

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 02/18/2025
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 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928</p> <p>Based on interview and record review the facility failed to provide the resident access personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it was readily producible in such form and format (including in an electronic form or format when such records were maintained electronically, or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays) and allow the resident to obtain a copy of the records or any portions thereof upon request and 2 working days advance notice to the facility for 1 of 2 residents (Resident #2) reviewed for access of records.</p> <p>The facility failed to provide Resident #2's legal representative copies of medical records after an oral request was voiced to the facility on [DATE].</p> <p>This failure could place residents at risk of violation of their rights.</p> <p>Findings include:</p> <p>Record review of Resident #2's face sheet, dated 02/12/25, indicated an [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2's had diagnoses which included type 2 diabetes (a chronic condition that affects how the body uses sugar for energy), Alzheimer's disease (progressive and irreversible brain disorder that gradually destroys memory, thinking skills, and the ability to perform everyday tasks), heart failure (a chronic condition that occurs when the heart cannot pump enough blood and oxygen to the body) and anxiety (mental health condition characterized by excessive worry, fear, and nervousness).</p> <p>Record review of Resident #2's care plan, dated 01/26/23, indicated she had an ADL self-care deficit performance deficit with interventions to assist with personal hygiene as required and required one person staff participation with bathing.</p> <p>Record review of Resident #2's significant change in status MDS assessment, dated 01/29/25, indicated she was sometimes understood and sometimes understood others. Resident #2 had a BIMS score of 3, which indicated her cognition was severely impaired.</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 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of an email, dated 11/24/24 at 12:09 PM, addressed to Medical Records and the Regional Director of Medical Records and sent by the MDS Coordinator stated, We had a care plan with the [Resident #2's] family and the ombudsman is requesting medical records for the family from January 2023 to present day 11-12-2024. The email proceeded to inform them of the Ombudsman's name with the Ombudsman's email since the Ombudsman had requested the records be emailed to her.</p> <p>Record review of an email, dated 11/24/24 at 12:58 PM, addressed to Medical Records, the MDS Coordinator, the AIT and sent by the Regional Director of Medical Records stated, They will need to complete the authorization PHI form just like the family member would for our records.</p> <p>During an interview on 02/10/25 at 09:27 AM, the Ombudsman said Resident #12's family member and herself requested Resident #2's medical records from the facility on 11/12/24, during a care plan meeting. The Ombudsman said she had even emailed the facility reminding them of the requested records and even had called them, but no medical records had been released. The Ombudsman said the facility requested a signed medical release form from the family member or herself before medical records could be released. The Ombudsman said she did not sign the form but handed the facility a copy of the state regulation indicating the ombudsman had access rights to all files, records and other information concerning a resident.</p> <p>During an interview on 02/10/25 at 09:47 AM, Resident #2's family member said he requested medical records from the facility during their last care plan meeting in November 2024. Resident #2's family member said the Ombudsman was present at the care plan meeting and the facility knew he wanted Resident #2's records. He said he still had not received them. Resident #2 said the facility had informed him of a PHI form he was required to sign before those records could be released but he had not signed it since the Ombudsman had said she was going to handle it. Resident #2's family member said he had requested the records so he would review an incident that happed over a year ago for his peace of mind and resolution.</p> <p>Record review of Resident #2's electronic medical records on 02/10/25 did not reveal a signed PHI form.</p> <p>During an interview on 02/11/25 at 09:52 AM, the MDS Coordinator said the family requested medical records during a care plan meeting. The MDS Coordinator said she sent an email to Medical Records over Resident #2 family's request and the Ombudsman. The MDS Coordinator said there was a process the family had to go through to receive the requested records, but they had the right to receive them. The MDS Coordinator said Medical Records was responsible for medical records requests.</p> <p>During an interview on 02/11/24 at 4:10 PM, the DON said Resident #2's family member requested Resident #2's medical records during a care plan meeting, but he had not followed the facility policy. The DON said Resident #2's family member was given the medical records release form, but he had not returned it back to the facility. The DON said the process for medical records request was as follows: the family member would sign a request for medical records form, the signed form was given to Medical Records, Medical Records sent the form to the corporate office, and then corporate office would review the form and send Medical Records authorization to release the records. The DON said Medical Records was responsible for medical records request forms. The DON said Resident #2's family member had the right to obtain those records if they followed their policy.</p> <p>(continued on next page)</p>		

