

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455968	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025
NAME OF PROVIDER OR SUPPLIER Graham Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on observation , interview and record review the facility failed to ensure the assessments accurately reflected the resident status for 2 of 11 residents (Residents #4 and #24) reviewed for assessments . 1. The Facility failed to ensure Resident #4's MDS was accurately completed with the residents tobacco use. 2. The facility failed to ensure Resident #24's MDS was accurately completed with Resident #24's anticoagulant. These failures could place residents at risk by decreasing the accurate information available to determine the care and services needed for each resident. The findings include: 1. Record review of Resident # 4's face sheet, dated 1/22/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included Rhabdomyolysis (rare muscle injury where your muscles break down), high blood pressure and congestive heart failure. Record review of Resident #4's Annual MDS, dated [DATE], revealed Section C- Cognitive Patterns BIMS score of 5, which indicated Severely impaired cognition. Section J- Health Conditions revealed no evidence of current tobacco use. Record review of Resident #4's Care Plan, dated 12/23/2024, revealed no problem, goal or intervention related to Resident #4's use of smokeless tobacco. During an observation and interview on 01/202/2025 at 2:43 PM Resident # 4 was sitting up in his bed. A brown ball of substance was sitting on his bedside table. Resident #4 stated the substance was his chewing tobacco. Resident #4 stated he took it out to eat and then put it back into his mouth. 2. Record review of Resident #24's face sheet, dated 1/22/2025, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. with a readmitted on 01/07/2025 with the following diagnosis of respiratory failure, dementia, high blood pressure, congestive heart failure and Cerebral Infraction (stroke). (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #24's Physician order revealed a start date of 09/26/2024 Pradaxa oral capsule 150 MG (Dabigatran Etexilate Mesylate) Give 1 capsule by mouth two times a day related to Cerebral Infraction. Record review of Resident #24's Quarterly MDS, dated [DATE], revealed: Section C- Cognitive Pattern she had a BIMS score of 13, which indicated cognitively intact cognition. Section N- Medications documented no evidence of anticoagulant use. During an interview on 01/22/2025 at 3:18 PM, LVN B stated she was the MDS coordinator and the MDS should have included Resident #4's tobacco use and Resident #24's anticoagulant use. LVN B stated their cooperate monitored the MDS. LVN B stated the effect on residents could have affected residents' ability to receive outside resources. LVN B stated what led to the failure was oversight staff not looking at documentation completely. During an interview on 01/22/2025 at 3:33 PM, the DON stated her expectation was for MDS to be completed correctly and include all resident care needs. The DON stated the MDS was responsible to ensure MDS's were completed and their corporate monitored. The DON stated the effect on residents could have had interference with the resident's plan of care and what was being done to meet their goals. The DON stated they did not have a policy for the MDS, they followed the CMS Resident Assessment Instrument User's Manual. Record review of the CMS Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf accessed on 01/22/2025) documented the following: J1300 Current Tobacco Use: Steps for Assessment 1. Ask the resident if they used tobacco in any form during the 7-day look-back period. 2. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1, yes. DEFINITION TOBACCO USE Includes tobacco used in any form. CMS's RAI Version 3.0 Manual CH 3: MDS Items [J] October 2023 Page J-27 (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	J1300: Current Tobacco Use (cont.) 3. If the resident is unable to answer or indicates that they did not use tobacco of any kind during the look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period. Coding Instructions o Code 0, no: if there are no indications that the resident used any form of tobacco. o Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period. N0415: High-Risk Drug Classes: Use and Indication .Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). N0415E2. Anticoagulant: Check if there is an indication noted for all anticoagulant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days) . N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). N0415I2. Antiplatelet: Check if there is an indication noted for all antiplatelet medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days).		

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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** 44558 Based on observation , interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 3 of 24 residents (Resident #4, Resident #44 and Resident #76) reviewed for comprehensive person-centered care plans. 1. The facility failed to ensure Resident #4's comprehensive care plan was person centered and measurable when addressing Resident #4's Tobacco use. 2. The facility failed to ensure Resident #44's comprehensive care plan contained the resident's use of Trapeze bar (medical device used to help patient move and positions themselves in bed) for bed mobility. 3. The facility failed to ensure Resident # 76's comprehensive care plan contained Resident #76's amputation . 4. The facility failed to ensure Resident #76's use of a fall mat was implemented as documented in the resident's care plan. These failures could place residents at risk for not receiving care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Findings include: 1. Record review of Resident #4's electronic face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included Rhabdomyolysis (breakdown of muscle tissue causing chemical release) Syncope and collapse (brief loss of consciousness), Hypertension (high blood pressure), Congestive heart failure , and Unsteadiness on feet. Record review of Resident #4's Annual MDS, dated [DATE], revealed Section C cognitive Patterns BIMS score 05, which indicated severely impaired cognition. Section FF0115 Functional Limitation in range of Motion Upper Extremity impairment on one side. Lower extremity impairment on both sides. Section GG0120 Mobility Devices Wheelchair. Section J 1300 Current Tobacco use No. Record review of Resident #4's Care Plan, dated 12/23/2024, revealed no problem, goal or intervention related to Resident #4's use of smokeless tobacco. During an observation and interview on 01/20/2025 at 2:43 PM revealed Resident # 4 was sitting up in his bed. A brown ball of substance sat on his bedside table. Resident #4 stated it was his chewing tobacco. Resident #4 stated he took it out to eat and then put it back into his mouth. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #44's electronic face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE] with a previous admission on 09/23/2022. Resident #44 had diagnoses which included Encounter for orthopedic aftercare involving surgical amputation, Heart Failure, Nicotine Dependence, Pressure ulcer of sacral region, stage 4 and Acquired Absence of left leg below knee. Record review of Resident #44's Physician Orders, last reviewed 11/17/2024, revealed no orders for use of a Trapeze bar. Record review of Resident #44's Annual MDS, dated [DATE], Section C cognitive Patterns BIMS score 14, which indicated Intact cognition). Section GG Functional Abilities-GG0130 Toileting Dependent, Lower body dressing setup or clean-up assistance, lying to sitting on bed Independent, Chair to bed transfer Independent. Section I Active Diagnosis Amputation. J1300 Current Tobacco Use Yes. Record review of Resident #44's Care Plan, dated 12/20/204, did not address use of a Trapeze Bar for bed mobility. No goals or interventions for use of a Trapeze Bar were addressed in the Care Plan, dated 12/20/2024. During an observation on 01/21/2025 at 09:03 AM revealed Resident #44 lying in bed and a trapeze bar attached to the bed frame . During an interview on 01/22/2025 at 12:05 PM, LVN A stated she was not sure how long Resident #44 had been using the trapeze bar. She stated she thought therapy recommended it. She stated she was not sure if he needed a physician order for the trapeze bar or if it should be on care plan. During an interview on 01/22/2025 at 1:30 PM with PTA D stated Resident #44 had a trapeze bar for a long time. PTA D stated he did not believe the therapy department recommended use of the trapeze bar. During an interview on 01/22/2025 at 2:40 PM with MDS Coordinator LVN B stated use of a trapeze bar should be care planned. LVN B stated if not care planned staff would not have known he needed the trapeze bar and how often he needed it. LVN B stated she did not know how long the resident had been using the trapeze bar. LVN B stated she was not sure who ordered the trapeze bar for this resident. LVN B stated if there was no order then it would not be triggered to be care planned . During an interview on 01/22/2025 at 2:45 PM, the DON stated use of trapeze bars should be care planned and did not need an order. The DON stated this could affect residents in that staff would not be able to monitor the effectiveness of the trapeze bar. The DON stated this could be a negative effect on the resident if trapeze bar use was not monitored and not being used correctly by the resident. The DON stated she did not know why this was not care planned and she monitored care plans for accuracy. The DON stated no one else at the facility monitored care plans . 3. Record review of Resident #76's electronic face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #76 had diagnoses which included Diabetes Mellitus, Acute Kidney Failure, Hypertension , Acquired Absence of Right Leg Below Knee (Amputation) (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #76's Physician Orders, dated 01/21/2025, revealed: no orders for fall mat at bedside. Record review of Resident #76's Admission MDS, dated [DATE], Section C Cognitive status BIMS score 14, which indicated the resident was intact cognitively. Section GG0115 Functional Limitation in Range of Motion Upper extremity impairment on one side, Lower extremity impairment on one side. GG0120 Mobility Devices Walker, Wheelchair, Limb Prosthesis Section J Health Conditions J1300 Current Tobacco User No. Section J1 900 Number of falls since Admission/Entry two or more. Record review of Resident #76's Care Plan, dated 12/18/2024, reflected Focus: the resident is risk for fall. Date initiated: 12/06/2024 Revision on 12/18/2024 Goal: the resident will be free of falls through the renew date.12/17/2024. Intervention included fall mat while in bed. Amputation of right leg below knee was not addressed. Use of Prosthetic leg was not addressed. During an observation on 01/2025 at 10:30 AM and 01/21/2025 at 09:03 AM revealed no fall mat was observed by the bed in the room for Resident #76. During an interview on 01/22/25 at 09:20 AM, the DON stated she was responsible for entering fall risk assessments on care plans and MDS Coordinators entered items triggered on the CAA (Care Area Assessment)from the MDS. The DON stated care plans were reviewed weekly during the standard of care meeting. The DON stated she conducted quarterly audits to identify issues that had been resolved and needed to be cancelled. The DON stated equipment specified in the care plan must be in place for the resident such as a f all mat. The DON stated the expectations were interventions on the care plan were done and if not coaching/retraining was provided. The DON stated if a fall mat was noted in an intervention, a fall mat should be in place if the resident was in bed or in the room . During an interview on 01/22/2025 at 01:46 PM, LVN C stated she looked at care plans from time to time. LVN C stated the DON reviewed changes during the daily morning meeting. LVN C stated any equipment used for a resident should be on the care plan. LVN C stated the consequences for a resident if the equipment was not addressed on the care plan, a needed device could be missed by the caregiver and not be used. Record review of the facility's, undated, policy titled Comprehensive Care Planning, reflected: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that include 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 reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented. Record review of the facility's, undated, policy titled Uniform Smoke Free Policy reflected. Residents will be allowed to keep smokeless tobacco, i.e., chewing tobacco, snuff, in their room and in their possession. Residents may use smokeless tobacco at their own discretion. Residents will be educated regarding cleanliness and proper disposal of the smokeless tobacco. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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