STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Gardens	3500 Park St Greenville, TX 75401

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on observation, interview and record review, the facility failed to provide respect, dignity and care in a manner and in an environment that promoted maintenance or enhancement of quality of life for 1 of 24 residents reviewed for resident rights. (Resident #27) The facility did not provide a privacy curtain or shut the door during administration of G-tube (a tube inserted through the abdominal wall into the stomach to bring nutrition and medications directly to the stomach) exposing Resident #27. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth. Findings included: 1. Record review of the consolidated physician orders dated 12/08/21 indicated Resident #27 was [AGE] years old, admitted [DATE] with diagnoses including dementia, muscle wasting, need for assistance with personal care, hemiplegia (paralysis of one side of the body) and hemiparesis (mild or partial weakness or loss of strength on one side of the body), schizophrenia and dysphagia (difficulty swallowing food or drinks). Record review of the most recent MDS dated [DATE] indicated Resident #27 makes self-understood and understands others. The MDS indicated Resident #27 was severely cognitively impaired with a BIMS of 00. The MDS indicated Resident #27 required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. Record review of the most recent care plan updated on 11/03/21 indicated Resident #27 required tube feeding related to dysphagia secondary to history of stroke. The care plan indicated Resident #27 had impaired cognition function or impaired thought processes related to dementia and schizophrenia. The care plan indicated Resident #27 had a communication problem related to stroke with effects of left sided hemiplegia/hemiparesis and dysphagia. (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: 675367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2021
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/07/21 at 08:14 a.m. LVN Q was administering medications via g-tube to Resident #27. LVN Q did not close the door to Resident #27's room or pull the privacy curtain in the room prior to administering medications via g-tube. Resident #27 had a roommate lying in the room while LVN Q was administering medications via g-tube without the curtain pulled. Staff members were observed passing by Resident #27's room during medication administration via g-tube with door not closed. During an interview on 12/07/21 at 08;27 a.m. LVN Q said she usually pulled the curtain and shut the door to Resident #27's room when administering medications via g-tube. LVN Q said it was her bad for forgetting to shut the door or pull the privacy curtain prior to administering medications via g-tube to Resident #27. LVN Q said not pulling the privacy curtain or shutting the door to a resident's room while providing care was a dignity issue. LVN Q said the resident's roommate and anyone passing by in the hall could have seen Resident #27 lying with covers pulled down and in his brief. LVN Q said Resident #27's roommate and anyone passing by in the hall could have seen his G-tube site. During an interview on 12/07/21 at 10:57 a.m. CNA P said anytime care was provided to a resident privacy curtains should be pulled and the doors to the rooms should be shut. CNA P said not providing privacy when providing care could lead to humiliation and violated resident rights. During an interview on 12/07/21 at 11:00 a.m. LVN A said the privacy curtain should be pulled and door should be shut when staff is providing care including administering medication via g-tube to a resident. LVN A said not pulling the privacy curtain or shutting door was a dignity issue for the residents. During an interview on 12/07/21 at 11:04 a.m. CMA R staff should shut the door to the resident's room and pull the privacy curtain every time care was provided including administering medication via g-tube. CMA R said pulling the privacy curtain and shutting the door promotes dignity and provides privacy. During an interview on 12/07/21 at 11:16 a.m. RN G said door to resident rooms should be shut and the privacy curtain should be pulled when providing care including administering medication via g-tube. RN G said providing privacy promoted dignity for the resident. RN G promoting dignity increased the resident's quality of life. During an interview on 12/08/21 at 02:34 p.m. the DON said she expected staff to close doors to resident rooms and pull the privacy curtains after entering a resident's room and explaining what care they were to provide. The DON said administration of medication via g-tube was considered hands on care. The DON said doors to resident's rooms should be shut and privacy curtains should be closed/pulled when staff were administering medication via g-tube. The DON said the importance of closing the resident's doors and pulling the privacy curtains was to provided privacy and promote dignity for the residents. The DON said the staff were in-serviced on providing privacy to residents. The DON said random rounds were performed by management to ensure privacy is being upheld. During an interview on 12/08/21 at 02:40 p.m. the Administrator said he expected doors to resident rooms to be closed and privacy curtains to be pulled when staff provided resident care. The Administrator said administering medication via g-tube was considered providing care. The Administrator said providing privacy to the residents during care protected the resident's dignity. The Administrator said the staff was in-serviced and rounds were made to ensure privacy maintained. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled Privacy and Dignity dated 06/20 indicate, .The facility promotes resident care in a manner and an environment that maintains or enhances dignity and respect, in full recognition of each resident's individuality .(I.) Staff assists the resident in maintaining self-esteem and self-worth .(VI.) The facility respects the resident's private space and property .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on observation, interview, and record review the facility failed to ensure a homelike environment was provided for 1 of 18 residents (Resident #41) reviewed for environment. The facility did not provide any homelike items for Resident #41's room This failure could place residents at risk of increased symptoms of depression, anxiety and decreased quality of life. Findings included: Record review of the physician order summary report dated 12/8/21 indicated Resident #41 was readmitted to the facility on [DATE] with diagnoses including history of stroke, bipolar disorder, and post-traumatic stress disorder. Record review of the MDS dated [DATE] indicated Resident #41 had a serious mental illness. The MDS indicated Resident #41 made himself understood and understood others. The MDS indicated Resident #41 had severe cognitive impairment (BIMS of 6). The MDS indicated Resident #41 had minimal depression. The MDS indicated Resident #41 had no behavior of rejecting care. The MDS indicated Resident #41 required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. The MDS indicated Resident #41 was totally dependent on staff for transfers, locomotion in his wheelchair, and bathing. The MDs indicated Resident #41 required supervision only with eating. The MDS indicated he always incontinent bowel and bladder. The MDS indicated Resident #41 had received an antidepressant and antianxiety medication daily during the 7 day look back period. Record review of the care plan reviewed on 12/8/21 indicated Resident #41 needed in room socialization and sensory stimulation. The care plan intervention indicated Resident #41 would be provided sensory stimulation. The care plan indicated Resident #41 had anxiety. The care plan interventions included Resident #41 would be administered anxiety medications and be monitored for effectiveness. During an observation on 12/5/21 at 10:40 a.m., Resident #41 was laying in his bed. There was a single baseball cap hanging on the wall to the right of the bed. There were no portraits, posters other homelike items on the walls. There were no personal or homelike items on the bedside table or dresser. During an observation and interview on 12/6/21 at 10:20 a.m., Resident #41 was laying in his bed. There was a single baseball cap hanging on the wall to the right of the bed. There were no portraits, posters other homelike items on the walls. There were no personal or homelike items on the bedside table or dresser. Resident # 41 said he wished the room wasn't so gloomy. Resident #41 said he used to have posters on his wall when he was at another facility and wished he had some more. (continued on next page)

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	675367	A. Building B. Wing	12/08/2021

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/7/21 at 1:00 p.m., Resident #41 was laying in his bed. There was a single baseball cap hanging on the wall to the right of the bed. There were no portraits, posters other homelike items on the walls. There were no personal or homelike items on the bedside table or dresser. Resident #41 indicated the appearance of his room was kind of sad and made him feel down. During an observation on 12/8/21 at 11:32 p.m., Resident #41 was laying in his bed. There was a single baseball cap hanging on the wall to the right of the bed. There were no portraits, posters other homelike items on the walls. There were no personal or homelike items on the bedside table or dresser. During an interview on 12/8/21 at 3:50 p.m., NAIT U said Resident #41's room was gloomy and bare compared to other resident rooms on the hall. NAIT U said he had never complained to her about his room. NAIT U said she was not sure who was responsible for ensuring Resident #41's room was homelike but assumed the family had just not brought had any items. During an interview on 12/8/21 at 4:03 p.m., CNA T said a Residents rooms should have a homelike environment even if the family does not bring anything. She said the room Resident #41 resided in was his home and there should be something on the wall beside the wall. CNA T said she was not sure who responsible to ensure residents had a homelike environment. During an interview on 12/8/21 at 4:10 p.m., LVN H said if Resident #41 wanted items in his room to make the room more homelike he should have them. LVN H said he was not sure who responsible to ensure residents had a homelike environment. LVN H said even the break room had a generic picture on the wall. LVN H said he had not noticed how bare Resident #41s room was. He said Resident #41 had never complained to him about his (Resident #41) room. During an interview on 12/8/21 at 5:05 p.m., the DON said residents should have a homelike environment. The DON said she had not noticed how bare Resident #41s room was. The DON said the activity director could obtain some items to place in Resident #41's room to make it more home like for him. The DON said there was no rounding or system in place to ensure residents had a homelike environment. During an interview on 12/8/21 at 5:20 p.m., the Administrator said residents should be provided a homelike environment. The Administrator said the facility performed stop and watch rounds. He said these rounds were completed 2-3 times a week in place of the ambassador rounds (which were more a questioner guided rounding tool) which the facility had utilized in the past. The Administrator said the stop and watch rounds were more clinically focused and could have missed the un-homelike state of Resident #41's room. Record review of the facility policy and procedure titled Resident Rooms and Environment revised August 2020 stated, Purpose; To provide residents with a safe, clean, comfortable, and homelike environment. Policy; The facility provides residents with a safe, clean, comfortable, and homelike environment. Facility Staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences .Procedure (I) Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to the following: .(d) personalized furniture and room arrangements .VI. Facility Staff work to minimize, to the extent possible, the characteristics of the Facility that reflect depersonalized, institutional setting.