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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/12/25 at 09:29 AM, Medical Records said she was responsible for medical records requests. Medical Records said when a resident's family member requested records, they needed to fill out an application for the medical release at its entirety. Once they filled out the application, it was returned to her, and she would then send it over to the corporate office and wait for approval. Medical Records said there was an \$87.14 fee for obtaining medical records and would then therefore ask the family how they wanted to proceed with payment in either a check or money order. She then would let the corporate office know payment was received. Corporate then would let her know when to release the files to the family. Medical Records said Resident #2 family member was provided the medical release form, but it was never brought back to her. Medical Records said the family has the right to receive their family's medical records if they followed the facility's policy.</p> <p>During an interview on 02/12/25 at 09:47 AM, the Regional Director of Medical Records and Central Supply said when a family member requested medical records their process was as followed: a letter requesting medical records was filled out with what they were looking for, the letter was sent to the corporate office, and then the corporate office would approve or deny the request. The Regional Director of Medical Records said the Ombudsman also had to fill out the form if records were requested per the family so they could have a record of the person requesting records and the request. The Regional Director of Medical Records said, from what Medical Records reported to her, Resident #2's family was provided with the PHI form, but the PHI was not received back from the family. The PHI form needed to be completed, with the requestor's identification and a copy of the power of attorney as well. The Regional Director said the resident's family member had the right to have copies if they followed the facility's policy.</p> <p>During an interview on 02/12/25 at 10:06 AM, the AIT said the Ombudsman was at the facility and requested Resident #2's records and was provided the medical release form. The AIT said the Ombudsman did not return the signed form. She said she had questioned the corporate office regarding the Ombudsman requesting records and was informed she needed to fill out a medical release form the same as when a family member requested them. The AIT said records could not be released until the form was received. The AIT said the Ombudsman did not request access to Resident #2's medical records but if she had she would have given it to her with the family's permission and by following the facility policy. The AIT said Resident #2's family member was provided with the medical release form as well, but he had not brought it back. The AIT said Resident #2's family member had the right to her records if he followed the facility policy. The AIT said Medical Records handled all medical request forms.</p> <p>Record review of the facility's policy Health Information Requests, Release, and Production Fee Guidelines, revised 11/2017, indicated . Request for copies of Health Information: 1. When someone outside the facility requests copies of information from a Resident's chart it is first necessary to determine their identity and if they have legal authority to receive any information. Once rights to the health information has been established an Authorization to release health information form must be completed and sent to the Director of Health Information Management to be reviewed and approved. When sending the request in for approval the proper documentation should be send along with the request if the request is coming from anyone other than the resident, such as the power of attorney or guardian . Production fees for copies of Health Information: 2. Production fees are due at the time that health information is picked up. If they requested for the records to be mailed, the cost of postage and the production fee should be made prior to them being shipped</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928</p> <p>Based on interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as possible and failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 2 residents (Resident #1) reviewed for quality of care.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure Resident #1 was adequately supervised which resulted in Resident #1 leaving the facility on 08/22/24 and being found at a gas station in a town 38.1 miles east of the facility. 2. The facility failed to monitor and put measures in place to keep Resident #1 who was high risk for elopement from eloping from the facility on 08/22/24. 3. The facility failed to do a search of the surrounding area when they discovered a door alarm sounded on 08/22/24. <p>The noncompliance was identified as PNC. The IJ began on 08/22/24 and ended on 08/23/24. The facility had corrected the noncompliance before the survey began.</p> <p>These failures could place residents at risk of potential accidents, injuries, harm or death.