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	10/30/2025

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 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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

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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 0686 Level of Harm - Actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services was provided, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 3 resident (Resident #1) reviewed for pressure injuries. 1. The facility failed to ensure CNA B and CNA C provided incontinent care, and turning and repositioning for Resident #1 on 10/09/25 and 10/10/25 causing Resident #1's wounds to worsen. 2. The facility failed to identify a wound prior to a PRN hospice visit on 10/11/2025, where the hospice nurse identified a stage ll sacral wound closed and dark in color, and by 10/13/2025 there was, per the evidence, a right heel abrasion, a left heel blister, and a sacral wound with eschar. 3. The facility failed to initiate wound care orders on 10/11/2025 and 10/12/2025. An Immediate Jeopardy (IJ) situation was identified on 10/29/2025. The IJ template was provided to the facility on [DATE] at 1:37 PM. While the IJ was removed on 10/30/2025 at 1:57 PM, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk for worsening of existing pressure injuries, pain, and infection. Findings included: Record review of Resident #1's face sheet, dated 10/27/25, indicated an [AGE] year-old female who admitted to the facility on [DATE]. Resident #1 had diagnoses which included artherosclerotic heart disease (plaque buildup in arterial walls causing them to narrow), anxiety (excessive worry, fear, and nervousness), depression (persistent feelings of sadness and loss of interest in things), and high blood pressure. Record review of Resident #1's admission MDS assessment dated [DATE] indicated she could make herself understood and she was able to understand others. The MDS also indicated she had a BIMS score of 5 which meant she had severe cognitive loss. The MDS also indicated she required moderate assistance with toileting, bathing, transfers, and dressing, and supervision for eating and bed mobility. The MDS indicated she was at risk for pressure ulcers but did not have any unhealed pressure ulcers. Record review of Resident #1's care plan dated 08/18/25 indicated she had bladder incontinence and would remain free from skin breakdown with interventions to provide incontinent care at least every 2 hours. Record review of Resident #1's Braden scale for predicting pressure sore risk dated 08/26/25 indicated she was at a low risk for developing pressure sores. Record review of Resident #1's nurse progress notes dated 09/27/25-10/28/25 indicated there were no progress notes on 10/10/25, 10/11/25, nor 10/12/25. Record review of Resident #1's skin assessment dated [DATE] indicated she had no pressure, venous, arterial, or diabetic ulcers, but she did have redness to her buttocks with barrier cream applied. Record review of Resident #1's hospice note dated 10/11/25 indicated a hospice RN KK came for an as needed visit and observed a wound to Resident #1's sacral area dark in color. Record review of Resident #1's skin assessment dated [DATE] indicated she had an abrasion to her right heel that measured 3.0 cm X 3.0 cm with skin prep daily and offloading heels, a wound to her sacrum that measures 4. 0 cm x 3.5 cm x 0.1 with 2.7 cm x 2.4 cm eschar and treatment of calcium alginate, medihoney and cover with hydrocolloid dressing every Monday and Thursday, and a blister to her left heel that measured 5.0 cm X 8.5 cm with skin prep daily and to offload heels. Record review of Resident #1's care plan dated 10/13/25 indicated she had an actual wound to her sacrum, an abrasion to her right heel, and a blister to her left heel with interventions in place to encourage resident to get into bed and off sacrum, resident would be see by the wound doctor weekly, monitor wounds and report changes to the doctor, and heels would be floated at all times. Record review of Resident #1's order summary report dated 10/28/25 with orders since the admission date of 08/05/25 indicated an order for:1. May apply barrier cream as needed every shift with a start date of 08/05/25 and no other skin or wound care orders were noted until 10/13/25. Record review of Resident #1's order summary report, dated 10/28/25, indicated orders since the admission date of 08/05/25 reflected an order to:1 Apply skin prep to the abrasion on the right heel daily one time a day for Wound Healing with a start date of 10/13/2025 but now discontinued on an unknown date. 2 Apply skin prep to the blister on the left heel daily one time a day for Wound Healing with a start date of 10/13/2025 but now discontinued on an unknown date. 3 Cleanse the stage 3 on the left heel with wound wash, pat dry, and apply collagen powder, and cover with gauze island dressing every Monday, Wednesday, Friday and PRN if soiled or dislodged one time a day every Monday, Wednesday, Friday for Wound Healing with a start date of 10/24/2025 and no end date. 4 Apply skin prep to the unstageable DTI (deep tissue injury) on the right heel 3 times a week one time

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 6 residents (Resident #1, Resident #2 and, Resident #3) room reviewed for infection control practices and enhanced barrier precautions. 1) The facility failed to ensure the Treatment nurse implemented enhanced barrier precautions and used PPE while providing care for Resident #1 on 10/27/25. 2) The facility failed to ensure CNA OO and CNA PP used the proper enhanced barrier precautions while providing incontinent care to Resident #1. 3) The facility failed to ensure Resident #1 Resident #2 and Resident #3 had enhanced barrier precaution signage and PPE available for staff to be aware of EBP. These failures could place residents at risk for serious complications from a communicable disease that could diminish the resident's quality of life. Findings included: 1. Record review of Resident #1's face sheet, dated 10/27/25, indicated she was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #1 had with the diagnoses which included artherosclerotic heart disease (plaque buildup in arterial walls causing them to narrow), anxiety (excessive worry, fear, and nervousness), depression (persistent feelings of sadness and loss of interest in things), and high blood pressure. Record review of Resident #1's admission MDS assessment, dated 08/15/25, indicated she could make herself understood and she was able to understand others. The MDS also indicated Resident #1 she had a BIMS score of 5, which meant she had severe cognitive loss. The MDS also indicated She required moderate assistance with toileting, bathing, transfers, and dressing, and supervision for eating and bed mobility. The MDS indicated Resident #1 was at risk for pressure ulcers but did not have any unhealed pressure ulcers. Record review of Resident #1's care plan, dated 10/13/25, indicated she had an actual wound to her sacrum, an abrasion to her right heel, and a blister to her left heel with interventions in place to encourage resident to get into bed and off the sacrum, resident would be seen by the wound doctor weekly, monitor wounds and report changes to the doctor, and heels would be floated at all times. The care plan did not indicate enhanced barrier precautions. Record review of Resident #1s order summary report dated 08/28/25 indicated she did not have an order for enhanced barrier precautions. During an observation on 10/27/25 at 3:33 PM revealed Resident #1 was sitting up in bed with a low-pressure loss mattress being utilized. Resident #1 had a wedge under her left side and both feet floated on two pillows. The Treatment Nurse donned gloves and assisted by the hospice sitter they rolled Resident #1 over, removed her brief to expose a bandage (large Tegaderm bandage in place dated 10/27/25 with initials). The Treatment Nurse peeled back bandage to expose the wound. It appeared to be an unstageable, full thickness wound to Resident #1's sacrum present. The wound measured (Length x Width x Depth) 6.0 cm x 6.5 cm x not measurable due to necrosis (death of tissue due to no blood supply). The Eschar (thick layer of dead skin that forms over a wound, often appearing black) measurement was 3 cm x 2.5 cm x not measurable (due to necrosis). There was a tunnel at 12 o'clock that was 0.7 cm. and a tunnel at 2 o'clock that was 0.5 cm. The Treatment Nurse placed the bandage back over wound and then re-enforced with another bandage. The Treatment Nurse failed to use other PPE during care. There was no sign for PPE or PPE cart for use visible. During an observation and interview on 10/28/2025 at 7:10AM revealed CNA OO and CNA PP went into Resident #1's room to start their morning rounds. There was no EBP sign on the door or PPE cart at door prior to entrance. CNA OO and CNA PP provided incontinent care for Resident #1, but no PPE was used except gloves. CNA OO and CNA PP said they were unaware of the enhanced barrier precautions. During an observation on 10/28/2025 at 10:00 AM revealed Resident #1 was lying in bed on her right side and had no EBP sign on door or PPE at the door. 2. Record review of Resident #2's face sheet, dated 10/28/25, indicated she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had with the diagnoses which included kidney disease (disease causing the kidneys to no work properly), diabetes mellitus (disorder characterized by high blood sugar), open wound to right buttocks, open wound to left buttocks, and dementia (brain disorder that cause decline in cognitive abilities). Record review of Resident #2's care plan, dated 10/13/25, indicated she had an actual wound to her left and right buttocks with interventions to monitor and report any adverse reactions or changes and report to doctor and to provide treatment as ordered. The care plan also indicated enhanced barrier precautions of gown and gloves should be used while providing linen change, wound care, bathing, and any other high contact activity. Record