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42064 43047 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 2 of 24 residents reviewed for care plans. (Resident #40 and #13) The facility did not follow physician orders for wound care to right great toe for Resident #40. The facility did not follow physician orders for wound care to right arm for Resident #13. These failures could place residents at risk for unmet care needs due to lack of implementation and following orders. Findings include: 1. Record review of a consolidated physician orders dated 12/8/21 indicated Resident #40 was [AGE] years old, readmitted on [DATE] with diagnosis including hypertensive encephalopathy (brain dysfunction due to significantly high blood pressure), type 2 diabetes mellitus (impairment in the way that body regulates and uses sugar) ,bipolar disorder (mental condition marked by alternating periods of elation and depression) and dementia(loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). The order indicated clean right great toe with normal saline, pat dry, apply antibiotic ointment, and cover with clean dressing every day until resolved. (start date 12/2/21) Record review of the most comprehensive MDS dated [DATE] indicated Resident #40 usually made himself understood, usually understood others, and had a BIMS (brief interview of mental status) score of 02 indicating severe cognitive impairment. The assessment indicated Resident #40 did not reject care necessary to achieve the resident's goals for health or well-being. The assessment indicated Resident #40 had no physical or verbal behavior symptoms directed toward others. The MDS indicated Resident #40 required extensive assistance with bed mobility, transfers, dressing, eating, toileting, personal hygiene and total dependence with bathing. Record review of the care plan last reviewed on 9/26/21 indicated Resident #40 had alteration in skin (right great toe). The care plan interventions included, treatment as ordered, document healing process report to MD. Record review of a treatment administration record (TAR) dated 12/1/21-12/31/21 indicated Resident #40 wound care to his right great toe was to cleanse with normal saline, pat dry, apply antibiotic ointment and cover with clean dressing daily until resolved. During an observation on 12/5/21 at 11:07 a.m., Resident #40 was lying in bed, the dressing to his right great toe was dated 12/3/21. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/6/21 at 10:27 a.m., Resident #40 was lying in bed, the dressing to his right great toe was dated 12/3/21. 2. Record review of a consolidated physician orders dated 12/8/21 indicated Resident #13 was [AGE] years old, admitted on [DATE] with diagnosis including dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), heart failure, aortic aneurysm (bulge that occurs in a the wall of the major blood vessel that carries blood from the heart to the body) and Alzheimer's (progressive disease that destroys memory and other important mental functions). The order indicated clean right arm with Dakin's 0.25% diluted with equal parts normal saline (wound care supplies), apply Anasept (wound care supplies) and wrap with kerlex every day. (start date 11/18/21) Record review of the most comprehensive MDS dated [DATE] indicated Resident #13 made herself understood, understood others, and had a BIMS (brief interview of mental status) score of 00 indicating severe cognitive impairment. The assessment indicated Resident #13 did not reject care necessary to achieve the resident's goals for health or well-being. The assessment indicated Resident #13 had no physical or verbal behavior symptoms directed toward others. The MDS indicated Resident #13 required extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene, limited assistance with eating and total dependence with bathing. Record review of an undated care plan indicated Resident #13 had a potential/actual impairment to skin integrity related to fragile skin (right arm skin tear from a fall). The care plan interventions included, follow facility protocols for treatment of injury. Record review of a treatment administration record (TAR) dated 12/1/21-12/31/21 indicated Resident #13 wound care to her right arm was to clean with Dakin's 0.25% diluted with equal parts normal saline (wound care supplies), apply Anasept (wound care supplies) and wrap with kerlex every day. During an observation on 12/5/21 at 10:37 a.m., Resident #13 was sitting in her wheelchair at the dining room table, the dressing to her right arm was dated 12/3/21. During an interview on 12/6/21 at 10:50 a.m., LVN A said she was the treatment nurse and she completed wound care on Resident #40 this morning. LVN A said the date on the old dressing was 12/3/21. LVN A said the order was for the dressing to be changed daily. LVN A said on the weekends and when she was off work the charge nurses were responsible for providing wound care. LVN A said the failure of not having dressing changed per physician order was infection, wound decline and not following the physician orders. During an interview on 12/8/21 at 11:06 a.m., LVN B said she usually works M-F 6a-2p but had been called in to work on 12/5/21 to work 10p-6a shift. LVN B said she changed Resident #13 dressing on Sunday night (12/05/21). LVN B said she was unaware of Resident #40 requiring a dressing change to the right great toe. LVN B said the date on the wound dressing she removed was 12/3 and had the treatment nurse's initials. LVN B said the orders for the dressing was to be changed daily. LVN B said wound care should have been performed on 12/04/21. LVN B said on the weekends and when the wound care nurse off it was the charge nurse's responsibility to provide wound care. LVN B said it was important to provide wound care as ordered to keep the wound clean, promote healing and prevent healing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/8/21 at 12:17 p.m., RN C said she was the RN weekend supervisor. RN C said she was working as a charge nurse on 12/4/21. RN C said it was the charge nurse's responsibility for ensuring wound care was done on the weekend. RN C said on 12/4/21 she intended to perform wound care but due to her residents receiving visitors and having behavioral outbursts she did not perform the ordered wound care. RN C said the wound dressings should be changed daily. RN C said the failure of not changing the wound dressing daily would put the residents at risk for infection and wound decline. During an interview on 12/8/21 at 2:57 p.m., the DON said she expected residents wound care orders to be followed including weekends. The DON said the charge nurses were responsible for ensuring treatments (wound care) were done on the weekends and when the wound care nurse was off. The DON said the potential harm was risk for infection and decline in wound. The DON said there was not a system in place at this time to monitor wound care on the weekends, but she will physically start making rounds on the weekends to ensure the wound care was done. During an interview on 12/8/21 at 3:29 p.m., the Administrator said he expected residents wound care orders to be followed including weekends. The Administrator said charge nurses were responsible for ensuring treatments (wound care) were done on the weekends and when the treatment nurse was off. The Administrator said there was not a system in place at this time to monitor wound care on the weekends but the DON, ADON, and weekend supervisor will be reviewing charts in PCC on the weekends and calling up to the facility to ensure wound care was performed. The Administrator said he was not a clinician so he could not really speak on the potential harm. Record review of a Wound Management policy revised June 2020 indicated a resident who has a wound will receive necessary treatment and services to promote healing, prevent infection.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on observation, interview, and record review, the facility failed to ensure necessary services to maintain grooming and personal hygiene were provided for 3 of 18 residents reviewed for ADLs (Residents #10, #27, #2). The facility did not ensure resident #10 received showers. The facility did not clean Resident #2's nails. The facility did not clean/trim Resident #27's nails or shave his facial hair. These failures could place residents at risk of not receiving services/care, decreased quality of life, skin breakdown and infection. Findings included: 1.Record review of the consolidated physician orders dated 12/8/21 indicated Resident #10 was [AGE] years old readmitted to the facility on [DATE] with diagnoses including muscle wasting and atrophy (decrease in muscle size), lack of coordination, history of TIA (transient ischemic attack- a brief episode of neurological dysfunction resulting from an interruption in the blood supply, sometimes referred to as mini-strokes), anxiety, and heart failure. Record review of the MDS dated [DATE], indicated Resident #10 usually made herself understood and usually understood others. The MDS indicated Resident #10 had severe cognitive impairment (BIMS of 7). The MDS indicated Resident #10 had no behavior of rejecting care. The MDS indicated she required supervision only with bed mobility, transfers, dressing, eating, toilet use and personal hygiene. The MDS indicated Resident #10 was totally dependent on staff for bathing. The MDS indicated she was always incontinent of bowel and bladder. Record review of the care plan reviewed on 10/27/21 indicated Resident #10 had an ADL self-care deficit. The care plan interventions indicated Resident #10 required the assistance of one staff member to bathe and directed to assist her to be clean, dry and odor free. Record review of the undated shower sheet schedule for the 400-hall indicated Resident #10 was to be administered a bath/shower every Tuesday, Thursday and Saturday. Record review of the shower sheets for Resident #10 from 11/22/21 to 12/2/21 indicated she had refused a shower/bath on the following dates and were all signed by CNA T; *11/4/21. *11/9/21. *11/16/21. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*11/18/21. *11/22/21; and *12/2/21. Record review of the shower sheets for 11/22/21 to 12/2/21 indicated there was no shower sheet provided for the following dates:; *11/11/21. *11/13/21. *11/20/21. *11/25/21. *11/27/21; and *12/4/21. During an observation and interview on 12/5/21 at 10:12 a.m., Resident #10 was laying in her bed. Resident #10 said she had not received a shower or a bath in almost 2 weeks. During an interview on 12/7/21 at 12:45 p.m., NAIT U said Resident #10 had told her she had not had a bath in 2 weeks. NAIT U said Resident #10 was supposed to get a shower/bath three times a week. NAIT U said if a resident refused a shower/bath she would offer again later in her shift and if the resident still refused, she would notify the nurse. During an interview on 12/7/21 at 12:59 p.m., Resident #10 said she did not think she had refused any bath/showers but knew she had not refused multiple times. Resident #10 said she had just received a bath and was thankful to get clean after so long. During an interview on 12/8/21 at 4:02 p.m., CNA T said she was a shower aide at the facility. Resident #10 routinely refused bath/showers from her. CNA T said Resident #10 seemed to just have an issue with her. CNA T said if a resident refused a bath from her, she would notify the CNA working the hall. CNA T said the CNA working the hall should then attempt to provide the shower/bath. She said if the resident still refused the CNA should notify the nurse. CNA T said Resident #10 was very particular and liked to be clean. During an interview on 12/8/21 at 4:10 p.m., LVN H said if he was notified a resident had refused a shower he bath/shower he would attempt to talk to the resident and see why the resident refused. He said he would want to see if the resident wanted the assistance from bath/shower at different time or if they wanted assistance with their bath/shower from another resident. LVN H said he had not been notified Resident #10 had refused a bath/shower. He said she usually received her bath/shower on the 6am-2pm shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/8/21 at 5:02 p.m., the ADON said if resident refused a shower/bath because they would like another staff member to assist them, there may be a delay, but the resident should still receive the shower/bath. During an interview on 12/8/21 at 5:05 p.m., the DON said she expected residents to receive their showers/baths. She said if a