STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675084	A. Building B. Wing	06/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Nursing and Rehab of Granbury	600 Reunion Court 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45458 Based on observation, interviews, and record reviews the facility failed to ensure residents were free from neglect for 1 of 3 residents (Resident #1) reviewed for abuse. When Resident #1 obtained a skin tear on 05/17/24 that reopened on 05/25/24, the facility failed to obtain treatment orders and provide wound care treatment. After the wound reopened on 5/25/24, the facility did not provide wound care until 5/30/34 when a family member changed the dressing. On 06/01/24 maggots were found in the wound and dressing. The facility did not obtain treatment orders until 06/02/24. An IJ was identified on 06/07/2024. The IJ template was provided to the facility on [DATE] at 5:13 p.m. While the IJ was removed on 06/08/2024, the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of pain, mental anguish, emotional distress, diminished quality of life, and serious physical harm. Findings included: Record review of Resident #1's Face Sheet, dated 06/04/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE], with of diagnoses Chronic (persisting) obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), unspecified, Unspecified dementia (impaired ability to remember, think, or make decisions that interfere with completing daily activities), Spinal stenosis (occurs when the space inside the backbone was to small and can put pressure on the spinal cord), Essential Hypertension (high blood pressure), and Dysphagia (difficulty swallowing), oropharyngeal phase (affects the oral and pharyngeal [swallowing food or liquid through the pharynx and esophagus] of swallowing). (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Doctor Visit Progress Note with Physician D, dated 05/17/2024, revealed Resident #1 had profound hearing impairment and he had an otoplasty (procedure to change the shape, position, or size of the ear using permanent sutures) in the past and had his right ear removed as part of his surgery. Record review revealed diagnoses included a cerebrovascular accident (a stroke) and Degenerative joint disease (another name for osteoarthritis). Record review revealed Physician D noted Resident #1 had no infections or acute issues over the past four to six weeks. Skin and integument was noted as no acute changes. Record review of Resident #1's Admission MDS Assessment, dated 04/14/2024, Section C- Cognitive Response Patterns revealed a BIMS score of 14, which indicated intact cognitive response. Section B - Hearing, Speech, and Vision, under B0200 - Hearing, revealed Resident #1 had moderate hearing difficulty in which the speaker had to increase volume and speak distinctly. Under B1000 - Vision, revealed Resident #1 was highly impaired with object identification in question, but eyes appeared to follow objects. Review of Section J1700 - History of Falls on Admission/Entry or Reentry revealed Resident #1 had no falls in the last two (2) to six (6) months prior to admission. Record review of Resident #1's Care Plan, dated 05/17/2024, revealed the plan was updated to identify Resident #1 had a fall with a laceration to the back of head of 5/17/24 and a fall on 5/25/24 with skin tear to rt elbow. Record review of Resident #1's Event Report, dated 05/17/2024 at 11:45 a.m., and completed by LVN M, revealed Resident #1 fell , sustained a head injury and skin tear to left upper extremity, and was transported to the hospital. Record review of Resident #1's Progress Note, dated 05/17/2024 at 11:50 a.m., revealed Resident #1 was found on the floor in his room by Maintenance Director and had an abrasion on the top of his head and a skin tear to left upper extremity. Resident #1 was sent out by 911. Note documented by LVN M. Record review of Resident #1's Progress Note, dated 05/17/2024 at 6:03 p.m., revealed Resident #1 arrived back from the ER with the presence of a laceration of right forearm, wrapped with ace bandages and a laceration of the scalp. Review revealed there was no documentation LVN M contacted the facility doctor when Resident #1 returned from the emergency room to discuss the discharge orders or confer about orders for Resident #1's laceration on his right forearm. Record review of Resident #1's hospital discharge records, dated 05/17/2025, revealed Resident #1 wound Care to be: care for the wound with soap and water; wound cleanser, saline or germ-free water, gauze, and dressing; use mild soap and water and pat wound dry. Record review of Resident #1's Progress Note, dated 05/25/2024 at 2:15 p.m., revealed Resident #1 returned from the ER and LVN M notified the on-call for Physician G and would continue current care plan. Record review of Resident #1's Progress Note, dated 05/25/2024 at 2:15 p.m., revealed Resident #1 returned from the ER and LVN M notified the on-call for Physician G and would continue current care plan. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's clinical Medication Orders, dated 06/04/2024, revealed Resident #1's medication order history from 04/08/2024 - 06/02/2024 did not include an order for wound care until 06/02/2024. Record review of Resident #1 eMar for 05/17/2024 - 05/31/2024, revealed Resident #1 had no wound care orders in place. Record review of Resident #1's nursing progress notes from 05/25/2024 to 06/01/2024 revealed no evidence of nursing care provided wound care. During an interview on 06/05/2024 at 10:15 a.m., Resident #1's family member said she had a video camera in Resident #1's room. Resident #1's family member said she witnessed Resident #1 as he sat on the side of his bed on 05/17/2024 at 11:30 a.m. drop his med cup, bent over, reach toward the floor, and fell forward. Resident #1's family member said Resident #1 fell to the floor and hit his head on the nightstand by his bed. Resident #1's family member said she immediately called the facility to let them know Resident #1 had fell . Resident #1's family member said she went to the ER and met Resident #1 when he arrived and said he had a skin tear on his right elbow. Resident #1's family member said Resident #1 fell again on 05/25/2024 when Resident #1 was found on the floor and sent to the ER for the second time. Resident #1's family member said she went to the ER and met Resident #1 when he arrived and said he had reopened the skin tear on his right elbow. Resident #1's family member said she was at the facility with Resident #1 visiting at approximately 8:15 p.m., on 06/01/2024. Resident #1's family member said she was sitting to the left of Resident #1 and put her arm around his shoulders and Resident #1 said, ouch, that hurts. Resident #1's family member said she asked Resident #1 what hurt, and he told her his right elbow. Resident #1's family member said she looked at the bandage on Resident's elbow and saw movement of approximately 50 maggots on the outside of the bandage. Resident #1's family member said she moved the top layer of the bandage and underneath was approximately 100 to 150 baby maggots. Resident #1's family member said the bandage was saturated in bloody drainage. Resident #1's family member said she immediately called LVN A who came in and changed and cleaned the bandage. Resident #1's family member said she watched as LVN A cleaned the area and she said she saw maggots on the