stated she learned of the incident re: the laceration to Resident #1 right lower leg the following morning on 08/22/24 during morning meeting. The Administrator stated RN A should have notified her when the resident could not recall the incident during her assessment. The Administrator stated if she would have known of the incident, she would have reported it within 2 hours. The Administrator stated her and the ADON obtained statements from Resident #1, but no thorough investigation was completed. The Administrator stated she was responsible for overseeing by daily morning meetings and in-services to ensure changes of condition was addressed and reported to appropriate entities in a timely manner. The Administrator stated it was important to report an allegation of abuse to verify if anyone was connected to the abuse. The Administrator stated this failure could potentially put Resident #1 at risk for infection, abuse, or neglect. Record review of the facility policy for Abuse/Neglect revised 03/29/2018, indicated, The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation as defined in this subpart. This includes but was not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms E. Reporting .Facility employees must report allegations of abuse, neglect, exploitation, mistreatments of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 07/10/2019 . a. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observation, interview, and record review, the facility failed to have evidence that all alleged violations were thoroughly investigated for 1 of 3 (Resident #1) residents reviewed for abuse and neglect. The facility failed to conduct a thorough investigation when Resident #1 obtained a laceration to her right lower leg. This failure could place residents at risk of abuse and neglect. Findings included: Record review of Resident #1's face sheet, dated 09/09/24, indicated Resident #1 was originally admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus without complications (chronic condition that affects the way the body processes blood sugar), and laceration without foreign body (an object originating outside the body if an organism), right lower leg. Record review of the quarterly MDS assessment, dated 07/08/24, indicated Resident #1 made herself understood and usually understood others. Resident #1's BIMS score was 5, which indicated her cognition was severely impaired. Resident #1 required substantial/maximal assistance with upper and lower body dressing and taking off footwear. Resident #1 required setup or clean-up assistance with eating, supervision with oral hygiene and partial/moderate assistance with personal hygiene. Resident #1 was at risk for developing pressure ulcers/injuries and did not have any skin problems. Record review of Resident #1's comprehensive care plan dated 07/23/2024 did not reveal a care plan for the laceration to her right lower leg. Record review of Resident #1 event nurses' note dated 08/22/24 completed by RN A indicated Resident was sitting in her wheelchair a doorway. Resident has a laceration to right lower leg, shin, with horizontal laceration noted with gross amount of blood puddled at feet and around the room, pressure applied with towel. Resident unable to provide description of accident. EMS called and resident transferred to a local hospital for further evaluation and treatment. Record review of Resident #1's electronic medical records dated 09/07/24 did not address how Resident #1 obtained her injury to her right lower leg. Record review of a statement dated 08/22/24 completed by the ADON indicated Upon resident return to facility. Resident was interviewed by the ADON. Family members, LVN E, and wound nurse present. Resident states she bumped leg on bed. Family is present and is aware of interventions to pad bed with pool noodles to prevent injury. Record review of a statement dated 08/22/24 completed by the Administrator indicated I was asked to come to Resident #1 room by the ADON. Resident #1 had bumped her leg on her bed. Family members, LVN E and treatment nurse in room. Family is aware of interventions that we will pad bed with pool noodles to prevent any further injury. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 09/07/24 at 10:57 a.m., Resident #1 was currently at a local hospital. Resident #1 was lying in bed with family at bedside. An attempted interview with Resident #1, indicated she was non-interview able. During an interview on 09/09/24 at 12:01 p.m., CNA M stated she was at the nursing station charting when she heard someone yelled Help, Help on 08/22/24. CNA M stated she got up and went down the hall and saw Resident #1 sticking her head out of her room doorway. CNA M stated when she got to her room, she noticed there was blood on her right lower leg and floor. CNA M stated there was puddles of blood all in her room. CNA M stated she immediately called out for RN A. CNA M stated RN A came down and assessed her. CNA M stated Resident #1 was unable to tell her and RN A what happened. CNA M stated her, and RN A searched the room to see how the injury occurred but was unable to confirm the incident. During a telephone interview on 09/09/24 at 1:22 p.m., RN A stated she was called to the room by CNA M on 08/22/24, when she got there Resident #1 was sitting in her wheelchair wearing a bra and pull up. RN A stated she kept asking Resident #1 what happened, but she could not remember what occurred. RN A stated she assessed Resident #1 and called EMS for further evaluation and treatment. RN A stated she tried to contact the DON/ADON and Administrator via phone to report the incident, but they did not answer the call. RN A stated reporting timely was important to ensure the safety of the residents and staff. RN A stated the risk of not reporting timely was abuse and neglect. During an interview on 09/09/24 at 9:25 a.m., the DON stated she was notified by RN A via text the night of the incident on 08/22/24, but she was asleep and did not see it until the next morning. The DON stated she followed up on the incident. The DON stated since the incident was unwitnessed and Resident #1 was unable to tell how the incident occurred, the incident should have been reported to state within two hours. The DON stated it was important to report allegations to ensure resident safety. During an interview on 09/09/24 at 3:26 p.m. Resident #1's family member stated she recall the ADON and Administrator coming into Resident #1's room after she returned to the facility to discuss interventions that would be implemented. Resident #1's family member stated when Resident #1 was asked by the ADON and Administrator about how the injury occurred Resident #1 was unable to recall the incident. During an interview on 09/09/24 at 2:16 p.m., The Administrator stated she was the Abuse Coordinator for the facility. The Administrator stated she learned of the incident re: the laceration to Resident #1 right lower leg the following morning on 08/22/24 during morning meeting. The Administrator stated RN A should have notified her when the resident could not recall the incident during her assessment. The Administrator stated if she would have known of the incident, she would have reported it within 2 hours. The Administrator stated her and the ADON obtained statements from Resident #1, but no thorough investigation was completed. The Administrator stated she was responsible for overseeing by daily morning meetings and in-services to ensure changes of condition was addressed and reported to appropriate entities in a timely manner. The Administrator stated it was important to report an allegation of abuse to verify if anyone was connected to the abuse. The Administrator stated this failure could potentially put Resident #1 at risk for infection, abuse, or neglect. (continued on next page)

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Greenhill Villas	2530 Greenhill Rd Mount Pleasant, TX 75455

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy for Abuse/Neglect revised 03/29/2018, indicated, F. Investigation. Comprehensive investigations will be the responsibility of the Administrator and/or Abuse Preventionist. All allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated .6. The Abuse Preventionist and/or administrator will conduct a thorough investigation of the incident (s) .

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observations, interviews, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 3 (Resident #1) residents reviewed for quality of care. 1. The treatment nurse failed to transcribe Resident #1's physician orders for wound care and provide wound care (clean with normal saline/wound wash, pat dry, apply collagen powder, med honey pad and secure with gauze island adhesive border once daily) to Resident #1's right lower shin from 08/23/24-08/31/24 as ordered resulting in hospitalization with a diagnosis of cellulitis (bacterial skin infection). 2. The facility failed to assess, document, and monitor for Resident #1's wound. An IJ was identified on 09/09/24. The IJ template was provided to the facility on [DATE] at 12:05 p.m. While the IJ was removed on 09/09/24, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents of risk for not receiving appropriate care and treatment, a decreased quality of life, or death. Findings included: Record review of Resident #1's face sheet, dated 09/09/24, indicated Resident #1 was originally admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus without complications (chronic condition that affects the way the body processes blood sugar), and laceration without foreign body (an object originating outside the body if an organism), right lower leg. Record review of the quarterly MDS assessment, dated 07/08/24, indicated Resident #1 made herself understood and usually understood others. Resident #1's BIMS score was 5, which indicated her cognition was severely impaired. Resident #1 required substantial/maximal assistance with upper and lower body dressing and taking off footwear. Resident #1 required setup or clean-up assistance with eating, supervision with oral hygiene and partial/moderate assistance with personal hygiene. Resident #1 was at risk for developing pressure ulcers/injuries and did not have any skin problems. Record review of Resident #1's comprehensive care plan dated 07/23/2024 did not reveal a care plan for the laceration to her right lower leg. Record review of Resident #1 event nurses' note dated 08/22/24 completed by RN A indicated Resident was sitting in her wheelchair a doorway. Resident has a laceration to right lower leg, shin, with horizontal laceration noted with gross amount of blood puddled at feet and around the room, pressure applied with towel. Resident unable to provide description of accident. EMS called and resident transferred to a local hospital for further evaluation and treatment. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1 after-visit summary dated 08/22/2024 discharge instructions indicated to keep wound clean and dry, apply pressure dressings as needed for bleeding. Keep the bandage and ace wrap (wound care supplies) on the wound for the next 24 hours before changing. Follow up with PCP or return to the ER in 10-14 days for suture removal. Record review of a text message dated 08/23/24 beginning at 3:18 p.m. between the treatment nurse and wound care NP indicated a picture of the laceration to Resident #1's right shin was sent to the wound care NP informing of the wound and requesting treatment orders. The wound care NP sent back an order for medi-honey, collagen powder, and gauze island border QD. Record review of Resident #1's electronic monitoring records dated 09/07/24 did not indicate there was documentation the ordered that was text from the wound care NP was transcribed to the MAR. Record review of the order listing report dated 09/09/2024 indicated Resident #1 had an order with a start date 08/30/24 to cleanse with normal saline/wound wash, pat dry, apply collagen powder (wound healing product), med honey pad (wound healing product) and secure with gauze island adhesive border once daily to her right lower shin. Record review of Resident #1's WAR between 08/23/24-08/31/24, did not indicate she received any treatments to her right shin. Record review of Resident #1's initial skin assessment dated [DATE] completed by the treatment nurse, indicated Resident #1 had a laceration that required stitches to her RLE. Record review of Resident #1's weekly skin assessment dated [DATE] completed by the treatment nurse indicated a laceration to lower leg resulting in ER visit and stitches with compression bandage in place with orders to not remove for 24 hours. Record review of Resident #1's weekly skin assessment dated [DATE] indicated a laceration and stitches to right lower leg. The assessment failed to include the size of the laceration, drainage, or treatment. Record review of Resident #1 initial wound evaluation and management summary dated 08/29/24 completed by the wound care NP indicated a dressing treatment plan to Resident #1 right lower shin was to apply collagen powder and leptospermum honey and secure with gauze island with boarder daily for 30 days. Record review of Resident #1 wound evaluation and management summary dated 09/05/24 completed by the wound care NP indicated a dressing treatment plan to Resident #1 right lower shin was to apply collagen powder, leptospermum honey, gauze packing strips and secure with gauze island with boarder daily for 23 days. The wound care NP also ordered labs, x-rays, and doxycycline (antibiotics) 100 mg po bid x 10 days related to wound healing. Record review of a progress note dated 09/06/24 completed by LVN B indicated Resident #1 was admitted to a local hospital for an infected wound. Record review of the hospital medical records dated 09/06/24 indicated Resident #1 had a diagnosis of cellulitis and was started on ceftriaxone (antibiotic) in the ED. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 09/07/24 at 10:55 a.m., Resident #1 was currently at a local hospital. The hospital nurse stated Resident #1 was admitted to the hospital with cellulitis. The hospital nurse stated Resident #1 had received IV antibiotics (Rocephin) up until the IV accidently came out. The hospital nurse stated Resident #1 refused to be sticked again. The hospital nurse stated she was currently received amoxicillin 875-125 mg by mouth at this time. During an observation and interview on 09/07/24 at 10:57 a.m., Resident #1 was lying in bed with family at bedside. An attempted interview with Resident #1, indicated she was non-interview able. Resident #1's family member stated her wound was horrible. Resident #1's family member stated that there was a concern of the wound not been treated correctly. Resident #1's family member removed the sheet from her right leg and Resident #1 was noted to have a dark black tissue covering the wound bed that appeared to be dead tissue. The wound bed appeared to have depth, unable to measure. The wound edges had a red purplish discoloration with 5 visible sutures. During an interview on 09/07/24 at 12:33 p.m., the treatment nurse stated it was reported to her by LVN E that Resident #1 had an incident that required her to be sent to the local hospital for treatment and evaluation. The treatment nurse stated when Resident #1 returned from theER on [DATE] she had orders to leave the dressing in place for 24 hrs. The treatment nurse stated on 08/23/24 she removed the dressing and assessed the laceration but failed to take measurements or document the laceration. The treatment nurse stated after she removed the bandage, she took her personal cell phone and sent a picture of the laceration to the wound care NP. The treatment nurse stated he replied with an order for medi-honey, collagen powder, and gauze island border QD. The treatment nurse stated she provided wound care Monday-Friday off the text message that was given but forgot to input the orders in PCC and document she completed wound care. The treatment nurse stated the weekend RN supervisor would have not none to provide wound care since she did not transcribe the wound care order from 08/23/24. The treatment nurse stated her and the charge nurses that performed the wound care should have checked off the wound care on the WAR as completed if the resident was provided wound care. The treatment nurse stated if it was not