resident refused, a second attempt should be made by the CNA. The DON said if the resident still refused the CNA should notify the nurse. The DON said there should be an effort to determine why the resident refused. She said it could have been the resident refused because they prefer another staff member, or just did not want the shower at that particular time. The DON said the CNA should fill out a shower sheet and provide it to the nurse. She said the CNA could also document the shower in the EMR. The DON said the system to ensure residents received bath/showers was the shower sheet being provided to the nurse . She said it was important for residents to receive showers/bath because they should be clean. The DON said the system in place to ensure Residents received baths/showers was giving the shower sheets to the nurses. She said there was no administrative process in place to ensure nurses verified (through the shower sheets) that baths/showers had been completed. During an interview on 12/8/21 at 5:20 p.m., the Administrator said he expected residents to be provided with showers/baths. During an interview on 12/8/21 at 5:08 p.m., EMR documentation of showers/baths since 11/1/21 for Resident #10 was requested from the DON. This documentation was not received from the facility at the time of exit. 42064 2.Record review of consolidated physicians' orders dated 12/8/2021 indicated Resident #2 was [AGE] years old, readmitted on [DATE] with diagnosis including dementia (impaired ability to remember, think, or make decisions) with behavioral disturbance, depression, osteoarthritis (joint pain), and need for assistance with personal care. Record review of the most recent MDS dated [DATE], indicated resident #2 made himself understood and understood others. Resident #2 had a BIMS (brief interview for mental status) score of 15 (cognitively intact). The MDS indicated Resident #2 did not reject care. The MDS indicated Resident #2 required extensive assistance with bed mobility, transfers, dressing and toileting. The MDS indicated Resident #2 required limited assistance with personal hygiene including combing hair, brushing teeth, shaving, and washing and drying face and hands. Record review of the care plan dated 9/15/2021, indicated Resident #2 had an ADL self- care performance deficit related to dementia, history of hip fracture and osteoarthritis. The care plan indicated Resident #2 required extensive assist of one person for personal hygiene. During an observation and interview on 12/5/2021 at 10:56 a.m., Resident #2 was sitting in the common area. He said staff treated him well and assisted him with personal care. Resident #2 had a brown substance under his nails on both hands. During an observation on 12/6/2021 at 10:07 a.m., Resident #2 had a brown substance under the nails on both hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Gardens	3500 Park St Greenville, TX 75401

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/7/2021 at 10:00 a.m., Resident #2 had a brown substance under his nails on both hands. During an observation and interview on 12/8/2021 at 11:00 a.m., Resident #2 was sitting in a chair in the common area. Resident #2 said he was doing okay. Resident #2 said staff helped him with personal care including cleaning his nails. Resident #2 had a brown substance under the nails on both hands. During an interview on 12/8/2021 at 11:08 p.m., RN G said nail care was important and should be done on the residents' shower days and as needed. She said showers were done three days weekly on the residents scheduled shower days. RN G said nail care including cleaning the nails was very important for the resident's personal hygiene. RN G said residents often put hands in their mouths and if the nails were dirty, they could have germs that caused them to become sick. During an interview on 12/8/2021 at 1:49 p.m., LVN B said Resident #2's shower days were Monday, Wednesday and Friday. LVN B said Resident #2 was compliant with his showers. LVN B said on occasion Resident #2 would not allow her to assist with cleaning his hands and would say they were fine. LVN B said she did not always document when he did not allow her to assist with washing his hands or cleaning his nails. LVN B said aides should provide nail care on Resident #2's shower day. During an interview on 12/8/2021 at 2:05 p.m., LVN H said the nurses and aides could provide nail care. LVN H said he usually had no issues getting nail care completed with the residents he was assigned. LVN H said nail care should be done on scheduled shower days and as needed. LVN H said Resident #2 would sometimes refuse his help but at a minimum his nails could and should be cleaned during his shower. LVN H said nail care was important to prevent the spread of infection. During an interview on 12/8/2021 at 2:33 p.m., CNA J said aides were responsible for cleaning residents' nails. CNA J said nail care was provided during showers, before meals and as needed. CNA J said she was assigned to residents on the 300 hallway where Resident #2 resided and did not have anyone who refused nail cleaning or care. CNA J said nail care was part of the shower and documented as a shower on the shower sheets. During an interview on 12/8/2021 at 2:38 p.m., CNA K said aides were responsible for nail care and cleaning. She said this should be done on scheduled shower days and as needed. CNA K said nail care was important to prevent the spread of germs to the residents. CNA K said nail care was part of a shower and was only documented as a shower on shower sheets. During an interview on 12/8/2021 at 2:42 p.m., CNA L said nails should be cleaned during their shower on scheduled shower days. She said any refusal should be reported to the charge nurse. CNA L said nail cleanliness was important to prevent infections. During an interview on 12/8/2021 at 2:56 p.m. CNA N said this was her first day on the 300 hallway where Resident #2 resides. CNA N said she provided nail care for residents as needed. CNA N said nail cleaning was especially important prior to meals to prevent the spread of germs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/8/2021 at 3:00 p.m., the DON said she was responsible for overseeing care given by the nurses and aides at the facility. The DON said ADL's were monitored during rounds and by reviewing documentation. The DON said good hygiene including nail care and cleaning was important for all residents to prevent skin breakdown and infection. The DON said nails should be cleansed during their shower on scheduled shower days and as needed. During an interview on 12/8/2021 at 3:15 p.m., the Administrator said he expected ADL's to be completed as scheduled. He said if a resident refused, he expected staff to ask the resident again at another time and ask if the task could be completed on another day. He said repeated refusal should be documented and care planned. Record review of a policy titled grooming care of the fingernails and toenails indicated nail care was given to clean and keep the fingernails trimmed. 45144 3.Review of consolidated physician orders dated12/08/2021 indicated Resident #27 was 67years old, admitted on [DATE] with diagnoses including dementia, partial paralysis following a left sided stroke, need for assistance with personal care, schizophrenia, difficulty swallowing. The orders did not address nail care or facial hair shaving. Review of MDS dated [DATE] indicated Resident #27 was unable to complete a BIMS (Brief Interview for Mental Status). Resident#27 had difficulty focusing attention that changed in severity. Resident #27 had verbal behavioral symptoms directed towards others 1 to 3 days a week. Resident #27 is rarely/never understood. The MDS indicated Resident #27 did reject care 1 to 3 days a week. Resident #27 required extensive assistance for bed mobility, transfers, dressing, eating, toilet use and personal hygiene. Resident #27 was not steady and only able to stabilize with staff assistance. The MDS indicated Resident #27 had range of motion impairments on one side of both upper and lower extremities. Review of care plan updated on 11/03/2021 indicated Resident #27 required (2) staff participation with personal hygiene and oral care. The care plan did not indicate how often nail care or facial shaving were to be done. During observation on 12/05/2021 at 10:43 a.m., Resident #27 was calm and awake in bed. Resident #27's fingernails of both hands had a black substance under them and were 0.5 centimeters long. His face had visible beard stubble. During observation on 12/06/2021 at 10:06 a.m., Resident #27 was sleeping in bed. Resident #27's fingernails of both hands had a black substance under them and were 0.5 cm long. His face had visible beard stubble. During observation on 12/06/2021 at 1:35 p.m , Resident #27 was calm and awake in bed. Resident #27's fingernails of both hands had a black substance under them and were 0.5 cm long. His face had visible beard stubble. During observation on 12/07/2021 at 8:26 a.m., Resident #27 was sleeping in bed. Resident #27 s fingernails of both hands had a black substance under them and were 0.5 centimeters long. His face had visible beard stubble. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Greenville Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 3500 Park St Greenville, TX 75401	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 12/07/2021 at 2:24 p.m , Resident #27 was awake in bed. Resident #27's fingernails had a black substance under them and were 0.5 centimeters long. His face visible beard stubble. During observation on 12/08/2021 at 9:33 a.m., Resident #27 was awake in bed. Resident #27's fingernails had a black substance under them and were 0.5 centimeters long. His face had visible beard stubble. During an interview on 12/06/2021 at 11:14 a.m. Resident #27's daughter said her father preferred to be clean shaven and have regular nail care. During an interview on 12/8/2021 at 10:55 a.m., CNA S said the shower aide did the ADLs to include nail care and facial shaving for dependent residents. She said Resident #27 sometimes refused care. CNA S said that nail care and facial shaving was important to provide basic care. During an interview on 12/8/2021 at 11:17 a.m., shower aide CNA T said she had been the shower aide at this facility since September of this year. CNA T said the shower aide was responsible for providing nail care and shaving for Resident #27. She said Resident #27 would receive nail care and facial shaving on Monday, Wednesdays and Fridays as residents allow. CNA T said Resident #27 sometimes fought with staff and refuse care. CNA T said Resident #27 did better when sat up for nail care and facial shaving. CNA T said nail care and facial shaving was important for appearance. CNA T said documentation of nail care and facial shaving was recorded on the shower sheets. During an interview on 12/8/2021 at 11:52 a.m., LVN Q. said the aides were responsible for nail care and facial shaving. LVN Q said this care was provided when Resident #27 had showers and as needed. LVN Q said Resident #27 was often combative. LVN Q said nail care and facial shaving were necessary for dignity. During an interview on 12/8/2021 at 3:14 p.m., LVN H said the shower aide did the nail care and facial shaving for dependent residents. LVN H said that any staff can do nail care and facial shaving as needed. LVN H said nail care and facial shaving was done during resident's showers and is documented in the shower log. LVN H said nail care and facial shaving was important to ensure residents are clean and feel better. LVN H said he was not the nurse for Resident #27 and did not know if he refused care. During interview on 12/08/2021 at 2:25 p.m., the DON said resident's nail care should be done as needed daily, and by all shifts. The DON said nail care and facial shaving was important for proper hygiene. The DON said if a resident refuses nail care and/or facial shaving, staff should document the refusal on the shower log and nursing notes. The DON said she makes rounds each Monday to ensure that residents are receiving ADL care. During interview on 12/08/2021 at 2:05 p.m., the Administrator said nail care and facial shaving is important for hygiene. The Administrator said some men like to have their facial hair shaved and some do not. During interview on 12/08/2021 at 3:50 p.m. shower logs were requested from the DON, but none were received prior to exit conference.

