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	05/02/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on observations, interview, and record review the facility failed to maintain medical records on each resident, in accordance with accepted professional standards and practices, that were complete and accurate for 3 (Resident #1, Resident #3 and Resident # 7) of 7 residents reviewed for resident records. The facility failed to ensure weekly skin assessments were documented in the medical record for Resident #1, Resident #3, and Resident # 7. This failure could place residents at risk of having errors in care and treatment. The Findings included: Resident #1 Record review of Resident #1's face sheet dated 05/02/2025 revealed a [AGE] year-old-female admitted on [DATE], with the most recent admission on 06/14/2024 and with the following diagnoses: Alzheimer's disease, respiratory failure, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (weakness and partial paralysis of left side following a stroke). Record review of Resident #1's Significant Change MDS assessment dated [DATE] revealed, Section C-Cognitive Patterns: Resident #1 had a BIMS score of 5 (meaning severe cognitive impairment); Section GG-Functional Abilities: Resident #1 required substantial/maximal assistance for activities of daily living. Section M-Skin Conditions: Resident #1 had the risk of developing pressure ulcers/injuries and Resident #1 did not have pressure ulcers, wounds, or skin problems. Record review of Resident #1's care plan dated 02/18/2025 revealed Resident #1 required extensive assistance of 1 staff with transfers and activities of daily living. Record review of Resident #1's electronic medical chart revealed no evidence of weekly skin inspections completed weekly for the weeks of: 03/10/2025, 03/17/2025, 03/24/2025, 03/31/2025, 04/21/2025 and 04/28/2025. Further record review revealed Resident #1 did not have any skin issues and was admitted to hospital on 04/29/2025 due to an abscess to her tooth. Resident #3 (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's face sheet dated 05/02/2025 revealed an [AGE] year-old-female admitted on [DATE], with the most recent admission on 08/19/2024 and the following diagnoses: Alzheimer's disease, Type 2 diabetes, age-related osteoporosis, and high blood pressure. Record review of Resident #3's Quarterly MDS assessment dated [DATE] revealed, Section C- Cognitive Patterns: Resident #3 had a BIMS score of 14 (meaning cognitively intact); Section GG-Functional Abilities: Resident #3 required substantial/maximal assistance or was dependent for activities of daily living. Section M-Skin Conditions: Resident #3 had the risk of developing pressure ulcers/injuries and Resident #3 had a stage 4 pressure ulcer, (open wound through multiple layers of skin and tissue) to right heel and sacrum (large triangular bone at the base of the spine). Record review of Resident #3's care plan dated 03/04/2025 revealed Resident #3 had a stage 4 pressure ulcer to her sacrum area and right l heel. Resident #3 was receiving hospice care. Record review of Resident # 3's physician's orders dated 05/02/2025 revealed: Start date: 08/19/2024 admit to {name} service. Start date: 01/30/2025: {Name wound care company} to consult for skin and wound conditions/prevention. Start date 04/04/2025: Cleanse stage 4 pressure wound to sacrum with wound cleanser, pat dry with gauze, pack with calcium alginate with silver, cover with non-border foam dressing 3 times a week and PRN as needed for Stage 4 pressure wound of the sacrum. Start date: 04/04/2025 Cleanse stage 4 pressure wound to sacrum with wound cleanser, pat dry with gauze, pack with calcium alginate with silver, cover with non-border foam dressing 3 times a week and PRN one time a day every Monday, Wednesday, Friday for Stage 4 pressure wound of the sacrum. Record review of Resident #3's electronic medical chart revealed no evidence of weekly skin inspections completed weekly for the weeks of 03/17/2025, 03/24/2025, 03/31/2025, 04/21/2025 and 04/28/2025. During an observation and interview on 05/01/2025 at 11:00 AM revealed Resident #3 was sitting up in her bed. Resident #3 stated the staff did frequent checks on her and changed her often. Resident #3 stated she did not have any concerns with her care from the staff. Resident #3 stated that she had some issues with her skin, but the facility was treating them and they were getting better. Resident #7 Record review of Resident #7's face sheet dated 05/02/2025 revealed a [AGE] year-old-female admitted on [DATE], and with the following diagnosed : Alzheimer's disease and high blood pressure. Record review of Resident #7's Significant Change MDS assessment dated [DATE] revealed, Section C-Cognitive Patterns: Resident #7 had a BIMS score of 4 (meaning severe cognitive impairment); Section GG-Functional Abilities: Resident #7 required Partial/moderate to substantial/maximal assistance for activities of daily living. Section M-Skin Conditions: Resident #7 had the risk of developing pressure ulcers/injuries and Resident #7 did not have pressure ulcers, wounds, or skin problems. Record review of Resident #7's care plan dated 03/31/2025 revealed Resident #7 required extensive assistance of 1 staff with transfers and activities of daily living. Resident #7 had potential for pressure ulcer development. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's electronic medical chart revealed no evidence of weekly skin inspections completed weekly for the weeks of 02/24/2025, 03/03/2025, 03/10/2025, 03/17/2025, 03,24,2025, 03/31/2025, 04/21/2025 and 04/28/2025. During an observation and interview on 05/02/2025 at 8:45 AM revealed Resident #7 received incontinent care and her skin was observed to have no redness or drainage. Resident #7 stated she did not have any concerns with her care at the facility. During an interview on 05/02/2025 at 1:15 PM the ADON stated charge nurses were responsible to complete skin assessments weekly. The ADON stated the CNAs completed shower sheets when they gave residents their showers. The ADON stated the CNAs were good about letting the nurses know when there was a change in the resident's skin. The ADON stated the weekly skin assessments were triggered for the charge nurses to complete weekly. The ADON did not have an explanation as to why skin assessments were not complete. During an interview on 05/02/2025 at 1:26 PM CNA A stated she completed skin sheets when providing showers for residents. CNA A stated if during showers she noticed a problem she would contact the charge nurse. CNA A stated Resident #1, Resident #3, and Resident #7 were on her hall, and she had completed skin sheets for each resident. CNA A stated Resident #1, Resident #3 and Resident #7 did not have any new concerns with their skin. During an interview on 05/02/2025 at 1:39 PM RN B stated the charge nurses were responsible for completing skin assessments weekly and were to be documented under Assessments in the electronic medical record. RN B stated Resident #1 and Resident # 7 were residents on her hall. RN B stated Resident #3 had been treated for a pressure ulcer on her sacrum and her left buttock. RN B stated Resident #3's wounds had gotten smaller. RN B stated she did not know why skin assessments had been missed. RN B stated the skin assessments would populate on the electronic medical system. RN B stated she would make sure to complete them before she ended her shift. RN B stated CNAs completed shower sheets, when they gave showers, and would document any new skin issues and would turn them into the charge nurse. RN B stated the nurses would sign the sheets after reviewing them. RN B stated she did not see any negative impact on the residents from skin assessments not being documented in the system, because the residents' skin was being assessed. During an interview on 05/02/2025 at 1:40 PM the DON stated her expectation was that skin assessments should have been completed weekly and documented on the weekly skin assessment in the electronic medical system. The DON stated the charge nurses were responsible to complete the weekly skin assessments. The DON stated herself and the ADON would help the nurses with completing the skin assessments. The DON stated the ADON was responsible to monitor the completion of weekly skin assessments by running reports. The DON stated there had been some changes with the electronic medical record system and that had made it harder to catch the missed assessments. The DON stated what led to the failure was the updates to the electronic medical record system and nurses having to help with other duties. The DON stated she did not think there was a negative effect on residents because she felt nurses were assessing residents' skin and they were failing to document. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/02/2025 at 1:55 PM the ADMN stated her expectation was that skin assessments were to be completed upon admission and weekly. The ADMN stated skin assessments should have been documented under the assessment tab in the electronic medical chart. The ADMN stated the weekly skin assessment was to be completed by the charge nurse for the residents on their hall. The ADMN stated the DON and ADON were supposed to have been monitoring to ensure the weekly skin assessments were completed. The ADMN stated the skin assessments were to have been monitored during the standard of care meeting. The ADMN stated the effect on residents could have been missed skin breakdown. The ADMN stated the failure of skin assessments not being completed could have been changes in the electronic medical record system. The ADMN stated the electronic medical record system failed to notify nurse that assessments were needed to be done. Record review of the facility policy titled, Skin assessment dated [DATE], revealed: All residents should have a skin assessment on a weekly basis completed in {name of electronic medical system.