checked off on the WAR that meant the wound care was not completed. When asked why the order was not placed in PCC on 08/23/24, the treatment nurses stated, I forgot, no excuse. The treatment nurse stated the process when an order was given from the NP or MD, she should have clarified the order, enter the order in PCC, and notify the charge nurses, ADON and DON of all changes of wounds and treatments. The treatment nurse stated when the wound care NP came in to see Resident #1 on 08/29/24 after he completed his notes, she should have placed the orders in PCC on 08/29/24 not 08/31/24 and notified Resident #1's charge nurse, ADON and DON of the treatment. The treatment nurse stated this failure put Resident #1 at risk for an infection. During a telephone interview on 09/07/24 at 1:28 p.m., RN C stated she was the weekend RN supervisor. RN C stated she provided wound care to residents on the weekend. RN C stated she did not perform wound care to Resident #1 on 08/24/24 or 08/25/24 because there were no orders in PCC. RN C stated the only thing she did to Resident #1's right leg was to ensure the ace bandage was secured. RN C stated she did not notice any s/sx of infections. During an interview on 09/07/24 at 1:45 p.m., the ADON stated Resident #1 was sent to the local hospital on 09/06/24 for x-rays that the wound care NP ordered on 09/05/24. The ADON stated the treatment nurse did not have to do a wound assessment on 08/23/24 when she removed the bandage and assessed the wound. The ADON stated when a task such as wound care was completed by the treatment nurse she should have documented in PCC under WAR as completed. The ADON stated if the task was not checked off on the WAR that meant the wound care was not completed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 09/07/24 at 2:05 p.m., the Administrator stated she expected orders to be placed in PCC the day the order was given. The Administrator stated she expected documentation to be completed when an assessment or wound care was completed. The Administrator stated the DON was responsible for overseeing wound care/treatments. The Administrator stated these failures put Resident #1 at risk for an infection. During an interview on 09/09/24 at 9:36 a.m., the wound care NP stated he received a text message from the treatment nurse on 08/23/24 regarding Resident #1's laceration to her right leg. The wound care NP stated he replied with treatment orders that he expected her to start on 08/23/24. The wound care NP stated the outcome of the treatment not implemented was cellulitis. During an interview on 09/09/24 at 9:50 a.m., the DON stated she was unaware the treatment nurse received an order on 08/23/24 from the wound care NP and the order not been placed in PCC after the wound care NP visit on 08/29/24 until the state surveyor intervention. The DON stated the treatment nurse was responsible for ensuring wound care orders were implemented including not limited to wound treatments, antibiotics, etc. during rounds with the wound care NP or receiving the order on 08/23/24 via text message from the wound care NP. The DON stated the treatment nurse should have documented her assessment in PCC on 08/23/24 when she removed the dressing. The DON stated when the wound care was completed the treatment nurse should have documented in PCC under WAR as completed. The DON stated if the task was not checked off on the WAR that meant the wound care was not completed. When asked when an incident with a wound occurred did, she (DON) validate to ensure orders were in process, she stated, every morning I check the clinical dashboard for clinical alerts by reviewing the risk management and order listing report for residents with any skin related issues. The DON stated because the orders from 08/23/24 and 08/29/24 were not put in PCC the day the treatment nurse received them, there was no way her or the ADON could go in and validate the orders. The DON stated these failures could put Resident #1 at risk for infection and possible death. Record review of the facility policy titled, Skin Integrity Management, revised 10/05/16, indicated, 1. If wound is noted, performed an assessment, and initiate a treatment plan as soon as possible. Document in resident's chart, area of change, who you notified, and treatment applied . 3. Wound care should be performed as ordered by the physician . Record review of the facility's undated policy titled, Medication Orders,, indicated, 2. Documentation of the medication order . a. Each medication order is documented in the resident's medical record with the date, time and signature of the person receiving the order .The order is recorded on the physician order sheet, or the telephone order sheets (if it is a verbal order) and the MAR . b. the following steps are initiated to compete documentation: clarify the order, enter the orders on the medication order and receipt record, and transcribe newly prescribed medications on the MAR or treatment record . This was determined to be an Immediate Jeopardy (IJ) on 09/09/24 at 12:02 p.m. The Administrator was notified. The Administrator was provided with the IJ template on 09/09/24 at 12:05 p.m. The following plan of removal submitted by the facility was accepted on 09/09/24 at 2:28 p.m. and included the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/9/24 during an abbreviated survey a surveyor Identified an Immediate Jeopardy situation for F684. On 9/9/2024 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. F684 