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	675367	A. Building B. Wing	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on observation, interview and record review the facility failed to ensure a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections for 3 of 18 residents reviewed for appropriate treatment and services to prevent urinary tract infections (Resident #74, Resident #76 and Resident #2). The facility did not ensure NAIT U provided appropriate incontinent care for Resident #74 after she had been incontinent of bowel. The facility did not ensure Resident #76 had a catheter secure device in place. The facility did not ensure Resident #2 had a catheter secure device in place. These failures could place residents at risk for urinary tract infections, and urethral injury. Findings included: Record review of the physician order summary dated 12/8/21 indicated Resident #74 was [AGE] years old readmitted to the facility on [DATE] with diagnosis including acute cystitis (inflammation of the urinary bladder) with hematuria (blood in the urine), the presence of urogenital implants, acute kidney failure, sepsis, type 2 diabetes, history of skin infection, resistance to multiple antibiotics, and history of urinary tract infections. Record review of the MDS dated [DATE] indicated Resident #74 made herself understood and understood others. The MDS indicated she had a mild cognitive impairment (BIMS of 11). The MDS indicated Resident #74 had no history of rejecting care. The MDS indicated she required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. The MDS indicated she required supervision with transfers and eating. The MDS indicated she required limited assistance with locomotion in her wheelchair. The MDS indicated she was always incontinent of bowel and bladder. The MDS indicated Resident #74 had received antibiotics 3 of 7 days during the 7-day look back period. Record review of the care plan reviewed on 10/12/21 indicated Resident #74 had a history of urinary tract infections. The care plan interventions indicated Resident #74 was to be provided incontinent care every 2 hours as needed and the soiled areas were to be washed, rinsed, and dried. The care plan indicated Resident #74 had a self-care deficit and required extensive, total assistance of 1 staff member for toileting. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/7/21 at 2:27 p.m., NAIT U provided incontinent care for Resident #74 after she had been incontinent of bowel. After putting on gloves, NAIT U pulled clean wipes from the wipe container and laid them on the surface on the bed. NAIT U then opened the Resident #74's soiled brief. NAIT U picked up the wipes from the surface of the bed and began to wipe stool from Resident #74's thighs and perineal area (the region between the thighs, bounded by the opening of the vagina and the anus in females). She then rolled Resident #74 on her left side. NAIT U tucked the soiled brief under Resident #74's left hip. Without changing her gloves or performing hand hygiene (washing of hands or use of hand sanitizer), NAIT U removed a clean brief from the bedside table and started tuck the brief under Resident #74's left hip (next to the soiled brief). When NAIT U said she had completed incontinent care, the surveyor requested she clean between Resident #74's labia. NAIT U separated the labia and wiped with a clean wipe. There was visible stool on the wipe. NAIT U repeated this process with 3 wipes before there was no stool visible on the wipe. During an interview on 12/7/21 at 3:05 p.m., NAIT U indicated she did not realize she should not have placed clean wipes on the surface of Resident #74's bed before using them to provide incontinent care. NAIT U said she did not think about her gloves being dirty after she cleaned stool from Resident #74. NAIT U said she should have removed the gloves and washed her hands before she touched the clean brief. NAIT U indicated she did not realize she should not have placed the clean brief under Resident #74 while the soiled brief remained on the bed. NAIT U said she thought she had removed the stool from Resident #74 before surveyor intervention. NAIT U said she felt bad after repeated wipes had stool between the labia because she thought she had cleaned Resident #74 of stool. She said not ensuring Resident #74 was cleaned of stool could cause infection. During an interview on 12/8/21 at 12:17 p.m., CNA V said NAIT U should not have placed clean wipes on the surface of Resident #74's bed before using them to provide incontinent care. She said NAIT U should have removed her gloves after she cleaned Resident #74 of stool and performed hand hygiene before touching the clean brief. CNA V said NAIT U should not have placed the clean brief under Resident #74 while the soiled brief remained tucked under Resident #74. CNA V said NAIT U should have ensured the stool was completely removed between the labia before completing incontinent care. CNA V said all these errors could cause cross contamination and lead to infection. During an interview on 12/8/21 at 4:49 p.m., LVN M said he expected nurse aids to ensure residents were cleaned of stool before incontinent care was completed. LVN M said it was especially important to clean carefully between the labia of female residents. LVN M said not ensuring the area between the labia was cleaned could cause urinary tract infections. LVN M said NAIT U should not have placed clean wipes on the bed and should not have placed a clean brief next to the soiled brief. LVN M said NAIT U should have removed her gloves after cleaning the stool off Resident #74, washed her hands, and put on clean gloves before she touched the clean the brief. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2021
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/8/21 at 5:05 p.m., the DON said she expected nurse aids to ensure residents were cleaned of stool before completing incontinent care and expected them to ensure cross contamination did not occur. She said NAIT U should not have placed clean wipes on the bed and should not have placed a clean brief next to the soiled brief. The DON said NAIT U should have removed her gloves after cleaning the stool off Resident #74, washed her hands, and put on clean gloves before she touched the clean the brief. The DON said these actions were an infection control issue. The DON said the system in place to ensure nurse aides performed incontinent care correctly was the annual skills check off, which included evaluation of the incontinent care they provided. The DON said she was responsible for skill check offs and said NAIT U had her initial skills check off recently as she was new employee. 42064 2. Record review of the consolidated physicians' orders dated 12/8/2021, indicated Resident #76 was [AGE] years old, admitted on [DATE] with diagnosis including malignant neoplasm of the brain, muscle weakness, hypotension (low blood pressure), depression, chronic pain, high blood pressure and left above the knee amputation. The orders indicated Resident #76 required foley catheter (a plastic or rubber tube that is inserted into the bladder to drain the urine) care every shift. The orders indicated Resident #76 would have her catheter securement device changed every week starting 11/16/2021. Record review of the most recent comprehensive MDS dated [DATE], indicated Resident #76 made herself understood and understood others. The MDS indicated Resident #76 had a BIMS (brief interview for mental status) score of 2 (severe cognitive impairment). The MDS indicated Resident #76 did not reject care. The MDS indicated Resident #76 required extensive assistance with bed mobility, transfers, dressing, eating, toileting, and personal care. The MDS did not Resident #76 had a catheter. Record review of the care plan dated 10/27/2021, indicated Resident #27 had an indwelling catheter. The care plan indicated the catheter tubing should be secured to prevent trauma as resident allowed. During an observation and interview on 12/6/2021 at 11:37 a.m., Resident #76's catheter tubing was not secured. CNA K said Resident #76's catheter should be secured to the bed but was unsure about any other method of being secured. During an observation and interview on 12/6/2021 at 1:58 p.m., Resident #76's catheter tubing was not secured. CNA P said she had never seen Resident #76 with a catheter secure in place. CNA P said she always used the tubing clip and clipped it to the bedsheet. CNA P said it was important for the catheter tubing to be secured so it would not be pulled on. During an observation and interview on 12/7/2021 at 9:45 a.m., Resident #76's catheter tubing was not secured. CNA P said a catheter secure helped prevent pulling of the tubing and helped prevent skin breakdown. CNA P said the nurses were responsible for the catheter secure devices. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3 Record review of the consolidated physicians' orders indicated Resident #2 was [AGE] years old, readmitted on [DATE] with diagnosis including retention of urine, dementia with behavioral disturbances, calculus of kidney with calculus of ureter, need for assistance with personal care and muscle weakness. The orders indicated Resident #2 had a foley catheter due to urinary retention. The orders indicated Resident #2s catheter securement device should be changed weekly on the Sunday day shift beginning 11/21/2021. Record review of the most recent MDS dated [DATE], indicated resident #2 made himself understood and understood others. Resident #2 had a BIMS (brief interview for mental status) score of 15 (cognitively intact). The MDS indicated Resident #2 did not reject care. The MDS indicated Resident #2 required extensive assistance with bed mobility, transfers, dressing and toileting. The MDS indicated Resident #2 required limited assistance with personal hygiene including combing hair, brushing teeth, shaving, and washing and drying face and hands. The MDS did not address Resident #2s catheter. Record review of the care plan dated 9/15/2021, indicated Resident #2 had an ADL self- care performance deficit related to dementia, history of hip fracture and osteoarthritis. The care plan indicated Resident #2 required extensive assist of one person for personal hygiene. The care plan indicated Resident #2 had a foley catheter related to urinary retention. The care plan indicated resident #2 should have catheter tubing secured to prevent trauma. During an observation and interview on 12/6/2021 at 2:30 p.m., Resident #2s catheter tubing was not secured. CNA J said she thought Resident #2 had a catheter secure device in place. CNA J said securing catheter tubing to the resident was important to prevent breakdown and pulling on the catheter. During an interview on 12/8/2021 at 11:08 a.m., RN G said she was the charge nurse for hallway 400 but occasionally cared for the residents on hallway 300. RN G said it was important for catheter tubing to be secured to the leg to stabilize the catheter and prevent it from becoming dislodged or causing breakdown. RN G said she assessed each shift to ensure catheters were secured and documented this on the nurse administration record. During an interview on 12/8/2021 at 1:49 p.m., LVN B said catheters were secured so that they did not get ripped out and cause harm to the resident. She said residents were assessed at least daily to ensure their catheter tubing was secured. LVN B said this assessment was not documented anywhere but was done. LVN B said Resident #76's brief normally held her catheter in place because Resident #76 did not like tape on her skin and normally laid in the same position every day. LVN B said Resident #76 was an above the knee amputee but she would try to secure the catheter to Resident #76's other leg. During an interview on 12/8/2021 at 2:05 p.m., LVN H said all catheter tubing should be secured to the residents' leg to prevent kinking, rubbing, wounds and dislodgement. LVN H said he assessed residents with catheters at least each shift to ensure the catheter tubing was secured to the resident. LVN H said he cared for Resident #76 on a regular basis and there was not any reason her catheter tubing should not have been secured. During an interview on 12/8/2021 at 2:33 p.m. CNA J said catheters were to be secured to the resident, so the catheter did not get pulled out of resident. CNA J said any catheter not secured should be reported to the charge nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2021

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/8/2021 at 2:42 p.m., CNA L said the aides should ensure catheter tubing is secured and if not report to the charge nurse. During an interview on 12/8/2021 at 2:50 p.m., LVN L said all catheter tubing should be secured to the leg to prevent trauma and dislodgement. During an interview on 12/8/2021 at 2:56 p.m. CNA N said it was her first day working the 300 hallway and she was not very familiar with the residents. CNA N said she was unsure if catheter tubing should be secured to the resident. During an interview on 12/8/2021 at 3:00 p.m., the DON said was responsible for overseeing the care given by nurses and aides. The DON said all catheter tubing should be secured unless refused. The DON said it was important to secure catheters to prevent trauma, discomfort and pulling. She said catheters should be assessed during rounds and any refusal to secure the catheter should be documented and care planned. During an observation on 12/8/2021 at 3:15 p.m., the Administrator said he expected catheter tubing to be secured. Record review of an undated policy titled Catheter-Care of indicated the facility would ensure the catheter was properly anchored to prevent urethral tearing. Record review of a policy dated 6/2020 titled Perineal care indicated its purpose was to maintain cleanliness of the genital area, to reduce odor, and to prevent infection or skin breakdown. The policy indicated to wash pubic area for the female resident first separate the labia. Wash with soapy washcloth or cleansing wipe, moving from front to back on each side of the labia and in the center over the urethra and vaginal opening using clean washcloth/cleansing wipe for each stroke. Rinse the area, moving from front to back, using a clean washcloth/cleansing wipe for each stroke. Dry area moving from front to back, using a blotting motion with a towel. Turn the resident to the side. Wash, rinse and dry the buttock and peri-anal area without contaminating perineal area. Remove wet linen. Place dry linens or briefs or both under the resident. Remove gloves, wash hands or use alcohol-based sanitizer. Do not touch anything with soiled gloves after the procedure for example curtain, side rails, clean linen or call bell. Put on clean gloves, clean and return all equipment to its proper place. Place soiled linen in the proper container, remove gloves and wash hands.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2021
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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on observations, interview and record review the facility failed to ensure that a resident who needs respiratory care, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, goals and preferences for 3 of 5 residents (Resident #64 and Resident #37,#27) reviewed for respiratory care. The facility did not ensure Resident #64's oxygen concentrator filter was clean. The facility did not ensure Resident #37's nebulizer (a device used to deliver liquid medication in an aerosol form to a resident's lungs) was dated. The facility did not ensure Resident #27's suction canister, suction tip (an appliance used to remove excess secretions from mouth) and suction tubing were dated. These failures could place residents who required respiratory care at risk for respiratory infections. Findings included: 1.Record review of the physician order summary report dated 12/8/21 indicated Resident #64 was [AGE] years old admitted to facility with diagnoses including pain, depression, type 2 diabetes, high blood pressure and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) Record review of the MDS dated [DATE] indicated Resident #64 understood others and made herself understood. The MDS indicated Resident #64 had did not have cognitive impairment (BIMS of 15). The MDS indicated she mild depression (PHQ-9 of 6). The MDS indicated Resident #64 had no behavior of rejecting care. The MDS indicated Resident she required supervision only to for ADLS including bed mobility, transfers, walking with her walker, dressing, eating, toilet use and personal hygiene. The MDS indicated Resident #1 was independent with bathing. The MDS indicated she was never incontinent of bowel or bladder. The MDS indicated Resident #64 had an active diagnosis of asthma, chronic obstructive pulmonary disease, or chronic lung disease. Record review of the care plan reviewed on 11/17/21 indicated Resident #64 had chronic obstructive pulmonary disease and was a smoker. The care plan interventions indicated Resident #64 would be administered oxygen therapy as ordered by physician; and sources of respiratory irritation would be identified/eliminated. Record review of the active physician order with a start date of 12/5/21 indicated Resident #64's oxygen concentrator filter was to be cleaned weekly on the Sunday evening shift. Record review of the active physician order with a start date of 9/21/21 indicated Resident #64 was to be administered oxygen via a nasal cannula at 2-4 liters as needed for an oxygen saturation less than 92%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 12/5/21 at 10:50 a.m., Resident #64 was sitting in her bed. Resident #64 said she wore oxygen sometimes when her oxygen saturation was low. Resident #64 said she had not had any increased breathing problems. The filter on the back of Resident #64's oxygen concentrator was covered in a thick layer of dust. During an observation on 12/6/21 at 10:30 a.m., Resident #64 was laying in her bed. She had her nasal cannula (device used to deliver supplemental oxygen) on. The filter on the back of Resident #64's oxygen concentrator was covered in a thick layer of dust. During an observation on 12/7/21 at 10:00 a.m., Resident #64 was laying in her bed. She had her nasal cannula (device used to deliver supplemental oxygen) on. The filter on the back of Resident #64's oxygen concentrator was covered in a thick layer of dust. During an observation and interview on 12/8/21 at 12:15 p.m., Resident #64 was laying in her bed. The filter on the back of her oxygen concentrator was covered in a thick layer of dust. Resident #64 said she did not think the facility did anything with the filter on the oxygen concentrator but said they frequently change her oxygen tubing. During an interview on 12/8/21 at 4:03 p.m., CNA T said she thought the nurses were responsible for cleaning the oxygen concentrator filters for residents on oxygen therapy. She said CNAs did not touch the oxygen concentrators. During an interview on 12/8/21 at 4:10 p.m., LVN H said nurses were responsible to ensure residents on oxygen had the oxygen concentrator filter cleaned at least weekly. LVN H said the task was assigned to weekend nurses but he was not sure which shift was to ensure the task was performed. LVN H said although the task of cleaning the oxygen concentrator filter was not assigned to him if he noticed it needed to be done, he would perform the task. LVN H said he had not noticed Resident #64's oxygen concentrator filter was covered in dust. LVN H said it was important Resident #64's oxygen concentrator filter be cleaned as the collection of dust could cause increased breathing problems or respiratory infections. During an interview on 12/8/21 at 4:49 p.m., LVN M said nurses were responsible to ensure residents on oxygen had the oxygen concentrator filter cleaned at least weekly. He said the knew the filters were to be cleaned by the night shift nurses but was not sure which day it was performed. LVN M said it was important for any resident on oxygen, to have the oxygen concentrator filter cleaned as the collection of dust could cause increased breathing problems and respiratory infections. During an interview on 12/8/21 at 5:02 p.m., the ADON said the Sunday night shift nurses were responsible to ensure oxygen concentrator filters were cleaned. The ADON said Resident #64's oxygen concentrator filter should not have been covered in dust and could cause her to have increased breathing problems, infection and effect the efficiency of the oxygen concentrator. The ADON said he was not sure if there was a system in place to ensure the Sunday night shift nurses completed the task of cleaning the oxygen concentrator filters. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/8/21 at 5:05 p.m., the DON said the Sunday night shift nurses were responsible to ensure oxygen concentrator filters were cleaned. The DON said Resident #64's oxygen concentrator filter should not have been covered in dust and was an infection control issue. The DON said the current system in place to ensure the task of cleaning the oxygen concentrator filters was writing an order for the task so it would alert the nurse it needed to be performed. The DON said she assumed if the nurse signed the MAR, the task had been completed. During an interview on 12/8/21 at 5:20 p.m., the Administrator said he expected oxygen concentrator filters to be cleaned. He said spot checks should be performed to ensure oxygen concentrator filters were being cleaned but was not sure if clinical management had been performing spot checks of that kind. 45144 2. Record review of consolidated physician orders dated 12/08/2021 indicated Resident #37 was a [AGE] year-old female admitted on [DATE] with a diagnosis of acute respiratory failure with hypercapnia and shortness of breath. Resident #37 had an order dated 12/03/2021 for Ipratropium-Albuterol Solution 05-2.5 milligram per 3 milliliters inhaled orally four times a day for 7 days for cough/congestion/bronchitis. Resident #37 had an order dated 12/08/2021 to Change nebulizer mask and tubing once a week on Fridays and as needed. Review of physician orders on 12/06/2021 revealed no active order to change out nebulizer, mask, or tubing. Review of the most recent MDS dated [DATE] indicated Resident #37 had clear speech, made self-understood and understood others. Resident #37 had a BIMS (Brief Interview for Mental Status) of 14 and was cognitively intact. Resident #37 had active diagnosis of respiratory failure. Resident #37 had other health conditions of shortness of breath when lying flat. Review of the most recent Care Plan dated 10/10/2021 indicated Resident #37 had an altered respiratory status, difficulty breathing related to sleep apnea, a recent episode of respiratory failure, and had experienced shortness of breath when lying flat. There was no mention of the nebulizer treatments in the Care Plan. Observation on 12/05/2021 at 11:47 a.m., revealed Resident #27 was awake in bed. A nebulizer machine was on a bedside table. The disposable nebulizer, mask, and tubing were in a bag, and not dated. Observation on 12/06/2021 at 10:55 a.m., revealed Resident #37 was sleeping in bed. The nebulizer machine was on a bedside table. The disposable nebulizer, mask, and tubing were in a bag, and not dated. Observation on 12/06/2021 at 1:35 a.m , revealed Resident #37 was awake in bed. A nebulizer machine was on a bedside table. The disposable nebulizer, tubing, and mask were in a bag, and not dated. Observation on 12/07/2021 at 8:48 a.m., revealed Resident #37 was sleeping. A nebulizer machine was on the bedside table. The disposable nebulizer, mask, and tubing were in a bag, and not dated. 3. Record review of the most recent consolidated physician orders dated12/08/2021 indicated Resident #27 was 67years old, admitted on [DATE] with diagnoses of dementia, partial paralysis following a left sided stroke, need for assistance with (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	personal care, schizophrenia, difficulty swallowing. Resident #27 had an order dated 12/08/2021 to change suction canister and tubing once a week and as needed on Monday night shift. Resident # 27 had an order dated 10/21/2021 to suction prn (as needed), and a suction machine at bedside, as needed for congestion and or mucus build up. Review of physician orders on 12/06/2021 revealed no active order to change out of suction canister, suction tubing or suction tip. Record review of the most recent MDS dated [DATE] indicated Resident #27 had been unable to complete a BIMS (Brief Interview for Mental Status). Resident#27 had difficulty focusing attention that changes in severity. Resident #27 had verbal behavioral symptoms directed towards others 1 to 3 days a week. Resident #27 was rarely/never understood. The MDS indicated Resident #27 did reject care 1 to 3 days a week. Resident #27 required extensive assistance for bed mobility, transfers, dressing, eating, toilet use and personal hygiene. Resident #27 was not steady and only able to stabilize with staff assistance. The MDS indicated Resident #27 had range of motion impairments on one side of both upper and lower extremities. During observation on 12/05/2021 at 10:43 a.m., Resident #27 was resting in bed with head of bed elevated 45 degrees. A suction machine was on the bedside table. The suction canister, suction tubing and suction tip were not dated. The suction canister was not covered. The suction tip was dangling by the bedside table. The suction canister was approximately half (no level makings on container) full of mucus and water. During observation on 12/06/2021 at 10:06 a.m., Resident #27 was sleeping with head of bed elevated 45 degrees. A suction machine was on the bedside table. The suction canister, suction tubing and suction tip were not dated. The suction canister was not covered. The suction tip was stored in the original package and kept in the top drawer of the bedside table. The suction machine was approximately half full of white mucus and water. During observation on 12/06/2021 at 1:35 p.m , Resident #27 was awake with the head of the bed elevated 45 degrees. A suction machine was on the bedside table. The suction canister, suction tubing and suction tip were not dated. The suction canister was approximately a little over half full. The suction tip was in the original package inside a bedside table drawer. During observation on 12/07/2021 at 8:26 a.m., Resident #27 was sleeping with the head of bed elevated 45 degrees. A suction machine was on the bedside table. The suction canister, suction tubing and suction tip were not dated. The suction canister was a little over half full. The suction canister was not covered. The suction tip was in the original packaging in the top drawer of nightstand table. During observation on 12/07/2021 at 2:33 p.m , Resident #27 was sleeping with the head of bed elevated 45 degrees. A suction machine was on the bedside table. The suction canister, suction tubing and suction tip were not dated. The suction canister was a little over half full. The suction tip was in the original packaging in the top drawer of nightstand table. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/08/201 at 11:46 a.m., LVN Q said the night shift changes out the nebulizer equipment and suction canisters, tubing, and suction tips, but that any nurse can change them out when visibly dirty. LVN Q did not know how often, but believed it was weekly. LVN Q said the equipment needed to be changed out regularly to keep out bacterial pathogens. LVN Q was not sure if there was a task or check off for changing respiratory equipment but would check it out. LVN Q provided no further information was provided prior to exit conference. During an interview on 12/08/2021 at 12:01 p.m., the ADON, while working at nurse's station, said disposable nebulizer equipment and disposable suction equipment are changed out every Sunday night. The ADON said this task is scheduled in PointClickCare electronic medical records. The ADON said it was important to change out nebulizer and suction equipment to prevent infections During an interview on 12/08/2021 at 2:24 p.m. the DON said the nurse working on Sunday night shift are responsible for changing out disposable nebulizer and suction equipment. The DON said she make rounds on Monday morning to ensure that this task is completed. The DON said it was important to change out nebulizers on a regular basis to prevent infection. The DON said it was ultimately the nurse's responsibility to make sure nebulizer equipment is changed out and the order put in the computer. During an interview on 12/08/2021 at 1:05 p.m., the Administrator said nursing was responsible for changing out all respiratory equipment. The Administrator said it was important to date the equipment to know when it needed to be changed out. Record review of the facility's policy from and undated Nursing Manual-Nursing Care Oxygen Administration referenced source 42 C.F.R. S483.25 with no revision date, reflected the following: All oxygen tubing, humidifiers, masks, and cannulas will be changed weekly and when visibly soiled. The Administration did not provide a policy regarding nebulizer or suction equipment change out frequency.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on observation, record review, and interview, the facility failed to ensure pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences, for 1 of 18 residents (Resident #64) reviewed for pain management. The facility did not provide Resident #68 with her available and ordered pain medication during an episode of acute pain on 12/6/21. As a result, Resident #68 suffered severe pain for at least an approximate hour. This failure could place residents at risk for unnecessary pain, discomfort and decreased quality of life. Findings included: Record review of the physician order summary report dated 12/8/21 indicated Resident#64 was [AGE] years old admitted to facility with diagnoses including pain, schizophrenia, bipolar disorder, depression, type 2 diabetes, high blood pressure and chronic obstructive pulmonary disease. Record review of the MDS dated [DATE] indicated Resident #64 understood others and made herself understood. The MDS indicated Resident #64 did not have cognitive impairment (BIMS of 15). The MDS indicated she had mild depression (PHQ-9 of 6). The MDS indicated Resident #64 had no behavior of rejecting care. The MDS indicated she required supervision only to for ADLS including bed mobility, transfers, walking with her walker, dressing, eating, toilet use and personal hygiene. The MDS indicated Resident #1 was independent with bathing. The MDS indicated she was never incontinent of bowel or bladder. The MDS indicated Resident #64 had an active diagnosis of pain. The MDS indicated Resident #64 had received a scheduled pain management regimen during the 5-day look back period. The MDS indicated she had not received PRN (as needed) pain medication or non-medication intervention for pain relief during the 5-day look back period. The MDS indicated during the 5-day look back period Resident #64 had not had pain at any time. The MDS indicated she had received an opioid (a medication primarily used for pain relief) daily during the 7-day look back period. Record review of the active physician order with a start date of 9/17/21 indicated Resident #64 was to be administered Hydrocodone-Acetaminophen 10-325 mg by mouth every 6 hours for pain. Record review of the active physician order with a start date of 12/3/21 indicated Resident #64 was to be administered Oxycodone HCL 5 mg by mouth every 12 hours as needed for pain. Record review of the care plan reviewed on 11/17/21 indicated Resident #64 had history of seeking pain medication. The care plan interventions included administer medications as ordered and monitor/document for effectiveness; anticipate the resident's needs; and assist the resident to develop more appropriate methods of coping . (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview and observation on 12/5/21 at 10:55 a.m., Resident #64 was walking down the hall with her walker. Resident #64 said she was having trouble getting her pain medication when she needed it. Resident #64 said she was not hurting today. During an observation and interview on 12/6/21 at 10:30 a.m., Resident #64 was laying in her bed grimacing and rubbing her left hip. She moaned then said her hip and back were hurting. Resident #64 rated the pain at a 10 on 0-10 pain scale (0 being no pain at all 10 being severe pain). She said she had already asked for pain medication and was told by CMA X she could not have anything for pain until 12:00 p.m. During an interview at 12/6/21 at 10:46 a.m., LVN B said she believed Resident #64 was on a scheduled pain regimen. LVN B said Resident #64 had been administered scheduled pain medication at 6:00 a.m. and would receive the medication again at 12:00 p.m. LVN B said scheduled pain medications were administered by the CMAs. She said follow up pain assessments were not triggered in the EMR for scheduled pain medications. but if a resident reported pain when a scheduled pain medications,. but if a resident reported pain when a scheduled pain medication was given, then a follow up assessment should be completed . She clarified; the CMA should let the nurse know if a resident continued to have pain after a scheduled pain medication was administered and the nurse would assess the resident's pain at that time. LVN B said if a resident had a PRN (as needed) pain medication available it would be administered by the nurse. LVN B said CMA X had not reported Resident #64 had continued pain after the administration of scheduled pain medication. LVN B indicated if the resident continued to have pain after the administration of the prn pain medication, the nurse would notify the physician. During an observation on 12/6/21 at 11:10 a.m., Resident #64's call light was on. An unidentified housekeeper walked into the room. During an interview on 12/6/21 at 11:11 a.m., The unidentified housekeeper said Resident #64 told her she needed a pain pill and a muscle relaxer. The housekeeper said she would tell the nurse. During an observation on 12/6/21 at 11:12 a.m., CMA X entered Resident #64's room and told Resident #64 you have 30 more minutes. During an interview on 12/6/21 at 11:13 a.m., CMA X said Resident #64 told him she had oxycodone that could be administered. CMA X said he did not think Resident #64 had oxycodone and believed she just hydrocodone. CMA X said he was going to check and see if Resident #64 had any new pain medications . During an observation on 12/6/21 at 11:15 a.m., the ADON knocked on Resident #64's door but did not enter the room. The ADON then went to the end of the hall and talked to CMA X. During an observation and interview on 12/6/21 at 11:19 a.m,, Resident #64 was laying in her bed on her right side. She moved back and forth in a rocking motion while on her right side. She was tearful and said the pain was getting worse. Resident #64 said CMA X told her he would have to check if she had any new pain medications available. Resident #64 said she told CMA X she had oxycodone. She said CMA X told her she could have hydrocodone and a muscle relaxer in 30 minutes. During an observation on 12/6/21 at 11:20 a.m., the ADON entered Resident #64's room. The ADON did not have any medication with him. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an observation on 12/6/21 at 11:22 a.m., the ADON exited the room and went to the medication cart CMA X had just placed outside of Resident #64's room. During an interview on 12/6/21 at 12:04 p.m., Resident #64 said the pain had gotten better and she just wanted to sleep. Record review of Resident #64's MAR for 12/5/21-12/6/21 indicated she had not been administered her oxycodone since 8:30 p.m. on 12/5/21. The MAR did not indicate Resident #64 was administered oxycodone on 12/6/21. Record review of Resident #64's pain assessments on 12/6/21 indicated the following pain levels (on pain scale of 0-10) on the following times; *at 12:00 a.m.-0; *at 6:00 a.m.-0; *at 7:57 a.m.-5; *at 12:00 p.m.-NA; *at 2:26 p.m.-0; *at 6:00 p.m.-0; *at 7:05 p.m.-0; and *at 7:07 p.m.-0. During an interview on 12/8/21 at 10:13 a.m., RN G said she was the nurse for Resident #64 on 12/6/21 on the 6am to 2pm shift. RN G said Resident #64 was being managed by a pain management clinic and was to have back surgery. She said Resident#64 did have Oxycodone ordered by her pain management physician in addition to her scheduled Hydrocodone since 12/3/21. RN G said when she received the order for the Oxycodone, she contacted Resident #64's primary physician and reviewed her medications with him. RN G said at that time Resident #64's primary physician agreed with the Oxycodone administration and she put the order in the EMR system. RN G said the Oxycodone would not display on the CMAs medication list for Resident #64 because it was a PRN (as needed) medication and would only display on the nurse's medication list because the nurse would have to administer the medication. RN G said the process was if a Resident had scheduled pain medication, it could be administered by a CMA. But if a resident continued to have pain the CMA was to notify the nurse and the nurse would check the nursing MAR/physician orders for a PRN pain medication. RN G said RN G said Resident #64 would call for her pain medication if she needed it. RN G said she was not notified Resident #64 had unrelieved pain on 12/6/21. RN G said had she been notified she would have administered her the Oxycodone. During an interview on 12/8/21 at 3:52 p.m., NAIT U said Resident #64 complained of pain at least 3 times before 10:00 a.m. on 12/6/21. NAIT U said she notified RN G of Resident #64's pain every time Resident #64 complained of pain before 10:00 a.m. (continued on next page)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2021

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/8/21 at 4:43 p.m., CMA W said if a scheduled pain medication is administered and a Resident reports they are having pain; the CMA should follow up between 30 minutes to an hour after the pain medication administration to ensure the pain has been relieved. CMA W said if the resident reported they still had pain; the CMA should notify the nurse. During an interview on 12/8/21 at 5:02 p.m., the ADON said Resident #64 did not report pain to him on 12/6/21. During an interview on 12/8/21 at 5:05 p.m., the DON said she expected nurses to administer pain medication as ordered and expected CMAs to report unrelieved pain to nurses. The DON said if a Resident reports pain with scheduled pain medication the nurse should follow up and assess if the resident was still having unrelieved pain approximately an hour after the administration of the medication. The DON said the system in place to ensure resident pain was managed was to review resident charts for the follow up pain assessment. During an interview on 12/8/21 at 5:20 p.m., the Administrator said he expected staff to administer pain medication as ordered and expected CMAs to report unrelieved pain to nurses. He said the system in place to ensure pain management needs were met was the daily clinical morning meeting where new clinical issues were discussed. The Administrator said this system was dependent on staff communicating resident issues, which would include unrelieved pain. During an interview on 12/7/21 11:00 a.m., the DON was asked to provide a facility policy and procedure for pain management. This facility policy and procedure was not provided at the time of exit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food safety in the facility's only kitchen. The facility failed to ensure food items in the kitchen refrigerators and freezers were dated, labeled, and sealed appropriately. The facility failed to ensure food items in the kitchen refrigerators were used by the best by date. These failures could place the residents at risk for food-borne illness, and food contamination. Findings include: During an observation on [DATE] at 08:12 a.m., the following items were found with no date, no label and were not sealed; *crinkle cut French fries located in freezer #2 on the bottom shelf During an interview and observation on [DATE] at 08:15 a.m., the FSS was shown the opened, undated crinkle cut French fries. The FSS took the opened bag of French fries placed them in a sealable bag and dated the bag [DATE]. The FSS said he believed the French fries were opened and cooked over the weekend and that is why he dated them [DATE]. During an observation on [DATE] at 08:20 a.m., the following item was found to be past the best by date; * Gallon jug of milk with best by date of [DATE] approximately half full in refrigerator #2 on the top shelf. During an observation on [DATE] at 11:20 a.m. the gallon jug of milk with the best by date of [DATE] was removed from refrigerator #2. During an interview on [DATE] at 11:20 a.m. the FSS said the cornbread being served with lunch was usually made with milk. The FSS said he was not aware if the gallon jug of milk past the best by date of [DATE] was used to prepare the cornbread. During an interview and observation on [DATE] at 11:24 a.m. Dietary Cook F was shown the empty gallon milk jug with best by date of [DATE] laying on top in the trash. Dietary Cook F said the milk from the empty milk jug was the milk she had used to prepare the cornbread to be served with lunch. Dietary Cook F said she did not realize the milk was out of date before using it to prepare food. Dietary Cook F said food items past the expiration or best by date should not be used when preparing food. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Gardens	3500 Park St Greenville, TX 75401