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet, dated 08/29/24, indicated an [AGE] year-old female who admitted to the facility on [DATE]. Resident #1 had diagnoses which included dementia (memory loss) with behaviors, delusional disorder (a mental health condition characterized by persistent, false beliefs that are not based on reality), hallucinations (false perceptions), psychosis (mental health condition characterized by a loss of contact with reality), depression (persistent feeling of sadness), anxiety (mental health condition characterized by excessive worry, fear, and nervousness), and chronic obstructive pulmonary disease (group of lung diseases that cause airflow obstruction and breathing problems).</p> <p>Record review of Resident #1's elopement risk assessment, with an effective date of 07/30/24, indicated Resident #1 was not bedfast, in a Geri-chair, or unable to self-propel wheelchair. Resident #1 was able to ambulate independently or with a device, cognitive skills for daily decision making was moderately impaired, understood, and verbalized acceptance of need for nursing home care. Resident #1 had no history of previous attempts to leave own residence/facility. The assessment indicated Resident #1 had an elopement risk score of 10.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's elopement risk assessment, with an effective date of 08/07/24, indicated Resident #1 was not bedfast, in a Geri-chair, or unable to self-propel wheelchair. Resident #1 was able to ambulate independently or with device, cognitive skills for daily decision making was moderately impaired, and verbalized anger and frustration related to placement. Resident #1 had no history of previous attempts to leave own residence/facility. The assessment indicated Resident #1 had an elopement risk score of 15.</p> <p>Record review of Resident #1's Admission MDS assessment, dated 08/09/24, indicated Resident #1 was understood and understood others. Resident #1 had a BIMS score of 12, which indicated her cognition was moderately impaired. Resident #1 did not have behaviors, refused care, or wandered. Resident #1 required supervision or touching assistance with oral hygiene, toileting, showering, lower body dressing and personal hygiene.</p> <p>Record review of Resident #1's progress note, dated 08/10/24 and signed by LVN S, indicated Resident #1 stated she wanted to go home, she did not feel good and was requesting a family member to take her home. The note indicated Resident #1's family member was notified where she voiced the resident was taking an antidepressant at home. The Nurse Practitioner was notified with an order for the antidepressant medication. The progress note did not indicate Resident #1 was attempting to leave the facility.</p> <p>Record review of Resident #1's progress notes, dated 08/11/24-08/21/24, did not indicate Resident #1 had voiced wanting to leave the facility or made any attempts to leave the facility.</p> <p>Record review of Resident #1's comprehensive care plan, revised on 08/22/24, indicated Resident #1 had an elopement or elopement attempt, where she left the facility unattended. The care plan interventions included to admit to MCU upon arrival to facility per MD, assess/record/report to MD risk factors for potential elopement such as: resident's elopement or attempted elopement, wandering, repeated requests to leave facility, statements such as I'm leaving .I'm going home, attempts to leave facility, elopement attempts from previous facility, home, or hospital, and to determine the reason the resident is attempting to elope. The care plan interventions also included to distract resident from elopement attempts by offering pleasant diversions, structured activities, food, conversation, television, books, and if the resident was exit seeking to stay with the resident and notify the charge nurse by calling out, sending another staff member, or using the call system.</p> <p>Record review of Resident #1's order summary report, dated 08/01/24-08/31/24, indicated Resident #1 had the following orders:</p> <ul style="list-style-type: none"> o quetiapine fumarate 25 mg give one tablet by mouth one time a day related to psychosis with a start date of 08/11/24. o Refer to behavioral health to evaluate and treat as indicated one time only related to dementia with behaviors with a start date of 08/01/24. o Fluoxetine 40 mg one capsule daily for depression with a start date of 08/11/24. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's progress note, dated 08/22/24 at 4:56 PM, signed by LVN A, indicated At around 1:00 PM-1:30 PM trays were being passed on hall, upon entering her room she wasn't in it, staff started looking in dining room and all rooms up and down 200 west, 300 north and south, all bathrooms, closets, under bed anywhere any one could be hiding was looked, upon not finding her we call code orange and all other staff started looking for her thru (through) out facility, some went outside of facility looking, police notified, staff started reviewing camera.</p> <p>Record review of Resident #1's progress note, dated 08/22/24 at 5:35 PM, and signed by the previous DON, indicated At approximately 1730 [5:30 PM], [Resident #1] arrived back to facility via nursing home transportation bus. This DON accompanied resident back to facility at approximately Mile Marker 170. Upon arrival to assist van driver, resident was sitting in the front seat on the passenger side of the van. The resident was exit seeking by trying to unlock the front passenger side door. Resident was also trying to unlatch the seat belt. When this DON interviewed the resident and asked how did she end up at the gas station in [another town], the resident answered 'I don't know what you are talking about!' This DON then asked the resident, 'so are you getting into cars with strangers?' The resident stated, 'I never get into the cars with strangers!' This DON then asked the resident 'SO what happened?' And the resident stated, 'I'm not saying another word, I have already said too much!' Resident refused to say anything else. This DON asked resident was she hungry, resident stated 'no.' This DON went to the kitchen and received a dietary tray for resident and offered the meal to the resident. The resident refused. Resident was assisted to the restroom to toilet. Resident is currently on the secure unit sitting on the couch watching T.V. without any concerns at this time. No exit seeking noted at this time. Resident placed on one-on-one observation.</p> <p>Record review of Resident #1's hospital records, dated 08/22/24, indicated .Patient presents per paramedics. She eloped from her extended care facility dementia unit in [town nursing facility located]. She somehow got a ride up to [town that was 38.1 miles east of the facility] where she was found and brought here to meet her facility transport to go back home. Patient has no acute complaints. She denies trauma altered mental status relative to baseline. Paramedics state her vital signs were stable and patient has had no complaints with them as well . The hospital records also indicated . spoke with DON at [facility], she requested that pt be asked if she was harmed in any physical, emotional, or sexual way. Informed that pt is currently AAOx2. Nurse talked with pt and pt denied being harmed in any way and stated, 'That man that drove me here was just helping me get out of there'</p> <p>Record review of the [town resident was found] police call sheet report, date 08/22/24 at 2:06 PM, indicated the call was received from a gas station for a welfare check. The reporter advised a female came in with dementia and does not know where she is and then gave Resident #1's name. The report indicated Resident #1 arrived in a vehicle with a male who was scared to death and left, she did not know a number to call for help and was sitting in the store in the dining area.</p> <p>Record review of the [town facility located] police call detail report, dated 08/22/24 at 2:16 PM, indicated the DON had called regarding a missing person. The report indicated the missing person was Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the [town facility located] police department narrative by the corporal indicated .on 08/22/24 at approximately 1449 hours (2:49 PM) I, [name of corporal] was dispatched to the [facility] in reference to a UUMV. Prior to receiving this call, I was dispatched to the same address at approximately 1416 hours (2:16PM) in reference to a missing person. On the previous call, staff from the [facility] reported a dementia resident [Resident #1] had snuck out of the location through the west side laundry room door. While on scene searching for [Resident #1] a member of the staff advised officers [Resident #1] was located at the [gas station in the town located 38.1 miles east of the facility]. Upon my arrival, I made contact with [Laundry Aide C]. [Laundry Aide C] advised she works in the laundry room at the [facility]. [Laundry Aide C] advised after helping search for [Resident #1] when she was missing, she was getting ready to leave work. [Laundry Aide C] advised when she arrived to work that day, she parked her [car model] near the laundry room on the west side of the facility. [Laundry Aide C] advised she left her car keys in the vehicle. [Laundry Aide C] advised around 1200 hours (12:00 PM) she went to lunch with a co-worker and rode with them in their vehicle and arrived back around 1230 hours (12:30 PM). [Laundry Aide C] told me when she went to leave, she noticed her vehicle was no longer parked where she left it. Due to the timing of [Resident #1] going missing and the time of the vehicle was taken, staff member believed the two incidents could be related . I spoke with Human Resource, and she advised she spoke with an employee from the [gas station name]. [Human Resource] advised [gas station employee] observed [Resident #1] arrive at the location in a gold SUV with an unknown male. [Human Resource] said [gas station employee] was able to get ahold of [Resident #1's] family member who informed him she was supposed to be at the [facility name]. [Human Resource] advised that is how the facility was notified she was found in [town located 38.1 miles east of facility]. [Human Resource] told me they contacted [the other town's police department] and had an officer take [Resident #1] to the [hospital name] to be checked out. I watched the surveillance footage and observed at approximately 1222 hours (12:22 PM), [Resident #1] walked out of the building from the west hall (laundry room side). I observed at approximately 1234 hours (12:34 PM), [Laundry Aide C's car] could be seen going east on the southwest side of the building. No other camera captured [Laundry Aide C's car]</p> <p>Record review of Resident #1's consent for secure unit, with an effective date of 08/22/24, indicated Resident #1's representative verbally or by phone gave consent for Resident #1 to be placed in the secure unit.</p> <p>During an interview on 02/10/25 at 1:39 PM, LVN A said the day of the elopement incident she was in the dining room assisting with feeding since she was assigned to lunch duty. LVN A said she saw Resident #1 walking around in the dining room around noon and then went walking down the hall. LVN A said Resident #1 ate sometimes in the dining room or her room. LVN A said she did not remember if Resident #1 had been trying to exit seek prior or had voiced she wanted to leave the facility. LVN A said when the staff passed trays, approximately an hour after she last saw her, Resident #1 could not be found. LVN A said management was notified and everyone started looking for her. LVN A said they reviewed the cameras and noticed Resident #1 left through the back door, near the laundry room. LVN A said there was a code to exit the door, but also had a sign to hold for 15 seconds and the door would unlock. LVN A said Resident #1 could read and probably held the door for it to unlock.