Quality of Care The facility failed to transcribe resident #1's physician orders for wound care and assess, document, and monitor resident #1's right shin wound from 8/23/24-8/31/24. Interventions: As of 9/9/2024 Resident #1 has returned to the facility and all wound treatment orders initiated. Treatment nurse completed wound care per physicians' orders on 9/9/2024. All residents in the facility received a skin assessment by the ADON/Tx Nurse/Regional compliance nurse/MDS nurse as of 9/9/2024. No new skin issues identified. Wound treatment records audited to verify that all residents with skin conditions orders are in place and match current wound care physician orders. Completed by ADON and Treatment nurse as of 9/9/2024. A 1:1 in-service was completed by the Regional Compliance Nurse with the DON/ADON/Tx Nurse on 9/9/9/2024 on entering orders for treatments in EMR, completing all ordered treatments and documenting in EMR, and Assessing and reporting new or worsened wounds to the physician and family and documenting notification in EMR. The Medical Director was notified of the immediate jeopardy situation on 9/9/2024. An ADHOC QAPI meeting was conducted on 9/9/2024 to include the IDT Team to discuss the immediate jeopardy and subsequent plan of removal. DON or designee will monitor clinical alerts daily for any new skin issues and follow up to assure all skin conditions proper orders, assessments, and notifications in place in EMR. Implemented on 9/9/2024. Skin integrity Management policy reviewed on 9/9/2024 and no changes made to current policy. Identification: All residents residing in the facility received a skin assessment by the DON/ADON and treatment nurse. No new skin issues were identified as of 9/9/24. Wound treatment records audited to assure all residents with skin conditions have orders in place and that orders match current Wound care physician recommended treatment orders. completed as of 9/9/2024. In-services: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All charge nurses were in-serviced on the following topics below as of 9/9/2024 by the DON ADON and Treatment Nurse. All staff not present for in-servicing will not be allowed to resume their scheduled assignment until in-serviced. All new hired staff will be in-serviced during facility orientation. All agency staff will be in-serviced prior to start of their shift. Verification of comprehension will be made through a post test for topics in-serviced on. o Entering new physicians' orders in EMR without delay. o Completing all orders treatments and documenting treatments in EMR. o New or worsened wound should be assessed, and the physician and family notified and documented in EMR. On 09/09/24 the survey team confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: 1. During a telephone interview on 09/09/24 at 2:08 p.m., the Medical Director stated he was notified of the immediate jeopardy situation and attended a QAPI meeting via phone over the immediate jeopardy and subsequent plan of removal on 9/9/2024. 2. During an observation on 09/09/24 at 2:30 p.m., Resident #1 was observed in the dining room with a bandage noted to her right shin dated 09/09/24. 3. Record review of the skin assessments, were initiated on 09/07/24 and completed by 09/09/24, revealed all residents were reassessed for skin issues. No additional concerns were identified. 4. Record review of the wound treatment audit, were initiated on 09/07/24 and completed by 09/09/24, revealed all residents with skin conditions orders in place and match current wound care physician orders. 5. Record review of the ADHOC QAPI meeting, dated 09/09/24, revealed the meeting was conducted with Administrator, DON, Regional Nurse Consultant, and Medical Director. 6. Record review of the in-service form dated 09/09/24 revealed the DON/ADON/Treatment Nurse had received 1:1 in-service training with the Regional Compliance Nurse on entering orders for treatments in EMR, completing all ordered treatments and documenting in EMR, and Assessing and reporting new or worsened wounds to the physician and family and documenting notification in EMR. 7. Record review of the in-service forms and posttest dated 09/09/24, revealed RN D, LVN E, LVN F, LVN G, LVN H, LVN K, LVN L from all shifts were provided in-service education on entering new physicians' orders in EMR without delay, completing all orders treatments and documenting treatments in EMR, and new or worsened wound should be assessed, and the physician and family notified and documented in EMR. 8. Record review of the clinical alert monitoring tool for any new skin issues and follow up to assure all skin conditions proper orders, assessments, and notifications in place in EMR was implemented on 09/09/24. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	9. Record review of the Skin Integrity Management policy was reviewed on 09/09/24, no changes were made. 10. During interviews conducted on 09/09/24 between 2:35 p.m. and 3:25 p.m., revealed RN D, LVN E, LVN F, LVN G, LVN H, LVN K, LVN L from all shifts were in-service on and could verbalize understanding of inservices of entering new physicians' orders in EMR without delay, completing all orders treatments, documenting treatments in EMR, assessed new or worsened wounds, notify the physician/family and document in EMR. The Administrator was informed the IJ was removed on 09/09/24 at 3:35 p.m. The facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.