STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455915	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granbury Care Center	301 S Park St 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 (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 - Few	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** 41944 Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs, 1 of 5 residents (Resident #1) reviewed for comprehensive care plans. The facility failed to develop a comprehensive care plan for Resident # 1 that included the edema in his lower extremities and resisting care. This failure could place the resident at risk for a decline in health and providers not having the most current information for the Resident's plan of care. Findings included: Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed he was a [AGE] year-old male who was admitted on [DATE], with the following diagnoses: Downs syndrome (a genetic disorder caused by an extra set of chromosomes), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and aortic valve insufficiency (a condition in which a heart valve doesn't properly close, causing blood to flow backwards into the heart instead of pumping out). His BIMS score was 4, which indicated severe cognitive impairment. Record review of Resident 1's physician orders dated 8/4/24 reflected he had an order for knee high compression stockings each morning and to remove at night for bilateral lower extremity edema, and an order to encourage the resident to elevate his lower extremities when sitting. Record Review of Resident #1's treatment administration record reflected orders for knee high compression stockings that were implemented from 8/4/24 to 8/31/24 and no refusals were documented. Record Review of the nursing progress note by an unidentified nurse written on 8/4/24 reflected that Resident # 1 had refused to wear his compression stockings or elevate his legs. Record review of a progress not written 8/4/24 by NP reflected the resident had 3+ edema to his left lower extremity and 2+ edema to his right lower extremity. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's electronic health record on 10/10/24 revealed the most recent comprehensive care plan dated with a most recent revision date of 9/25/24 did not contain a problem area for Resident #1's edema and his refusal of care. During an interview on 10/10/23 at 3:32 PM, the Interim DON stated her expectation was the care plan should include the resident's refusal of care and his edema. She stated the care plan should be updated by the DON. She stated failure to update the care plan could result in the resident not receiving the care he needed. She stated it was her responsibility to update the care plans and ensure the care plan meetings were held. She stated the failure occurred because she was new to her job and had been busy learning the system. Review of the facility's undated policy titled: Comprehensive Care Plans revealed the following [in part]: The facility will develop and implement a comprehensive care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following: -the services to be provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944 Based on observations, interviews, and record review, the facility failed to ensure the medical record was complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for resident records. The facility failed to ensure LVN A and documented accurate skin assessments for Resident #1. These failures could place residents at risk of new or worsening pressure injuries, and not receiving required treatments and medications as ordered by the physician. Findings included: Record review of Resident #1's discharge MDS assessment dated [DATE] revealed he was a [AGE] year-old male who was admitted on [DATE], with the following diagnoses: Downs syndrome (a genetic disorder caused by an extra set of chromosomes), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and aortic valve insufficiency (a condition in which a heart valve doesn't properly close, causing blood to flow backwards into the heart instead of pumping out). His BIMS score was 4, which indicated severe cognitive impairment. Resident #1 was able to roll from side to side from the supine position, he had 3 unstageable pressure areas that were covered by eschar or slough that were not present on admission, and 1deep tissue pressure injury that was not present on admission. Record review of Resident # 1's care plan reflected: Resident #1 had an actual/potential impairment to skin integrity initiated on 8/10/24 with a goal of the resident will heal by target date of 10/30/24. Interventions included: Encourage good nutrition and hydration in order to promote healthier skin. Date Initiated: 09/21/2024. Follow facility protocols for treatment of injury. Date initiated: 08/30/2024. Keep skin clean and dry. Use lotion on dry skin. Initiated: 09/21/2024. Low air loss mattress Date Initiated: 09/21/2024. Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, symptoms of infection, maceration, to physician. Date Initiated: 08/30/2024. referred to wound care and was seen 9/6/24 Date Initiated: 08/30/2024. Reposition patient per protocol. Date Initiated: 09/21/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Date Initiated: 09/21/2024. wound care per orders Date Initiated: 08/30/2024. Record review of the Order Summary Report dated 9/1/24 indicated Resident #1 had orders for Daily skin prep to purple pressure are to lt lateral lower leg. Leave in place to build up layers. Off load feet. Start date. Daily wound care to right lateral foot blistered area, clean with saline or wound cleanser and pat dry cover with padded dressing. Wrap with kerlix to secure. Daily wound care to right leg blister, apply skin prep allow to dry do not remove allow to build up and form a protective layer. Off load heels or pressure relieving boots to legs. Record review of Resident#1's weekly skin assessment dated [DATE] completed by LVN A revealed the resident's skin was intact. Record review of Resident #1's wound evaluation note conducted by the wound care physician dated 09/13/24, indicated Resident #1 had a skin tear wound of the right lateral foot that was resolved on 9/13/24, a skin tear wound of the right distal lateral foot that measured 4.52 cm x 5 cm x unmeasurable cm which was improving, an unstageable deep tissue Injury of the right, dorsal, 5th toe that measured 0.6 cm x 0.8 cmx not measurable, skin tear wound of the right, dorsal medial foot that measured 2.0 cm x 0.8 cm x not measurable cm, skin tear wound of right lateral ankle that measured 2.1 cm x 1.8 cm x not measurable cm, skin tear of right heel 7 cm x 5.1 cm x not measurable, unstageable deep tissue injury of the right, proximal lateral ankle 0.7cm x 2.0 cm x not measurable. Area improved by decreased surface area, unstageable deep tissue injury the left, proximal, lateral, ankle 4.5 cm x 1.5 cm x not measurable cm. During an interview on 8/11/24 at 10:30 AM RN B stated she did not know why LVN A did not document her assessment accurately, unless she did not know how to fill the form out properly. She stated failure to document accurately could result in the Resident #1 not receiving needed care. Attempted to interview LVN A on 8/11/ 24 2:40 PM, but she did not return the call. During an interview on 10/16/24 at 3:16 PM, the Administrator said she expected for the nurses to report any new skin concerns to the physician and for them to document accurately and completely. The Administrator said it was important for skin assessments to be completed accurately to prevent any worsening of skin conditions. Record review of the facility's policy dated May 2015, titled, Documentation, indicated, The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets .