

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  12/04/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to provide pharmaceutical services, including the accurate acquiring, administering and receipt of all drugs and biologicals, to meet the needs of 1 of 13 (Resident #2) residents reviewed for pharmacy services. The facility failed to ensure MA B stayed with Resident #2 and made sure she took her medications during medication pass 11/12/25. This failure could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications. Findings Include: 1. Record review of the face sheet dated 12/3/25 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including COPD, diabetes, hypertension (elevated blood pressure), peripheral vascular disease (a circulatory issue with narrowed blood vessels causing leg pain), and congestive heart failure (disorder where the heart cannot pump enough blood to meet the body's needs resulting in fluid buildup). Record review of the entry MDS dated [DATE] indicated Resident #2 understood others and was understood by others. The MDS indicated Resident #2 had a BIMS of 15 and was cognitively intact. Record review of the care plan revised on 11/21/25 indicated Resident #2 has impaired visual function and she wears and had an ADL self-care deficit. Record review of the MAR dated November 2025 indicated Resident #2 received all her schedule medications on 11/12/25. Record review of a video dated 11/12/25 indicated MA B entered Resident #2's room and handed Resident #2 a medication cup. The video indicated Resident #2 took the medication cup, looked in it, and told MA B she would take the medication later. The video indicated MA B told Resident #2 that she needed to take the medication now, turned around, and left Resident #2's room prior to Resident #2 taking the medication. During an interview on 12/3/25 at 2:30 p.m. the DON said she expected staff when administering medications to watch and ensure each resident took their medications. The DON said the importance of ensuring residents took their medications was to make sure they were taking all prescribed medication so they would receive the therapeutic benefit of their medications. The DON watched the video dated 11/1/25 with the surveyor of MA B leaving medications on the bedside table for Resident #2. The DON said that situation had been brought to her attention and MA B had received a write (written counseling/disciplinary action) regarding leaving medications at the bedside. During an interview on 12/4/25 at 8:52 a.m. MA B said she did not leave the room when administering medications until the resident took their medications. MA B said she remembered the incident on 11/12/25 regarding Resident #2 and walking out of the room prior to her taking her medication. MA B said she had thought Resident #2 had taken her medications when MA B turned her back, but she had not. MA B said she left the room prior to Resident #2 taking her medications because she thought Resident #2 had already taken the medications. MA B said not ensuring Resident #2 had taken her medications was a mistake on her part. MA B said it was important to observe the residents taking their medication to ensure they were getting the medications that were prescribed to them and to ensure no one else took a medication not prescribed to them. Record review of the facility's Nursing Facility Medication Administration policy last revised 10/25/17 indicated, Medication shall be administered to a resident only by one of the following individuals on duty, who shall remain on duty for a sufficient amount of time to observe medication acceptance and reaction. 4. The person administering the medication shall: a. Observe the resident for adverse effects, contraindications, and medication effectiveness.</p>		