

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>455915 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                         | (X3) DATE SURVEY COMPLETED<br><br>07/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Granbury Care Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 S Park St<br>Granbury, TX 76048 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45458</p> <p>Based on interview and record review, the facility failed to immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident representative when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention, a significant change in the resident's physical, mental or psychosocial status, or a decision to transfer or discharge the resident from the facility for 1 (Resident #1) of 4 residents reviewed for notification of changes.</p> <p>The facility failed to ensure Resident #1's POA/resident representative was immediately notified when the resident had a change in condition that required her to be transported via ambulance to the hospital.</p> <p>The non-compliance was identified as PNC. The noncompliance began on 07/26/2027 and ended on 07/27/2027. The facility corrected the noncompliance before the survey began.</p> <p>This failure placed residents at risk of not having the comfort and company of their families during traumatic times.</p> <p>Findings include:</p> <p>Record review of Resident #1's Face Sheet, dated 07/29/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included of Unspecified Dementia (symptoms affecting memory, thinking, and social abilities), severe, without behavioral, psychotic, mood disturbances, or anxiety, Hypothyroidism (underactive thyroid), unspecified, Depression (mental state that can affect a person's thoughts, feelings, behavior, and sense of well-being), unspecified (term used when a patient's symptoms are primarily depressive but do not meet the full criteria for a specific depressive disorder), and Essential (primary) hypertension (high blood pressure that is multi-factorial and does not have one distinct cause). Resident #1 was discharged on [DATE] to the local hospital.</p> <p>Record review of Resident #1's Admission MDS Assessment, dated 04/28/2024, in Section C- Cognitive Response Patterns, C0100 revealed Resident #1 was rarely/never understood and a BIMS score was not able to be determined. Section C0500 BIMS Summary Score was blank. Section C1000 - Cognitive Skills for Daily Decision Making - was coded as 3 - severely impaired - never/rarely made decisions.</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

|   |       |           |
|---|-------|-----------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|-------|-----------|

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>455915  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                             | (X3) DATE SURVEY COMPLETED<br><br>07/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Granbury Care Center   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>301 S Park St<br>Granbury, TX 76048 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Record review of Resident #1's Event Nurses' Note - Fall, dated 07/27/2024 at 12:31 (12:31 p.m.), revealed RN C documented RN C contacted Resident #1's POA and resident representative on 07/26/2024 at 22:30 (10:30 p.m.).</p> <p>During a confidential interview revealed that Resident #1, who resided at the nursing facility, had a change in condition on 07/26/2024 at 7:05 p.m., which required Resident #1 to be transported to the local hospital via ambulance. The confidential person said Resident #1's POA/responsible party was not contacted by the facility and notified of the change of the condition or that Resident #1 was discharged and transported to the emergency room . The confidential person said Resident #1 was care flighted from the local hospital to a hospital 30 miles away and the POA/responsible party not being contacted by the facility was unacceptable. The confidential person's voice crack and there was a sound of crying. The confidential person said he was told Resident #1 was in the hospital when he received a call from an employee who identified himself as a Chaplin on 07/26/2024 at approximately 10:30 p.m., from the hospital located 30 miles away. The confidential person said Resident #1's family lost at least three (3) hours that could have been spent holding Resident #1's hand and the family could have been there for Resident #1.