wound. Resident #1's family member said she did not tell Resident #1 about the maggots because she was afraid Resident #1 would freak out. Resident #1's family member said Resident #1 was nearly blind and he could not see the larvae. During a follow-up interview on 06/05/2024 at 11:58 a.m., Resident #1's family member said she was at the facility on 05/30/2024 at 6:00 p.m., and at approximately 6:15pm, noticed Resident #1's bandaged on his elbow had not been removed since he returned from theER on [DATE]. Resident #1's family member said she removed the dressing and saw the area was soaked in dark, black colored drainage and had a bad smell. Resident #1's family member said she reported the wound to the nurse who was in the hall outside Resident #1's door. Review of video evidence submitted by Resident #1's family member, dated 06/01/2024 at 8:36 p.m., revealed an up-close view of the wound. Resident #1's arm laid on unwrapped cotton gauze and was wrapped in woven gauze bandage with small white larvae wiggling on the inside of the top layer of the gauze. The second layer of gauze had an area approximately 4 inches by 4 inches saturated in red blood with dark red colored drainage around the edges. The area was moist, the gauze was stretched, and small white larvae could be seen moving under the second layer. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of two (2) photos, submitted by Resident #1's family member, dated 05/30/2024 at 6:17 p.m. and 6:23 p.m., revealed Resident #1's wound on his right elbow was uncovered and laid on white bandage that covered the wound. The bandage was saturated in black and thick, dark red drainage and the gauze was stuck to Resident #1 skin. The wound, which was approximately 1 1/2 inches by 1 1/2 inches, was pink, soft, and raw. The skin around the outer edge of the bandage was dry and cracked, with large scales of dry skin present. Based on the photo image, Resident #1's family member was contacted by phone. During an interview on 06/06/2024 at 9:27 a.m., LVN A said on 05/30/2024, during daily head-to-toe assessments, she observed changed the bandage on Resident #1's left elbow at approximately 7:45pm. LVN A said Resident #1 did not have orders for wound care, but she saw the bandage and did not know when the bandage had been changed. LVN A said she had been off duty for a week and 05/30/2024 was her first shift upon return. LVN A said Resident #1 had fallen prior to her return and she was not aware if Resident #1 had wound care orders or not. Review of video evidence submitted by Resident #1's family member, dated 06/01/2024 at 8:39 p.m., revealed an up-close view of the wound. The video showed a bandage that was saturated with a circle of bloody drainage and multiple small white larvae could be seen moving under the gauze. Review of photograph evidence provided by Resident #1's family member, dated 06/01/2024 at 8:40 p.m., revealed an up-close view of the wound of Resident #1's bandage on his right elbow. The area was covered in woven gauze that was stretch and small, white larvae was seen between the fibers of the gauze. The gauze was observed saturated in red drainage with dark edges. During an observation on 06/04/2024 at 7:42 a.m., Resident #1 was observed with a gauze wrapped around his right elbow, with the gauze approximately an inch above and under the elbow. Observed a spot of bright red substance in the middle of the gauze about the size of a dime where the tape had come undone from the bandage and a spot of bright red substance on the tape, approximately 1/2 inch in length, that was unattached from the bandage. The bandage was dry. The skin on Resident #1's right arm around the outer edge of the bandage was extremely dry, flaking, and peeling from the mid-forearm, around the elbow, and upper arm. During an interview on 06/04/2024 at 7:46 a.m., Resident #1 said he did not remember who changed his bandage or seeing any type of bugs. Resident #1 said on Sunday (06/01/2024), he did not think he had white bugs on his bandage but Resident #1 said he could not remember. Resident #1 said he had trouble seeing. Record review of Resident #1's nursing progress notes dated 06/01/2024 at 10:05pm by LVN A revealed: (Recorded as Late Entry on 06/03/2024 at 4:11am) Upon assessment, noted dressing to be dry, clean and intact, with small amount of drainage noted on dressing. Date [on dressing] noted to be 5/30. Noted small white debris in dressing, noted to be smaller than grain of rice. Dressing was immediately removed, cleansed and changed. MD was notified and new orders received and placed into the MAR. No other orders received at this time. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/04/2024 at 6:58 a.m., LVN A said she was familiar with Resident #1 and was the nurse who found the bandage on Resident #1's right elbow covered with maggots on Saturday, 06/01/2024, at approximately 9:00 p.m. LVN A said she went into Resident #1's room to do his dressing change and noticed movement under the bandage. LVN A said she observed approximately 100 maggots in and around the bandage and in the gauze wrap. LVN A said the dressing was semi-saturated over the wound. LVN A described the bandage as wet with drainage and said blood had seeped through the gauze. LVN A said Resident #1 did not have doctor orders for wound care on 5/30/2024. LVN A said she cleaned and dressed the wound because she knew the area needed to be cleaned. During a follow-up interview on 06/06/2024 at 9:27 a.m., LVN A said on 05/30/2024, during daily head-to-toe assessments, she changed the bandage on Resident #1's elbow at approximately 7:45pm. LVN A said Resident #1 did not have orders for wound care, but she saw the bandage and did not know when the bandage had been changed. LVN A said she had been off duty for a week and 05/30/2024 was her first shift upon return. LVN A said Resident #1 had fallen prior to her return and she was not aware if Resident #1 had wound care orders or not. During an interview on 06/04/2024 at 9:38 a.m., LVN B said she was on duty the day Resident #1 fell (05/25/2024) but an agency nurse was assigned to Resident #1's hall. LVN B said she had not seen the wound, as it had been covered with a bandage when Resident #1 returned from theER on [DATE]. LVN B said she saw the wound on Resident #1's right elbow for the first time on Monday, 06/03/2024. LVN B said Resident #1 had new orders from the doctor that were started over the weekend on 06/02/2024, when Resident #1 was found with larvae. During an interview on 06/05/2024 at 11:01 a.m., LVN F said Resident #1 had wound care orders to change the dressing on Resident #1's elbow every shift and the orders were initiated on 06/02/2024. LVN F said Resident #1's orders were changed 06/04/2024 from every four hours to once every shift. LVN F said Resident #1 did not have wound care orders prior to 06/01/2024. LVN F said she was not sure how or when Resident #1 obtained the skin tear on his right elbow and had not seen the bandage on Resident #1's right elbow before 06/01/2024. Record review of nursing progress note by LVN H dated 05/28/2024 at 2:30pm revealed Dressing was checked and it was cleand, dry and intact. During an interview on 06/06/2024 at 3:10pm, LVN H said when a resident returned from the hospital or ER, she would get the resident comfortable and ensure interventions were in place. LVN H said she would review the paperwork and place the paperwork in the DON's box. LVN H said she usually did not contact the doctor, family, or the DON. LVN H said if the resident had new orders, she would enter the new orders into the resident's clinical record and text the doctor or call the on-call service During an interview 06/06/2024 at 3:52pm, CNA S stated she was familiar with Resident #1. She said that Resident's #1's family member would give Resident #1 a shower and let CNA S when the shower was completed. CNA S said she would then document the shower in the clinical records. CNA S said she noticed Resident #1's bandage but never looked underneath. CNA S said she never saw a nurse take the bandage off. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/06/2024 at 12:55pm, the ADON said she worked as the nurse on the floor on Saturday, 06/01/2024, 6 a.m. to 6 p.m., and Sunday, 06/02/2024 and did not know Resident #1 had a bandage on his right elbow. The ADON said the night nurse, LVN A, who came in on Saturday night changed the dressing with maggots after she had left at 6pm on 06/01/2024 and she was not notified until the ADON arrived at the facility on 06/02/2024 to work 6 a.m. to 6 p.m. During an interview on 06/05/2024 at 12:35 p.m., the DON said the nurse on duty when Resident #1 returned from theER on [DATE] was an agency nurse, LVN M, and she had not worked in the facility since that date. The DON said the nurse who was on duty when Resident #1 returned from theER on [DATE] was an agency nurse, LVN N. The DON said he was not sure if he would be able to obtain her number from the agency she worked for. During an interview on 06/06/2024 at 12:01 p.m., the DON said he was called by the charge nurse at the facility and informed fly larvae were found on and inside Resident #1's wound dressing located on his right elbow. The DON said he was sent a video by LVN A on 06/01/2024 at approximately 6:30 p.m., by text. The DON said he observed on the video the bandage had drainage on the dressing and he saw larvae moving. The DON said by looking at the dressing, he said the drainage did not look old and the amount of drainage did not concern him because he had seen wounds have copious amounts drainage and still be healthy. The DON said the larvae concerned him. The DON said his expectations when a resident returned the ER or hospital were for the nursing staff to follow the physician's orders. The DON said Resident #1 returned from theER on [DATE] with a bandage on his arm and did not have orders to care for the wound until 06/02/2024. The DON said his expectation was the nurse on duty when Resident #1 returned to the facility on [DATE] would have been to clarify Resident #1's discharge orders with the facility physician. The DON said the progress note in Resident #1's clinical record indicated the doctor was notified upon return from ER but agreed the documentation was not clear what was discussed in the phone conversation with the doctor. The DON said; if the family provided evidence of Resident #1's wound and the bandage appeared in a state that lacked attention by the facility nursing staff, this he would be based the doctor's orders. The DON said he agreed wound care orders were not put into place until 06/02/2024 for Resident #1's wound care until 06/02/2024. The DON said his expectations for was the CNAs to round every 2 hours and if a CNA witnessed drainage, to notify the nurse. During an interview on 06/06/2024 at 3:25pm, the DON said he worked on shift 6 p.m. to 6 a.m., on 05/25/2024 and 6 p.m. to 6 a.m., on 05/26/2024. The DON said he checked on residents during the overnight shift at least twice a shift. The DON said to his knowledge, he did not remember if he saw a bandage on Resident #1's right elbow. During a phone interview on 06/05/2024 at 3:18 p.m., Physician G said he was notified by facility staff when Resident #1 had maggots in his wound on his arm on 06/01/2024. Physician G said he ordered for the area to be flushed once or twice with hydron peroxide and put wound orders in place on 06/02/2024. Physician G said the facility had an in-house order for skin care and should have implemented the orders when Resident #1 returned from the emergency room with a wound or a bandage. Physician G said he was not familiar with Resident #1's fall or skin tear on 05/25/2024 but was aware Resident #1 went to the ER. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/07/2024 at 12:33 p.m., the Administrator said she was familiar with Resident #1 and was aware he fell on [DATE] and 05/25/2024. The Administrator said she, as the facility abuse coordinator, self-reported the incident with the bandage on Resident #1's right elbow that occurred on 6/1/2024. The Administrator said she was told the bandage contained a white debris that was smaller than a grain of rice. The Administrator said she did not see the larvae in Resident #1's bandage and could not confirm the bandage and wound had larvae present. The Administrator said she reported white debris the size of a grain of rice on Resident #1's right forearm near the elbow based on the fact she did not witness the wound at the time of the incident. Record review of the facility's policy, Abuse, Neglect, and Exploitation, dated 10/2023, revealed possible indicators of abuse include, but are not limited to: failure to provide care needs such as comfort and safety. The facility would prevent abuse by assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors, identification with ongoing assessment, care planning with appropriate interventions, and monitoring of residents with needs which might lead to conflict or neglect. This was determined to be an Immediate Jeopardy that was called on 06/07/2024. The Administrator was notified on 06/07/2024 at 5:13 p.m. that an Immediate Jeopardy (IJ) situation was identified due to the above failures. The Administrator was provided the Immediate Jeopardy (IJ) template on 06/07/2024 at 5:30 p.m. and the plan of removal was requested. The facility's plan of removal was accepted on 06/08/2024 at 1:23 p.m. and included the following: [facility name] Nursing and Rehabilitation Plan of Removal: 600: Free from Abuse and Neglect Date Initiated: 6/7/2024 Today's Date: 6/7/2024 Based on interviews, and record reviews, the facility failed to ensure residents were free from neglect for 1 of 3 residents (Resident #1) reviewed for abuse. All residents can be affected by this deficient practice. Action: Resident #1 received a skin assessment, physician notified, follow MD orders, RP notified. Identified Resident not showing any signs of distress or a negative physical outcome as a result of the event. Person(s) Responsible: Charge Nurse and/or Designee Date Action Completed: 06/01/24 Action: All residents received head-to-toe skin assessments. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All residents with wounds assessed with no additional adverse findings. Person(s) Responsible: Assistant Director of Nursing, Director of Nursing, and/or Designee Date Action Completed: 06/02/24 Action: Education-- Neglect (All Staff) a. Failing to Obtain treatment orders (Nurses) b. Failing to change wound dressings (Nurses) c. Failing to notify MD of resident status and discharge orders \after a return from hospital (Nurses) Test will be completed for competency and to ensure understanding. All identified staff will be educated and tested prior to working their next shift. All new and temporary staff will be educated and tested prior to working their first shift. Person Responsible: Director of Nursing, Assistant Director of Nursing, Administrator, and/or Designee Date Action Initiated: 06/08/24 Action: All residents that have returned from the hospital in the previous 30 days have been reviewed to ensure that the physician has been notified of any pertinent resident information and ensure we are following physician orders. Person(s) Responsible: Director of Nursing, Assistant Director, and/or designee Date: 6/7/2024 Action: Director of Nursing and/or Designee to observe and/or follow behind and confirm x3 skin assessments a week and verify treatment is in place and dated within the MD's order x2 a week with emphasis on residents, who smoke, go out on pass, and/or spend time outside with wounds for 4 weeks. Person(s) Responsible: Director of Nursing, Assistant Director of Nursing, and/or Designee Date Action Initiated: 06/02/24 Action: Ad hoc QAPI with on call physician reviewing 580 template and the facility's plan to remove the immediacy. Person(s) Responsible: Administrator (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Date: 6/7/2024 On 06/08/2024, the investigator confirmed the facility implemented their plan of removal sufficiently to remove Immediate Jeopardy (IJ) by: On 06/08/2024 at 12:55 p.m., completed a record review of a random sample of residents who resided in the facility based on the action that all resident received head-to-toe assessment. Reviewed Resident #4's Clinical Progress Note, dated 06/02/2024 at 6:54 a.m., that indicated Resident #4 received a head-to-toe assessment completed by LVN F. Reviewed Resident #5's Clinical Progress Note, dated 06/04/2024 2:04 p. m., which revealed Resident #5 had a head-to-toe assessment completed by LVN B. Reviewed Resident #9's Clinical Progress Note, dated 06/04/2024 at 7:27 a.m., which revealed Resident #9 received a head-to-toe assessment completed by LVN F. 06/08/2024 at 1:15 p.m., reviewed progress note dated 06/01/2024, completed by the DON that revealed Resident #1 was assessed immediately after the discovery of the larvae on his right elbow. Reviewed Progress Note dated 06/01/2024 that Physician G was notified on 06/01/2024. Notification was verified by interview with Physician G and review of doctor orders dated 06/02/2024. On 06/08/2024 at 1:25 p.m., completed a record review of Resident #8's clinical record when he returned to the facility on [DATE]. Discharge records, progress notes, doctor orders, and care plan reviewed with no issues noted. During an interview on 06/08/2024 at 1:41 p.m RN O said she worked 6 a.m. to 2:30 p.m. on the weekends and PRN. RN O said she was in-serviced on how to readmit a resident who returned to the facility from the ER prior to her shift that morning. RN O said the process was to receive and review the discharge orders, notify the doctor, family, and put new orders in place after she discussed the orders with the facility doctor. RN O said she would notify the doctor if a resident fell , had new lab orders, showed a change in conditions, or any request by family or resident requesting orders. RN O said if a resident had an open area or wound and no orders for wound care, she would contact the doctor and inform the doctor of the issues and ask if new orders are needed. RN O said she was in-serviced on abuse/neglect and assessments, including head-to-toe, vital signs, and to notify the doctor of results. During an interview on 06/08/2024 at 1:55 p.m., RN, Weekend Supervisor said she worked 8 a.m. to 5 p.m., Saturday and Sunday. RN, Weekend Supervisor said she was recently in-serviced on fall precautions, identifying wounds, abuse/neglect, patient rights, fire safety, and the evacuation plan. RN, Weekend Supervisor said the wound care in-service included notifying the doctor if orders were needed. RN, Weekend Supervisor said wound care orders were need to complete wound care. RN, Weekend Supervisor said if a resident returned from ER, she would notify family, complete an assessment, review the discharge report and orders, contact doctor to obtain any needed orders, and put all orders into the MAR and clinical record. (continued on next page)

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	675084	A. Building B. Wing	06/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Nursing and Rehab of Granbury	600 Reunion Court Granbury, TX 76048

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/08/2024 at 2:06 p, m., LVN C said she worked a 6 a.m. to 6 p.m., rotation that included weekdays and weekends. LVN C said she was in-serviced prior to shift. LVN C said the contents of the in-services were admission protocols, following doctor orders, and going over the meds and wound orders with the facility doctor, LVN C said wound care could not be complete without doctor orders. LVN C said when a resident returned from ER, she would ensure the resident was comfortable in bed, complete a head-to-toe assessment to include vital signs and skin assessments. LVN C said she would call the doctor and review the orders to let the doctor know the resident had returned to the facility. LVN C said she would clarify wound care orders to ensure products are available that were included in the ER or facility doctor's order. LVN C said she would notify the family and the administrator. LVN C said she was in-serviced to ensure skin assessment were completed at least weekly, but she would complete more frequently or as needed. During an interview on 06/08/2024 at 3:08 p.m., Housekeeping Q said she had been recently in-serviced on abuse/neglect prior to her shift on this date. Housekeeping Q said if she saw a call light on too long, she would get an aide. Housekeeping Q said examples of abuse included if she saw someone getting to rough or not being physically careful, or residents being mean to each other could be abuse. Housekeeping Q said she identified the categories of abuse as neglect, physical, emotional, or financial. Housekeeping Q said neglect could be a resident that was thirsty and had no water at his bedside. Housekeeping Q said if a resident was wet and had been laying wet for a long time could be neglect. During an interview on 06/08/2024 at 3:15p.m., CNA R said she worked a 6 p.m. to 6 a.m. rotation that included weekdays and weekends. CNA R said she was recently in-serviced on abuse/neglect prior to her shift that morning. CNA R said neglect was not providing resident proper care or not providing care when they needed it. CNA R said an example could be not answering a call light or not providing pain medication. During an interview on 06/08/2024 at 3:27 p.m., LVN A said she worked a 6 p.m. to 6 a.m. rotation that included weekdays and weekends. LVN A said she was in-serviced on 06/07/24 when she came on shift at 6 p.m. LVN A said the in-service covered documentation, abuse/neglect, which including a test, and what action to take when a resident returned from the ER. LVN A said she was to notify the facility doctor and family. LVN A said she was required to scan in the documents and if the discharge orders had new orders, she would enter the new orders into the eMar after she verified with the facility physician. LVN A said if a resident had a wound and no treatment orders, she was in-serviced to notify the facility doctor prior to completing wound care. LVN A said she could not do wound care without doctor orders. LVN A said she would do a head-to-toe assessment when a resident returned from the ER. During an interview on 06/06/2024 at 3:10pm, LVN H said when a resident returned from the hospital or ER, she would get the resident comfortable and ensure interventions were in place. LVN H said she would review the paperwork and place the paperwork in the DON's box. LVN H said she usually did not contact the doctor, family, or the DON. LVN H said if the resident had new orders, she would enter the new orders into the resident's clinical record and text the doctor or call the on-call service On 06/08/2024 at 2:17 p.m., received the Plan of Removal notebook which contained documentation for the action plan of the facility's POR, from the Administrator. Reviewed Resident #1's Doctor's Order History, which revealed wound care orders were initiated 06/02/2024. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/08/2024 at 2:34 p.m., reviewed the following in-services and signature sheets: - When do you notify the Attending Physician? Dated 06/02/2024 - Abuse & Neglect Inservice - dated 6/02/2024 for all staff - Wound Treatment Orders, How to input orders into the electronic record - dated 6/08/2024, signed by LVN A - When a resident returns from the ER: steps to take - dated 06/07/2024 - Resident Assessment: reviewed what steps were included - dated 6/02/2024 - Skin assessment and wound orders: when to be completed, who to notify - dated 6/02/2024 - Orders: directions and key points to remember - dated 6/02/2024 - Change in Condition, notifying proper parties - dated 6/03/2024 - Documentation - dated 6/02/2024 - Neglect test - nine (9) random employees included in sample - Resident returning from ER - four (4) nurses included in random sample - Ad Hoc QAPI Meeting Agenda dated 06/07/2024 - [facility name] Tracking Sheet for skin assessments - dated as started 6/02/2024; entries for 6/06/24 & 06/07/24 - List of Last 30 discharge/readmissions ER - dated 6/07/2024 During an interview on 06/08/2024 at 3:37 p.m., the DON said he would use a form similar to a calendar to document that all resident hospital discharge paperwork was reviewed in morning meetings and was documented on the 24-hour report. Overall, the DON said the Plan of Removal was effective and the IJ brought to light the fact that the discharge paperwork needed to be reviewed more carefully to ensure continuity of care. The DON said review of the discharge paperwork with the facility doctor and clear, precise documentation of what the conversation with the facility doctor included would have prevented a lot of issues related to the IJ. On 06/08/2024 at 3:50 p.m., notified Admin [TRUNCATED]

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45458 Based on observation, interviews, and record reviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #1) of 3 residents reviewed for quality of care. When Resident #1 obtained a skin tear on 05/17/24 that reopened on 05/25/24, the facility failed to obtain treatment orders and provide wound care treatment. After the wound reopened on 5/25/24, the facility did not provide wound care until 5/30/24 when a family member changed the dressing. On 06/01/24 maggots were found in the wound and dressing. The facility did not obtain treatment orders until 06/02/24. An IJ was identified on 06/07/2024. The IJ template was provided to the facility on [DATE] at 5:13 p.m. While the IJ was removed on 06/08/2024, the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems These failures placed residents of having unidentified skin conditions leading to delays in necessary medical interventions, pain, worsening conditions, and decline in health. Findings included: Based on observation, interviews, and record reviews the facility failed to ensure residents were free from neglect for 1 of 3 residents (Resident #1) reviewed for abuse. When Resident #1 obtained a skin tear on 05/17/24 that reopened on 05/25/24, the facility failed to obtain treatment orders and provide wound care treatment. After the wound reopened on 5/25/24, the facility did not provide wound care until 5/30/34 when a family member changed the dressing. On 06/01/24 maggots were found in the wound and dressing. The facility did not obtain treatment orders until 06/02/24. An IJ was identified on 06/07/2024. The IJ template was provided to the facility on [DATE] at 5:13 p.m. While the IJ was removed on 06/08/2024, the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of pain, mental anguish, emotional distress, diminished quality of life, and serious physical harm. Findings included: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Face Sheet, dated 06/04/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE], with of diagnoses Chronic (persisting) obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), unspecified, Unspecified dementia (impaired ability to remember, think, or make decisions that interfere with completing daily activities), Spinal stenosis (occurs when the space inside the backbone was to small and can put pressure on the spinal cord), Essential Hypertension (high blood pressure), and Dysphagia (difficulty swallowing), oropharyngeal phase (affects the oral and pharyngeal [swallowing food or liquid through the pharynx and esophagus] of swallowing). Record review of Resident #1's Doctor Visit Progress Note with Physician D, dated 05/17/2024, revealed Resident #1 had profound hearing impairment and he had an otoplasty (procedure to change the shape, position, or size of the ear using permanent sutures) in the past and had his right ear removed as part of his surgery. Record review revealed diagnoses included a cerebrovascular accident (a stroke) and Degenerative joint disease (another name for osteoarthritis). Record review revealed Physician D noted Resident #1 had no infections or acute issues over the past four to six weeks. Skin and integument was noted as no acute changes. Record review of Resident #1's Admission MDS Assessment, dated 04/14/2024, Section C- Cognitive Response Patterns revealed a BIMS score of 14, which indicated intact cognitive response. Section B - Hearing, Speech, and Vision, under B0200 - Hearing, revealed Resident #1 had moderate hearing difficulty in which the speaker had to increase volume and speak distinctly. Under B1000 - Vision, revealed Resident #1 was highly impaired with object identification in question, but eyes appeared to follow objects. Review of Section J1700 - History of Falls on Admission/Entry or Reentry revealed Resident #1 had no falls in the last two (2) to six (6) months prior to admission. Record review of Resident #1's Care Plan, dated 05/17/2024, revealed the plan was updated to identify Resident #1 had a fall with a laceration to the back of head of 5/17/24 and a fall on 5/25/24 with skin tear to rt elbow. Record review of Resident #1's Event Report, dated 05/17/2024 at 11:45 a.m., and completed by LVN M, revealed Resident #1 fell , sustained a head injury and skin tear to left upper extremity, and was transported to the hospital. Record review of Resident #1's Progress Note, dated 05/17/2024 at 11:50 a.m., revealed Resident #1 was found on the floor in his room by Maintenance Director and had an abrasion on the top of his head and a skin tear to left upper extremity. Resident #1 was sent out by 911. Note documented by LVN M. Record review of Resident #1's Progress Note, dated 05/17/2024 at 6:03 p.m., revealed Resident #1 arrived back from the ER with the presence of a laceration of right forearm, wrapped with ace bandages and a laceration of the scalp. Review revealed there was no documentation LVN M contacted the facility doctor when Resident #1 returned from the emergency room to discuss the discharge orders or confer about orders for Resident #1's laceration on his right forearm. Record review of Resident #1's hospital discharge records, dated 05/17/2025, revealed Resident #1 wound Care to be: care for the wound with soap and water; wound cleanser, saline or germ-free water, gauze, and dressing; use mild soap and water and pat wound dry. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Progress Note, dated 05/25/2024 at 2:15 p.m., revealed Resident #1 returned from the ER and LVN M notified the on-call for Physician G and would continue current care plan. Record review of Resident #1's clinical Medication Orders, dated 06/04/2024, revealed Resident #1's medication order history from 04/08/2024 - 06/02/2024 did not include an order for wound care until 06/02/2024. Record review of Resident #1 eMar for 05/17/2024 - 05/31/2024, revealed Resident #1 had no wound care orders in place. Record review of Resident #1's nursing progress notes from 05/25/2024 to 06/01/2024 revealed no evidence of nursing care provided wound care. During an interview on 06/05/2024 at 10:15 a.m., Resident #1's family member said she had a video camera in Resident #1's room. Resident #1's family member said she witnessed Resident #1 as he sat on the side of his bed on 05/17/2024 at 11:30 a.m. drop his med cup, bent over, reach toward the floor, and fell forward. Resident #1's family member said Resident #1 fell to the floor and hit his head on the nightstand by his bed. Resident #1's family member said she immediately called the facility to let them know Resident #1 had fell . Resident #1's family member said she went to the ER and met Resident #1 when he arrived and said he had a skin tear on his right elbow. Resident #1's family member said Resident #1 fell again on 05/25/2024 when Resident #1 was found on the floor and sent to the ER for the second time. Resident #1's family member said she went to the ER and met Resident #1 when he arrived and said he had reopened the skin tear on his right elbow. Resident #1's family member said she was at the facility with Resident #1 visiting at approximately 8:15 p.m., on 06/01/2024. Resident #1's family member said she was sitting to the left of Resident #1 and put her arm around his shoulders and Resident #1 said, ouch, that hurts. Resident #1's family member said she asked Resident #1 what hurt, and he told her his right elbow. Resident #1's family member said she looked at the bandage on Resident's elbow and saw movement of approximately 50 maggots on the outside of the bandage. Resident #1's family member said she moved the top layer of the bandage and underneath was approximately 100 to 150 baby maggots. Resident #1's family member said the bandage was saturated in bloody drainage. Resident #1's family member said she immediately called LVN A who came in and changed and cleaned the bandage. Resident #1's family member said she watched as LVN A cleaned the area and she said she saw maggots on the wound. Resident #1's family member said she did not tell Resident #1 about the maggots because she was afraid Resident #1 would freak out. Resident #1's family member said Resident #1 was nearly blind and he could not see the larvae. During a follow-up interview on 06/05/2024 at 11:58 a.m., Resident #1's family member said she was at the facility on 05/30/2024 at 6:00 p.m., and at approximately 6:15pm, noticed Resident #1's bandaged on his elbow had not been removed since he returned from theER on [DATE]. Resident #1's family member said she removed the dressing and saw the area was soaked in dark, black colored drainage and had a bad smell. Resident #1's family member said she reported the wound to the nurse who was in the hall outside Resident #1's door. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of video evidence submitted by Resident #1's family member, dated 06/01/2024 at 8:36 p.m., revealed an up-close view of the wound. Resident #1's arm laid on unwrapped cotton gauze and was wrapped in woven gauze bandage with small white larvae wiggling on the inside of the top layer of the gauze. The second layer of gauze had an area approximately 4 inches by 4 inches saturated in red blood with dark red colored drainage around the edges. The area was moist, the gauze was stretched, and small white larvae could be seen moving under the second layer. Review of two (2) photos, submitted by Resident #1's family member, dated 05/30/2024 at 6:17 p.m. and 6:23 p.m., revealed Resident #1's wound on his right elbow was uncovered and laid on white bandage that covered the wound. The bandage was saturated in black and thick, dark red drainage and the gauze was stuck to Resident #1 skin. The wound, which was approximately 1 1/2 inches by 1 1/2 inches, was pink, soft, and raw. The skin around the outer edge of the bandage was dry and cracked, with large scales of dry skin present. Based on the photo image, Resident #1's family member was contacted by phone. During an interview on 06/06/2024 at 9:27 a.m., LVN A said on 05/30/2024, during daily head-to-toe assessments, she observed changed the bandage on Resident #1's left elbow at approximately 7:45pm. LVN A said Resident #1 did not have orders for wound care, but she saw the bandage and did not know when the bandage had been changed. LVN A said she had been off duty for a week and 05/30/2024 was her first shift upon return. LVN A said Resident #1 had fallen prior to her return and she was not aware if Resident #1 had wound care orders or not. Review of video evidence submitted by Resident #1's family member, dated 06/01/2024 at 8:39 p.m., revealed an up-close view of the wound. The video showed a bandage that was saturated with a circle of bloody drainage and multiple small white larvae could be seen moving under the gauze. Review of photograph evidence provided by Resident #1's family member, dated 06/01/2024 at 8:40 p.m., revealed an up-close view of the wound of Resident #1's bandage on his right elbow. The area was covered in woven gauze that was stretch and small, white larvae was seen between the fibers of the gauze. The gauze was observed saturated in red drainage with dark edges. During an observation on 06/04/2024 at 7:42 a.m., Resident #1 was observed with a gauze wrapped around his right elbow, with the gauze approximately an inch above and under the elbow. Observed a spot of bright red substance in the middle of the gauze about the size of a dime where the tape had come undone from the bandage and a spot of bright red substance on the tape, approximately 1/2 inch in length, that was unattached from the bandage. The bandage was dry. The skin on Resident #1's right arm around the outer edge of the bandage was extremely dry, flaking, and peeling from the mid-forearm, around the elbow, and upper arm. During an interview on 06/04/2024 at 7:46 a.m., Resident #1 said he did not remember who changed his bandage or seeing any type of bugs. Resident #1 said on Sunday (06/01/2024), he did not think he had white bugs on his bandage but Resident #1 said he could not remember. Resident #1 said he had trouble seeing. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's nursing progress notes dated 06/01/2024 at 10:05pm by LVN A revealed: (Recorded as Late Entry on 06/03/2024 at 4:11am) Upon assessment, noted dressing to be dry, clean and intact, with small amount of drainage noted on dressing. Date [on dressing] noted to be 5/30. Noted small white debris in dressing, noted to be smaller than grain of rice. Dressing was immediately removed, cleansed and changed. MD was notified and new orders received and placed into the MAR. No other orders received at this time. During an interview on 06/04/2024 at 6:58 a.m., LVN A said she was familiar with Resident #1 and was the nurse who found the bandage on Resident #1's right elbow covered with maggots on Saturday, 06/01/2024, at approximately 9:00 p.m. LVN A said she went into Resident #1's room to do his dressing change and noticed movement under the bandage. LVN A said she observed approximately 100 maggots in and around the bandage and in the gauze wrap. LVN A said the dressing was semi-saturated over the wound. LVN A described the bandage as wet with drainage and said blood had seeped through the gauze. LVN A said Resident #1 did not have doctor orders for wound care on 5/30/2024. LVN A said she cleaned and dressed the wound because she knew the area needed to be cleaned. During a follow-up interview on 06/06/2024 at 9:27 a.m., LVN A said on 05/30/2024, during daily head-to-toe assessments, she changed the bandage on Resident #1's elbow at approximately 7:45pm. LVN A said Resident #1 did not have orders for wound care, but she saw the bandage and did not know when the bandage had been changed. LVN A said she had been off duty for a week and 05/30/2024 was her first shift upon return. LVN A said Resident #1 had fallen prior to her return and she was not aware if Resident #1 had wound care orders or not. During an interview on 06/04/2024 at 9:38 a.m., LVN B said she was on duty the day Resident #1 fell (05/25/2024) but an agency nurse was assigned to Resident #1's hall. LVN B said she had not seen the wound, as it had been covered with a bandage when Resident #1 returned from theER on [DATE]. LVN B said she saw the wound on Resident #1's right elbow for the first time on Monday, 06/03/2024. LVN B said Resident #1 had new orders from the doctor that were started over the weekend on 06/02/2024, when Resident #1 was found with larvae. During an interview on 06/05/2024 at 11:01 a.m., LVN F said Resident #1 had wound care orders to change the dressing on Resident #1's elbow every shift and the orders were initiated on 06/02/2024. LVN F said Resident #1's orders were changed 06/04/2024 from every four hours to once every shift. LVN F said Resident #1 did not have wound care orders prior to 06/01/2024. LVN F said she was not sure how or when Resident #1 obtained the skin tear on his right elbow and had not seen the bandage on Resident #1's right elbow before 06/01/2024. Record review of nursing progress note by LVN H dated 05/28/2024 at 2:30pm revealed Dressing was checked and it was cleand, dry and intact. During an interview on 06/06/2024 at 3:10pm, LVN H said when a resident returned from the hospital or ER, she would get the resident comfortable and ensure interventions were in place. LVN H said she would review the paperwork and place the paperwork in the DON's box. LVN H said she usually did not contact the doctor, family, or the DON. LVN H said if the resident had new orders, she would enter the new orders into the resident's clinical record and text the doctor or call the on-call service (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview 06/06/2024 at 3:52pm, CNA S stated she was familiar with Resident #1. She said that Resident's #1's family member would give Resident #1 a shower and let CNA S when the shower was completed. CNA S said she would then document the shower in the clinical records. CNA S said she noticed Resident #1's bandage but never looked underneath. CNA S said she never saw a nurse take the bandage off. During an interview on 06/06/2024 at 12:55pm, the ADON said she worked as the nurse on the floor on Saturday, 06/01/2024, 6 a.m. to 6 p.m., and Sunday, 06/02/2024 and did not know Resident #1 had a bandage on his right elbow. The ADON said the night nurse, LVN A, who came in on Saturday night changed the dressing with maggots after she had left at 6pm on 06/01/2024 and she was not notified until the ADON arrived at the facility on 06/02/2024 to work 6 a.m. to 6 p.m. During an interview on 06/05/2024 at 12:35 p.m., the DON said the nurse on duty when Resident #1 returned from theER on [DATE] was an agency nurse, LVN M, and she had not worked in the facility since that date. The DON said the nurse who was on duty when Resident #1 returned from theER on [DATE] was an agency nurse, LVN N. The DON said he was not sure if he would be able to obtain her number from the agency she worked for. During an interview on 06/06/2024 at 12:01 p.m., the DON said he was called by the charge nurse at the facility and informed fly larvae were found on and inside Resident #1's wound dressing located on his right elbow. The DON said he was sent a video by LVN A on 06/01/2024 at approximately 6:30 p.m., by text. The DON said he observed on the video the bandage had drainage on the dressing and he saw larvae moving. The DON said by looking at the dressing, he said the drainage did not look old and the amount of drainage did not concern him because he had seen wounds have copious amounts drainage and still be healthy. The DON said the larvae concerned him. The DON said his expectations when a resident returned the ER or hospital were for the nursing staff to follow the physician's orders. The DON said Resident #1 returned from theER on [DATE] with a bandage on his arm and did not have orders to care for the wound until 06/02/2024. The DON said his expectation was the nurse on duty when Resident #1 returned to the facility on [DATE] would have been to clarify Resident #1's discharge orders with the facility physician. The DON said the progress note in Resident #1's clinical record indicated the doctor was notified upon return from ER but agreed the documentation was not clear what was discussed in the phone conversation with the doctor. The DON said; if the family provided evidence of Resident #1's wound and the bandage appeared in a state that lacked attention by the facility nursing staff, this he would be based the doctor's orders. The DON said he agreed wound care orders were not put into place until 06/02/2024 for Resident #1's wound care until 06/02/2024. The DON said his expectations for was the CNAs to round every 2 hours and if a CNA witnessed drainage, to notify the nurse. During an interview on 06/06/2024 at 3:25pm, the DON said he worked on shift 6 p.m. to 6 a.m., on 05/25/2024 and 6 p.m. to 6 a.m., on 05/26/2024. The DON said he checked on residents during the overnight shift at least twice a shift. The DON said to his knowledge, he did not remember if he saw a bandage on Resident #1's right elbow. (continued on next page)

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	675084	A. Building B. Wing	06/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Nursing and Rehab of Granbury	600 Reunion Court Granbury, TX 76048