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/10/25 at 1:47 PM, the DON said when the staff reported Resident #1 could not be found they searched everywhere, even the neighbor's house. The DON said when they could not find her, they called the police. The DON said they reviewed the cameras and they saw she had left the building. The DON said they did not have a camera facing where the car was parked so was unsure if Resident #1 drove or someone took her. The DON said Resident #1 was found in another town and she asked the paramedics to take her to the hospital to be checked out. Laundry Aide C's car was found at the location where Resident #1 was found and Resident #1 had the keys. The DON said at the gas station, someone had said Resident #1 was dropped off. The DON said Resident #1 was brought back to the facility and placed in the secured memory care unit. The DON said she was unable to recall if Resident #1 had verbalized wanting to leave the facility and had made no prior attempts of leaving. The DON said Resident #1 was referred to psych services as well due to her hallucinations. The DON said two staff members answered the door alarm and had checked but saw no one there. The DON said they completed elopement risk assessments for all residents in the building at the time of the incident, completed daily monitoring of doors, and performed elopement drills.</p> <p>During an interview on 02/10/25 at 2:14 PM, the AIT said the day of the incident she was not at the facility, but staff called her and reported Resident #1 could not be found. The AIT said she returned to the facility to assist. The AIT said they told her Resident #1 left in a car, and police found her in another town. The AIT said the previous Maintenance Supervisor and the previous Medical Records staff had answered the door alarm but did not know there was a resident involved as each one thought the other one set the door alarm. The AIT said when Resident #1 returned to the facility she was not confused but it took forever to get her to come down off the facility van as she did not want to come inside. The AIT said they completed in-services, monitoring, placed Resident #1 in the unit, completed elopement assessments on all residents, safety assessments, and elopement drills. The AIT said Resident #1 voiced once wanting to go home but made no attempts of leaving the facility. The AIT said the staff was also educated on not leaving their keys in their vehicles.</p> <p>During an interview on 02/10/25 at 10:52 PM, LVN B said she worked the 6:00PM-6:00AM shift and was the nurse who had taken care of Resident #1. LVN B said Resident #1 had not voiced wanting to leave the facility or made any attempts of wanting to leave the facility prior to her elopement on 08/22/24.</p> <p>During an interview on 02/10/25 at 11:17 PM, Laundry Aide C said the day of Resident #1's elopement, she went to her car to get something out because she was leaving to go eat lunch with a friend and left her keys on the seat when she placed them down. Laundry Aide C said around 2:00 PM, she was getting ready to leave and her car was no longer where she parked it. Laundry Aide C said her car was found at a gas station in [town 38.1 miles east of the facility]. Laundry Aide C said Resident #1 had her keys on her when she arrived back to the facility. Laundry Aide C said the facility in serviced her on parking, not leaving the keys inside the car, code orange, answering the door alarms and checking to see if no one was outside. Laundry Aide C said she had not heard Resident #1 wanting to go home and had not seen her make any attempts to leave the facility.</p> <p>(continued on next page)</p>		

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 02/18/2025
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.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/10/25 at 11:28 PM, CNA D said she had been Medical Records at the time of Resident #1's elopement. CNA D said she was putting up medical supplies when she heard the door to the laundry exit alarming. CNA D said she went to the door and looked around but had not seen anyone. CNA D said there were no residents outside, and no one was leaving. CNA D said she had not heard of Resident #1 voicing wanting to leave the facility or seen Resident #1 make any attempts to leave the facility. CNA D said the facility in-serviced her when answering an alarming door, they need to ensure no residents were leaving the building. She said she was instructed to check outside and around the building. CNA D said when there was a code orange it indicated there was a missing person and everyone had to help in locating the missing resident.</p> <p>Interviews on 02/10/25 between 1:39 PM and 11:54 PM with (LVN A, DON, AIT, LVN B, Laundry Aide C, CNA D, LVN E, CNA F, CNA G) and interviews with (CNA H, CNA K, Maintenance Supervisor, CNA R, CMA Q, LVN P, Speech Therapist, Treatment Nurse, MDS Coordinator, Housekeeping Supervisor, LVN S, Housekeeping L, LVN M, Dietary Aide N) on 02/11/25 between 12:11 AM and 1:12 PM revealed they were able to answer questions regarding in-services on abuse and neglect, immediately notifying the abuse coordinator for any abuse allegations, response on what to do when a resident was exit seeking which was to notify nurse and management staff, responding to the door alarms, checking to ensure no residents had left the building, if no residents were seen they were to notify the nurse and do a count of residents to ensure no one had left, code orange was for a missing resident that was unable to be located and not leaving their keys in their vehicles.