</p> <p>During an interview on 07/29/2024 at 12:29 p.m., Resident #1's POA said she was not contacted on 07/26/2024 at 7:30 p.m. or at 10:30 p.m., by the nursing facility that Resident #1 had a change in condition or had been transported to the hospital by EMS at 7:30 p.m. and Resident #1's POA said absolutely no one from the nursing home had contacted her since the incident had occurred. Resident #1's POA stated the first time she became aware Resident #1 was transported to the hospital was when she received a call on 07/26/2024 at 10:18 p.m., by an employee of a hospital approximately 30 miles from the facility who stated Resident #1 was at the ER and the hospital employee requested additional information for Resident #1 to be treated. Resident #1's POA said at the same time, her family member received a call from an employee from the same hospital and another family member was contacted and informed Resident #1 was care flighted from the local hospital. Resident #1's POA said she went up to the nursing home the morning of 07/27/2024 to pick up some of Resident #1's belongings and spoke with the Administrator by phone, but never received a call from an employee from the facility.</p> <p>Attempted interview on 07/29/2024 at 1:41 p.m., with RN C was unsuccessful. The phone went straight to voice mail and the message indicated the mailbox was full and the caller could not accept messages at that time.</p> <p>(continued on next page)</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>455915   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                             | (X3) DATE SURVEY COMPLETED<br><br>07/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Granbury Care Center   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>301 S Park St<br>Granbury, TX 76048 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview on 07/29/2024 at 1:52 p.m., the DON said she was not aware Resident #1's POA was not contacted by the facility when Resident #1 had a change in condition on 07/26/2024 at 7:05 p.m., and was transported to the hospital via ambulance until 07/27/2024 at approximately 8:30 a.m. The DON said the Administrator informed her at that time. The DON said she called RN C on 07/27/2027 at approximately 9:00 a.m. and asked RN C to come into the facility to finish completing the documentation related to the incident. The DON said when RN C arrived, the DON asked her if she called Resident #1's POA/family member and RN C replied to her that she had become busy with another resident and by the time RN C finished, the time was 10 p.m. The DON said RN C admitted at this time she failed to contact Resident #1's POA. The DON said her expectation when a resident left the building by EMS was for the nurse to contact the family, ensure the doctor was notified, and for the nurse to notify herself, as the DON. The DON said the actions of RN C did not meet her expectations. The DON said the POA/resident representative/family should be informed immediately of a change of in condition to be aware the resident was no longer in the facility, and the family could be there with the resident. The DON said notification was important for the resident to have family with them and to have an advocate in an emergency situation. The DON said all staff had been in-serviced on notification when a resident had a change-condition and to make sure all nursing staff understood that if an emergency occurred, the doctor was notified to obtain orders to transfer the resident out, the POA/resident representative, and DON were notified immediately. The DON said RN C was terminated and under the circumstances, and felt the disciplinary action was appropriate. The DON said the resident would need family present during an emergency situation for comfort.</p> <p>During an interview on 07/29/2024 at 2:23 p.m., the ADON said her expectations when a resident had a change in condition and was transported out to the hospital was for the charge nurse to call the family, the doctor, the DON, and the administrator. The ADON said she typed out a short list that contained multiple situations and who was required to be contacted and posted the list at both of the nurses' stations for a reference. The ADON said she was contacted on 07/26/2024 at approximately 8:30 p.m., by the Administrator that Resident #1 had a change in condition and was transported to the ER by ambulance. The ADON said she was not contacted by RN C at any time.</p> <p>During an interview on 07/29/2024 at 2:34 p.m., LVN E said if a resident was sent to the ER, she would contact the DON, Administrator, the doctor, and the family. LVN E said it was important to contact the residents' family so they would know about any changes in condition and families would not get a phone call from a hospital in the middle of night. LVN E said it was important for the resident, especially for residents who were confused, to have a familiar face to help with the transition in unfamiliar place. LVN E said the family could assist the resident to not be scared. LVN E said she was in-serviced on who to notify for emergency situations, falls, change in conditions, and abuse and neglect following the incident with Resident #1.