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:26 a.m. the FSS said even though the milk was past its best by date because it was cooked it should not be a risk for illness. The FSS said since the milk was not recognized to be past its best by date it could have been served in a glass to someone. The FSS said using food items past the expiration or best by date could put residents at risk for foodborne illness. During an interview on [DATE] at 10:54 a.m. Dietary Aide D said after food items were opened, they should be put in a sealed bag, dated, and used within 3 days. Dietary Aide D said if food items were found not dated or sealed, they should be thrown away. Dietary Aide D said food items found opened should never be placed in sealed bag and a date put on them. Dietary Aide D said food items that were expired or past the best by date should have be disposed of. Dietary Aide D said all kitchen staff were responsible for checking dates and proper storage. Dietary Aide D said serving food items to residents that were past the expiration or best by date and serving food items that were not properly stored could cause foodborne illness. During an interview on [DATE] at 10:20 a.m. Dietary Aide F said after food items were opened, they should be put in a sealed bag and dated. Dietary Aide F said food items found opened and not sealed or dated should be thrown away. Dietary Aide F said food items past the expiration or best by date should be thrown away. Dietary Aide F said serving food items to residents that were past the expiration or best by date and serving food items that were not properly stored could cause foodborne illness. Dietary Aide F said all kitchen staff were responsible for checking dates and proper food storage. During an interview on [DATE] at 10:24 a.m. the FSS said he expected all dietary staff to seal and date food items after opening. The FSS said if food items are found not dated or sealed staff should look at when it was last used to determine the date to label the item. The FSS said dietary staff can determine the date opened, undated food was last used by asking staff member on other shifts. The FSS said all food items should be properly sealed and dated. The FSS said on [DATE] he dated the opened French fries [DATE] and placed them in a sealed bag because other bags of unopened French fries were dated [DATE]. The FSS said all freezer items should be sealed after opening. The FSS said the French fries he placed in a sealed bag and dated [DATE] were not good because they had been in the freezer unsealed. The FSS said the opened bag of French fries should have been discarded. The FSS said food items past the expiration or best by date should be disposed of. The FSS said using improperly stored food items or food items past the expiration or best by date could cause illness. The FSS said all dietary staff was responsible for checking for properly stored food items and food items past the expiration or best by date. During an interview on [DATE] at 02:40 p.m. the Administrator said when food items were opened, they should be put in a closed/sealed bag, dated, and put in freezer/refrigerator. The Administrator said opened food items not in a sealed bag or dated should be discarded. The Administrator said food items past the expiration or past best buy dates should be discarded and not used. The Administration said the FSS was responsible for ensuring food items were handled and stored properly. The Administrator said food items served that were improperly stored or past the expiration or best by date could cause foodborne illness. Record review of the facility's policy and procedure titled, Food and Nutrition Services: Dry Food and Supply Storage dated ,d+[DATE] indicated, . (4) Open packages of food are stored in closed, air-tight containers or sealed plastic bags. Each container must be labeled and dated . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy and procedure titled, Food and Nutrition Services: Cleaning Refrigerators, Coolers, and Freezers dated ,d+[DATE] indicated, . (2) Remove any foods that are spoiled or have expired and discard. (3) Check that all foods are properly covered, labeled, and dated . Record review of an undated article provided by the facility titled, Food Product Dating indicated, .A Best if Used By/Before date indicates when a product will be of the best flavor or quality. It is not a purchase or safety date If the date passes during home storage, a product should still be safe and wholesome if handled properly until the time spoilage is evident .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on observation and interview, the facility failed to maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment to help prevent the development and the transmission of disease and infection for 1of 18 residents (Resident #74) reviewed for infection control. NAIT U did not maintain infection prevention strategies when she provided incontinent care for Resident #74 after she had been incontinent of bowel. This failure could place residents at risk for cross contamination and infection. Findings included: Record review of the physician order summary dated 12/8/21 indicated Resident #74 was [AGE] years old readmitted to the facility on [DATE] with diagnoses including acute cystitis (inflammation of the urinary bladder) with hematuria (blood in the urine), the presence of urogenital implants (injections of material into the urethra to help control urine leakage), acute kidney failure, sepsis, type 2 diabetes, history of skin infection, resistance to multiple antibiotics, and history of urinary tract infections. The MDS indicated Resident #74 had received antibiotics 3 of 7 days during the 7-day look back period. Record review of the MDS dated [DATE] indicated Resident #74 made herself understood and understood others. The MDS indicated she had a mild cognitive impairment (BIMS of 11). The MDS indicated Resident #74 had no history of rejecting care. The MDS indicated she required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. The MDS indicated she required supervision with transfers and eating. The MDS indicated she required limited assistance with locomotion in her wheelchair. The MDS indicated she was always incontinent of bowel and bladder. Record review of the care plan reviewed on 10/12/21 indicated Resident #74 had a history of urinary tract infections. The care plan interventions indicated Resident #74 was to be provided incontinent care every 2 hours as needed and the soiled areas were to be washed, rinsed and dried. During an observation on 12/7/21 at 2:27 p.m., NAIT U provided incontinent care for Resident #74 after she had been incontinent of bowel. After putting on gloves, NAIT U pulled clean wipes from the wipe container and laid them on the surface on the bed. NAIT U then opened the Resident #74's soiled brief. NAIT U picked up the wipes from the surface of the bed and began to wipe stool from Resident #74's thighs and perineal area (the region between the thighs, bounded by the opening of the vagina and the anus in females). She then rolled Resident #74 on her left side. NAIT U tucked the soiled brief under Resident #74's left hip. Without changing her gloves or performing hand hygiene (washing of hands or use of hand sanitizer), NAIT U removed a clean brief from the bedside table and started tuck the brief under Resident #74's left hip (next to the soiled brief). When NAIT U said she had completed incontinent care, the surveyor requested she clean between Resident #74's labia. NAIT U separated the labia and wiped with a clean wipe. There was visible stool on the wipe. NAIT U repeated this process with 3 wipes before there was no stool visible on the wipe. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/7/21 at 3:05 p.m., NAIT U indicated she did not realize she should not have placed clean wipes on the surface of Resident #74's bed before using them to provide incontinent care. NAIT U said she did not think about her gloves being dirty after she cleaned stool from Resident #74. NAIT U said she should have removed the gloves and washed her hands before she touched the clean brief. NAIT U indicated she did not realize she should not have placed the clean brief under Resident #74 while the soiled brief remained on the bed. NAIT U said she thought she had removed the stool from Resident #74 before surveyor intervention. NAIT U said she felt bad after repeated wipes had stool between the labia because she thought she had cleaned Resident #74 of stool. During an interview on 12/8/21 at 12:17 p.m., CNA V said NAIT U should not have placed clean wipes on the surface of Resident #74's bed before using them to provide incontinent care. She said NAIT U should have removed her gloves after she cleaned Resident #74 of stool and performed hand hygiene before touching the clean brief. CNA V said NAIT U should not have placed the clean brief under Resident #74 while the soiled brief remained tucked under Resident #74. CNA V said NAIT U should have ensured the stool was completely removed between the labia before completing incontinent care. CNA V said all of these errors could cause cross contamination and lead to infection. During an interview on 12/8/21 at 4:49 p.m., LVN M said he expected nurse aides to ensure residents were cleaned of stool before incontinent care was completed. LVN M said it was especially important to clean carefully between the labia of female residents. LVN M said not ensuring the area between the labia was cleaned could cause urinary tract infections. LVN M said NAIT U should not have placed clean wipes on the bed and should not have placed a clean brief next to the soiled brief. LVN M said NAIT U should have removed her gloves after cleaning the stool off Resident #74, washed her hands, and put on clean gloves before she touched the clean the brief. During an interview on 12/8/21 at 5:05 p.m., the DON said she expected nurse aides to ensure residents were cleaned of stool before completing incontinent care and expected them to ensure cross contamination did not occur. She said NAIT U should not have placed clean wipes on the bed and should not have placed a clean brief next to the soiled brief. The DON said NAIT U should have removed her gloves after cleaning the stool off Resident #74, washed her hands, and put on clean gloves before she touched the clean the brief. The DON said these actions were an infection control issue. The DON said the system in place to ensure nurse aides performed incontinent care correctly was the annual skills check off, which included evaluation of the incontinent care they provided. The DON said she was responsible for skill check offs and said NAIT U had her initial skills check off recently as she was new employee. Record review of a policy dated 6/2020 titled Perineal Care, indicated its purpose was to maintain cleanliness of the genital area, to reduce odor, and to prevent infection or skin breakdown. The policy indicated to wash pubic area for the female resident first separate the labia. Wash with soapy washcloth or cleansing wipe, moving from front to back on each side of the labia and in the center over the urethra and vaginal opening using clean washcloth/cleansing wipe for each stroke. Rinse the area, moving from front to back, using a clean washcloth/cleansing wipe for each stroke. Dry area moving from front to back, using a blotting motion with a towel. Turn the resident to the side. Wash, rinse and dry the buttock and peri-anal area without contaminating perineal area. Remove wet linen. Place dry linens or briefs or both under the resident. Remove gloves, wash hands or use alcohol-based sanitizer. Do not touch anything with soiled gloves after the procedure for example curtain, side rails, clean linen or call bell. Put on clean gloves, clean and return all equipment to its proper place. Place soiled linen in the proper container, remove gloves and wash hands.