</p> <p>During an interview on 02/11/25 at 10:32 AM, the Regional Compliance Nurse said when a resident had an elopement risk score of 10 or higher, they were considered at risk for elopement. She said they updated the residents care plan to reflect their risk of elopement and if the residents wandered, they educated staff. The Regional Compliance Nurse said all doors at the facility were locked and required a code to get in or out. The Regional Compliance Nurse said when a resident was actually exit seeking, they ruled out any underlying medical condition, found placement, or placed them in their secure unit. She said Resident #1 was placed in the memory care secure unit upon her return to the facility and her care plan was updated.</p> <p>Record review of the in-services dated 08/22/24 indicated the staff was in-serviced on elopement prevention policy, abuse and neglect policy, not leaving their keys in their vehicle, if a resident was exit seeking to stay with the resident and notify the DON, ADON and the Administrator.</p> <p>Record review of the in-services dated 08/23/24 indicated the staff was in-serviced on responding to door alarms by walking outside to check to see if any resident may have exited the door and would need to be directed back inside, once it was determined that a resident had not exited the door, the code was pressed to turn the alarm off, code orange (missing resident) and the steps to take if a code orange was called, elopement prevention policy, and the abuse and neglect policy.</p> <p>Record review of the missing resident/elopement monitoring check off indicated the following had been completed:</p> <p>Ensuring the locking mechanism and alarm were functioning properly on all exit doors of the facility 5 days a week.</p> <p>Conducted at least 3 elopement drills weekly.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>5 staff members were asked weekly on what to do if a resident was exit seeking, the process to follow if a door alarm was sounding, and what to do if a resident was discovered missing.</p> <p>Record review of the elopement drills revealed they were completed three times a week with no concerns noted with a start date of 08/22/24.</p> <p>Record review of the Assessment History Elopement Risk Assessment Report indicated 76 assessments were completed on 08/22/24. Three residents with an elopement risk assessment score of 10 or higher were reviewed. The three residents resided in the memory care secure unit and their care plan indicated they were a high risk for elopement.</p> <p>Record review of Safe Assessments completed on 08/22/24 for residents residing on Resident #1's hall.</p> <p>Record review of the facility's policy Elopement Prevention revised January 2023 indicated Every effort will be made to prevent elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement. 1. The Elopement Risk Assessment will be completed upon admission . at least quarterly, after an elopement attempt, upon new exit seeking behavior, and upon change of condition .4. The residents' care plan will be modified to indicate the resident is at risk for elopement episodes. Interventions into elopement episodes will be entered onto the resident's care plan and medical records . 7. If a resident is discovered to be missing, a search shall begin immediately .</p> <p>Record review of the facility's policy Elopement Response revised January 2023 indicated Nursing personnel must report and investigate all reports of missing residents. When an elopement has occurred or is suspected, our elopement response plan will be immediately implemented. 1. It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the charge nurse as soon as practical 2. Determination of missing resident either by routine nursing rounds or door alarms: A. Note: A resident is determined to be missing when he/she leaves the facility without the staff's knowledge . 4. Should an employee discover the resident is missing from facility (Code Orange), he/she should: A. Report to the charge nurse, B. Determine if the resident is out on authorized leave or pass. If not; C. Make a thorough search of the building (s) and premises, If not located; D. Notify the Administrator and the Director of Nursing; E. Notify the resident's responsible party. Notify the attending physician; G Notify VP of Risk Management, ADO, COO, Divisional VP of clinical, Director of Secure Care Services, Compliance Nurse, and Sr, VP of Clinical Services .J. Make an extensive search of the surrounding area.5. Deployment Procedure: A. Charge nurse on each unit send staff down each hall to check each room, including bathroom closet and bed for correct resident. B. Check all rooms on the hall including tub and bathrooms, linen closets and any recreations rooms. Check all common areas and offices. 6. If unable to locate resident in the building, proceed as follows: A. Unaffected Area- Charge nurse designates one CNA per hall to remain on unit along with him/himself and sends remaining staff to affected area. B. Affected Area- Charge Nurse assigns to specific outside areas to ensure that all surrounding areas are searched. C. After 30 minutes, if the resident has not been found, the following call must be made: report missing resident to the police, update responsible party .</p> <p>The noncompliance was identified as PNC. The IJ began on 08/22/24 and ended on 08/23/24. The facility had corrected the noncompliance before the survey began.</p>		