</p> <p>During an interview on 07/29/2024 at 2:45 p.m., LVN F said if a resident was sent to the ER, she would call the doctor to obtain orders for the resident to be sent to the ER, contact the family, call the DON, and Administrator to let them know a resident was transported and was discharged to the hospital. LVN F said the contact was done quickly and usually prior to the arrival of the ambulance. LVN F said she was recently in-serviced on this topic, reporting change of condition to physician, DON/ADON, and resident representative immediately, but this was standard procedure for a nurse, and she had done the steps for a long time. LVN F said she was in-serviced on abuse/neglect. LVN F said she was not on duty when Resident #1 was sent out to theER on [DATE].</p> <p>(continued on next page)</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>455915   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                             | (X3) DATE SURVEY COMPLETED<br><br>07/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Granbury Care Center   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>301 S Park St<br>Granbury, TX 76048 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview on 07/29/2024 at 3:01 p.m., the Administrator said she was notified on 07/26/2024 at approximately 8:30 p.m., by CMA A Resident #1 had a change in condition and was sent out by ambulance to the ER. The Administrator said she was contacted on 07/26/2024 at approximately 10:30 p.m. that the POA of Resident #1 was not notified by the facility and she spoke with the POA on 07/27/2024 by phone when Resident #1's POA arrived at the facility to retrieve Resident #1's personal items and demanded an explanation as to why she, the POA was not contacted when Resident #1 was transported to the ER. The Administrator said RN C came into the facility on the morning of 7/27/2024 and admitted she had not contacted the POA or the family immediately or any time after Resident #1 was transported to the hospital via ambulance. The Administrator said termination was the appropriate action and felt the facility had taken the appropriate corrective actions. The Administrator said Resident #1's family needed to be notified of her change in condition and Resident #1 was transferred outside the facility. The Administrator said the negative effects were the family was unable to be with Resident #1 when she left the facility until they were able to get to the hospital over 2 1/2 hours later. The Administrator said it was important for all residents to have their resident representative notified to protect their rights and comfort. The Administrator said her expectation was for the nurse to contact the doctor to receive orders, the responsible party, the DON, and the Administrator. The Administrator said she monitored contact of the resident representative when she was contacted of the incident as she would ask the nurse on the phone to ensure the family was notified. The Administrator said she would monitor documentation.</p> <p>Record review of the Facility: [Facility] Employee Disciplinary Report, dated 07/26/2024, revealed RN C would be discharged , with the following specific reasons for disciplinary action: [RN C] has failed to adhere to the Corporate Code of Conduct and Job Duties/Responsibilities. [RN C] on 07/26/2024 failed to adhere to her job duties/responsibilities. [RN C] failed to notify the responsible party about resident being transferred to emergency room . [RN C] is aware of her job duties/responsibilities as indicated by her signature on her employee handbook acknowledgement. [RN C] meets the criteria for immediate termination. [RN C] will be terminated effective immediately.</p> <p>Record review of in-service training, Topic: Incident Reporting: Notify RP, Physician, DON/ADON, Administrator, dated 07/27/2024, conducted by the Administrator, revealed nursing staff was in-serviced on the topic including LVN E, LVN F, CMA A and the ADON.</p> <p>Record review of in-service training, Topic: Reporting Change of Condition to physician, DON/ADON, and RP immediately, dated 07/27/2024, conducted by the Administrator, revealed nursing staff were in-serviced on the topic including LVN E, LVN F, and the ADON.</p> <p>Record review of in-service training, Topic: Reporting Change of Condition to charge nurse immediately, dated 07/27/2024, conducted by the Administrator, revealed nursing staff had been in-serviced on the topic including CMA A.</p> <p>Record review of in-service training, Topic: Provide clear directives to nursing staff re: incidents, Follow-up to ensure proper notifications have been made and confirm time of notification, dated 07/27/2024, revealed the Administrator was in-serviced on 07/27/2024 by the Area Director of Operations.</p> <p>(continued on next page)</p> |  |  |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>455915  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                             | (X3) DATE SURVEY COMPLETED<br><br>07/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Granbury Care Center   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>301 S Park St<br>Granbury, TX 76048 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Record review of the facility's policy, Transfer of Residents from the Facility, dated 2003, revealed the objectives of the policy were to assist in necessary resident transfers and to prevent trauma at the time of transfer. Emergency transfers of residents for medical reasons would be completed promptly and family notification would occur as soon as possible.