STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455968	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graham Oaks Care Center	1325 First St Graham, TX 76450

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 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** Based on interview, and record review the facility failed to maintain clinical records that were complete and/or accurate for 1 of 10 residents (Resident #1) reviewed for clinical records in that: The RN A did not document Resident # 1 was transferred to the ER on 5.12.25. This failure could place residents at risk of inaccurate and incomplete clinical records resulting in an inaccuracy in the care the resident received. The findings include: Record review Record review of Resident # 1's Face Sheet revealed she was a [AGE] year-old female originally admitted to the facility on 4.20.25 and readmitted on 5.20.25. She had diagnoses of fracture of hip, end stage renal disease (last stage of kidney failure) osteoporosis (porous brittle bone that breaks easily with spontaneous fractures common), and calciphylaxis (rare and life-threatening syndrome which involves calcium buildup in the skin and fat tissue leading to clotting and painful lesions). Record review of admission MDS dated 5.3.25 documented Resident #1 had a BIMS score of 7 (which indicated moderate cognitive impairment). Record review of Resident #1's Nursing progress Notes for 5.12.25 stated: Transfer Notification - Late entry Effective Date: 5/12/2025 10:38:0 Created By: DON Created Date : 5/23/2025 11:21:03 Resident was transferred to a hospital on [DATE] 10:38 AM related to AMS (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Hypoxia(low oxygen content in the blood) This is intended to serve as notice of an emergency transfer Record review of the nurses note dated 5.12.25 indicated Resident #1 returned to the facility with a diagnoses of urinary tract infection at 1:39 PM on 5.12.25 Resident #1 was nonresponsive and unavailable for an interview at the time of the investigation. In an interview on 5.22.25 at 2:30 PM, Resident # 1's family member said she was not aware of Resident #1's transfer to the emergency room on 5.12.25 @ 10:38 AM when she experienced an altered mental status. She stated she found out the resident had a UTI when she visited the resident at the nursing facility later that day. In an interview on 5.23.25 at 11.43 AM RN A stated she thought she did notify Resident #1's family member of the transfer on 5.12.25 but if it was not documented, and the family member stated she did not notify her she could not state with certainty that she did notify her. She stated she failed to follow proper procedure by not documenting the event when it occurred which could result in an inaccuracy in the care the resident received. In an interview on 5.23.25 at 11:50 AM the DON stated she was in the facility and she and another nurse were present and assisted with the transfer. She stated it was her expectation that resident information was documented in a resident's record at the time it occurred. She stated if documentation were not made a late entry could be made at a later date and identified as a late entry with the date and time the event occurred and the time and date the documentation was created. Record review of the facility's policy, Documentation not dated, revealed [in part]: Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. The facility will maintain complete and accurate documentation for each resident. The facility will ensure that information is comprehensive and timely and properly signed. Complete documentation in the electronic health record in a timely manner.