</p> |  |  |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>455915  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                         | (X3) DATE SURVEY COMPLETED<br><br>07/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Granbury Care Center   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 S Park St<br>Granbury, TX 76048 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45458</p> <p>Based on interview, and record review, the facility the facility failed to maintain medical records on each resident, in accordance with accepted professional standards and practices, which were complete and accurately documented for 1 (Resident #1) of 4 residents reviewed for documentation.</p> <p>RN B failed to accurately document the notification of Resident #1's resident representative when Resident #1 had a change in condition and was sent via ambulance to the hospital.</p> <p>This failure could place residents at risk of inaccurate documentation in residents' records and decreased confidence in the facility staff.</p> <p>Findings include:</p> <p>Record review of Resident #1's Face Sheet, dated 07/29/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Unspecified Dementia (symptoms affecting memory, thinking, and social abilities), severe, without behavioral, psychotic, mood disturbances, or anxiety, Hypothyroidism (underactive thyroid), unspecified, Depression (mental state that can affect a person's thoughts, feelings, behavior, and sense of well-being), unspecified (term used when a patient's symptoms are primarily depressive but do not meet the full criteria for a specific depressive disorder), and Essential (primary) hypertension (high blood pressure that is multi-factorial and does not have one distinct cause). Resident #1 was discharged on [DATE] to the local hospital.</p> <p>Record review of Resident #1's Admission MDS Assessment, dated 04/28/2024, in Section C- Cognitive Response Patterns, C0100 revealed Resident #1 was rarely/never understood and a BIMS score was not able to be determined. Section C0500 BIMS Summary Score was blank. Section C1000 - Cognitive Skills for Daily Decision Making - was coded as 3 - severely impaired - never/rarely made decisions.</p> <p>Record review of Resident #1's Event Nurses' Note - Fall, dated 07/27/2024 at 12:31 (12:31 p.m.), revealed RN C documented RN C contacted Resident #1's POA and resident representative on 07/26/2024 at 22:30 (10:30 p.m.).</p> <p>Record review of Resident #1's Progress Note, dated 07/26/2024 at 07:25 military time, (7:25 a.m.), revealed RN C documented Resident #1 was taken by EMS to the emergency room . The family, DON, and doctor were contacted. Documentation was recorded in military time.</p> <p>Record review of Resident #1's Progress Note, dated 07/26/2024 at 19:00 military time, (7:00 p.m.), revealed RN C documented she called 911. EMS transported Resident #1 to the hospital. Provider, RP, and ADON notified.</p> <p>Record review of Resident #1's Progress Note, 07/26/2024 at 22:23 military time, (10:23 p.m.), revealed RN C documented Resident #1 was taken by EMS to the emergency room . Family, DON, and doctor were contact. This entry was struck out with a line through the sentences. Strike Out Reason identified as Incomplete Documentation; Strike Out Date: 07/27/2024 03:00 military time, (3:00 a.m.).</p> <p>(continued on next page)</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>455915   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                             | (X3) DATE SURVEY COMPLETED<br><br>07/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Granbury Care Center   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>301 S Park St<br>Granbury, TX 76048 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview a confidential person said Resident #1, who resided at the nursing facility, had a change in condition on 07/26/2024 at 7:05 p.m., which required Resident #1 to be transported to the local hospital via ambulance. The confidential person said Resident #1's POA/responsible party was not contacted by the facility or notified of the change of the condition or Resident #1 was discharged and transported to the emergency room . The confidential person said the facility nurse documented in Resident #1's permanent clinical record that the patient's family was contacted on 07/26/2024 after a change in condition occurred and Resident #1 was taken by EMS to the emergency room . The confidential person said he met with the facility administration staff on the morning of 7/27/2024 and the facility admitted the nurse falsified documentation when she recorded the resident representative was notified and was shown the clinical documentation and took a screen shot of the information. The confidential person said the facility reported the nurse who falsified the documentation was terminated but he felt this did not make up for what had happened. The confidential person said Resident #1 could have been conscious for several hours at the hospital and the family were not present to hold Resident #1's hand.</p> <p>During an interview on 07/29/2024 at 12:29 p.m., Resident #1's POA said she was not contacted on 07/26/2024 by the facility that Resident #1 had a change in condition or had been transported to the hospital by the nursing facility immediately after the incident between 7:05 p.m. - 7:30 p.m. Resident #1's POA said she was not contacted by the facility at 10:30 p.m., by a facility nurse and said absolutely no one from the nursing home had contacted her since the incident had occurred.</p> <p>Attempted interview on 07/29/2024 at 1:41 p.m., with RN C was unsuccessful. The phone went straight to voice mail and the message indicated the mailbox was full and the caller could not accept messages at that time.</p> <p>During an interview on 07/29/2024 at 1:52 p.m., the DON said she was not aware Resident #1's POA was not contacted by the facility when Resident #1 had a change in condition on 07/26/2024 at 7:05 p.m., and was transported to the hospital via ambulance until 07/27/2024 at approximately 8:30 a.m. The DON said the Administrator informed her at that time. The DON said she called RN C on 07/27/2027 at approximately 9:00 a.m. and asked RN C to come into the facility to finish completing the documentation related to the incident. The DON said when RN C arrived, the DON asked her if she called Resident #1's POA/family member and RN C replied to her that she had become busy with another resident and by the time RN C finished, the time was 10 p.m. The DON said RN C admitted at this time she failed to contact Resident #1's POA. The DON said her expectation was for the nursing staff to document clear and precise records that were accurate. The DON said incorrect documentation could cause miscommunication with family and anxiety for the resident. The DON said Resident #1's family not being contacted was unacceptable to her.</p> <p>(continued on next page)</p> |  |  |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>455915  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                             | (X3) DATE SURVEY COMPLETED<br><br>07/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Granbury Care Center   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>301 S Park St<br>Granbury, TX 76048 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview on 07/29/2024 at 3:01 p.m., the Administrator said she was notified on 07/26/2024 at approximately 8:30 p.m., by CMA A when Resident #1 had a change in condition and was sent out by ambulance to the ER. The Administrator said she was contacted on 07/26/2024 at approximately 10:30 p.m. that the POA of Resident #1 was not notified by the facility and she spoke with the POA on 07/27/2025 by phone when Resident #1's POA arrived at the facility to retrieve Resident #1's personal items and demanded an explanation as to why she, the POA was not contacted immediately when Resident #1 was transported to the ER. The Administrator said RN C came into the facility on [DATE] and admitted she had not contacted the POA or the family immediately or any time after Resident #1 was transported to the hospital via ambulance. The Administrator said at this time, the facility became aware the documentation in the clinical records was inaccurate. The Administrator said the documentation revealed RN C notified the ADON on 07/26/2024 at 7:00 p.m. and an interview with the ADON revealed she was not contacted. The Administrator said termination was appropriate action and felt the facility had taken the appropriate corrective actions. The Administrator said she would monitor documentation and what occurred on Friday (07/26/2024) was unacceptable.</p> <p>Record review of the Facility: [Facility] Employee Disciplinary Report, dated 07/26/2024, revealed RN C would be discharged , with the following specific reasons for disciplinary action: [RN C] has failed to adhere to the Corporate Code of Conduct and Job Duties/Responsibilities. [RN C] on 07/26/2024 failed to adhere to her job duties/responsibilities. [RN C] failed to notify the responsible party about resident being transferred to emergency room . [RN C] is aware of her job duties/responsibilities as indicated by her signature on her employee handbook acknowledgement. [RN C] meets the criteria for immediate termination. [RN C] will be terminated effective immediately.</p> <p>Record review of the facility's policy, Documentation, dated 05/2015, revealed the facility would maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. The facility would ensure that information was comprehensive and timely, and properly signed. It has legal requirements regarding accuracy and completeness, legibility, and timing.</p> |  |  |