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 06/05/2024 at 3:18 p.m., Physician G said he was notified by facility staff when Resident #1 had maggots in his wound on his arm on 06/01/2024. Physician G said he ordered for the area to be flushed once or twice with hydron peroxide and put wound orders in place on 06/02/2024. Physician G said the facility had an in-house order for skin care and should have implemented the orders when Resident #1 returned from the emergency room with a wound or a bandage. Physician G said he was not familiar with Resident #1's fall or skin tear on 05/25/2024 but was aware Resident #1 went to the ER. During an interview on 06/07/2024 at 12:33 p.m., the Administrator said she was familiar with Resident #1 and was aware he fell on [DATE] and 05/25/2024. The Administrator said she, as the facility abuse coordinator, self-reported the incident with the bandage on Resident #1's right elbow that occurred on 6/1/2024. The Administrator said she was told the bandage contained a white debris that was smaller than a grain of rice. The Administrator said she did not see the larvae in Resident #1's bandage and could not confirm the bandage and wound had larvae present. The Administrator said she reported white debris the size of a grain of rice on Resident #1's right forearm near the elbow based on the fact she did not witness the wound at the time of the incident. This was determined to be an Immediate Jeopardy that was called on 06/07/2024. The Administrator was notified on 06/07/2024 at 5:13 p.m. that an Immediate Jeopardy (IJ) situation was identified due to the above failures. The Administrator was provided the Immediate Jeopardy (IJ) template on 06/07/2024 at 5:30 p.m. and the plan of removal was requested. The facility's plan of removal was accepted on 06/08/2024 at 1:23 p.m. and included the following: [facility name] Nursing and Rehabilitation Plan of Removal: 684: Professional Standards Date Initiated: 6/7/2024 Today's Date: 6/7/2024 Based on interviews and record reviews, the facility failed to ensure that resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #1) of 3 residents reviewed for quality care. All residents can be affected by this deficient practice. Action: Identified Resident received a skin assessment, physician notified, follow MD orders, RP notified. Identified Resident not showing any signs of distress or a negative physical outcome as a result of the event. Person(s) Responsible: Charge Nurse and/or Designee Date Action Completed: 06/01/24 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: All residents received head-to-toe skin assessments. All residents with wounds assessed with no additional adverse findings. Person(s) Responsible: Assistant Director of Nursing, Director of Nursing, and/or Designee Date Action Completed: 06/02/24 Action: Education Wound Care/Treatment Orders/Physician Orders (Nurses) a. Completing head to toe assessments when a Resident returns from the hospital b. Completing wound care treatments as ordered and performing Weekly Skin assessments Change in Condition (Nurses) a. Notification of MD for new or changing wounds and obtaining treatment orders b. Resident Assessment Test will be completed for competency and to ensure understanding. All identified staff will be educated and tested prior to working their next shift. All new and temporary staff will be educated and tested prior to working their first shift. Person(s) Responsible: Director of Nursing, Assistant Director of Nursing, Administrator, and/or Designee Date Action Initiated: 06/08//24 Action: All residents that have returned from the hospital in the previous 30 days have been reviewed to ensure that the physician has been notified of any pertinent resident information and ensure we are following physician orders. Person(s) Responsible: Director of Nursing, Assistant Director, and/or designee Date: 6/7/2024 Action: Director of Nursing and/or Designee to observe and/or follow behind and confirm x3 skin assessments a week and verify treatment is in place and dated within the MD's order x2 a week with emphasis on residents, who smoke, go out on pass, and/or spend time outside with wounds for 4 weeks. Person(s) Responsible: Director of Nursing, Assistant Director of Nursing, and/or Designee Date Action Initiated: 06/02/24 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: Ad hoc QAPI with on call physician reviewing 684 template and the facility's plan to remove the immediacy. Person(s) Responsible: Administrator Date: 6/7/2024 On 06/08/2024, the investigator confirmed the facility implemented their plan of removal sufficiently to remove Immediate Jeopardy (IJ) by: On 06/08/2024 at 12:55 p.m., completed a record review of a random sample of residents who resided in the facility based on the action that all resident received head-to-toe assessment. Reviewed Resident #4's Clinical Progress Note, dated 06/02/2024 at 6:54 a.m., that indicated Resident #4 received a head-to-toe assessment completed by LVN F. Reviewed Resident #5's Clinical Progress Note, dated 06/04/2024 at 2:04 p.m., which revealed Resident #5 had a head-to-toe assessment completed by LVN B. Reviewed Resident #9's Clinical Progress Note, dated 06/04/2024 at7:27 a.m., which revealed Resident #9 received a head-to-toe assessment completed by LVN F. 06/08/2024 at 1:15 p.m., reviewed progress note dated 06/01/2024, completed by the DON that revealed Resident #1 was assessed immediately after the discovery of the larvae on his right elbow. Review Progress Note dated 06/01/2024 that Physician G was notified on 06/01/2024. Notification was verified by interview with Physician G and review of doctor orders dated 06/02/2024. On 06/08/2024 at 1:25 p.m., completed a record review of Resident #8's clinical record when he returned to the facility on [DATE]. Discharge records, progress notes, doctor orders, and care plan reviewed with no issues noted. During an interview on 06/08/2024 at 1:41 p.m RN O said she worked 6 a.m. to 2:30 p.m. on the weekends and PRN. RN O said she was in-serviced on how to readmit a resident who returned to the facility from the ER prior to her shift that morning. RN O said the process was to receive and review the discharge orders, notify the doctor, family, and put new orders in place after she discussed the orders with the facility doctor. RN O said she would notify the doctor if a resident fell , had new lab orders, showed a change in conditions, or any request by family or resident requesting orders. RN O said if a resident had an open area or wound and no orders for wound care, she would contact the doctor and inform the doctor of the issues and ask if new orders are needed. RN O said she was in-serviced on abuse/neglect and assessments, including head-to-toe, vital signs, and to notify the doctor of results. During an interview on 06/08/2024 at 1:55 p.m., RN, Weekend Supervisor said she worked 8 a.m. to 5 p.m., Saturday and Sunday. RN, Weekend Supervisor said she was recently in-serviced on fall precautions, identifying wounds, abuse/neglect, patient rights, fire safety, and the evacuation plan. RN, Weekend Supervisor said the wound care in-service included notifying the doctor if orders were needed. RN, Weekend Supervisor said wound care orders were need to complete wound care. RN, Weekend Supervisor said if a resident returned from ER, she would notify family, complete an assessment, review the discharge report and orders, contact doctor to obtain any needed orders, and put all orders into the MAR and clinical record. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/08/2024 at 2:06 p, m., LVN C said she worked a 6 a.m. to 6 p.m., rotation that included weekdays and weekends. LVN C said she was in-serviced prior to shift. LVN C said the contents of the in-services were admission protocols, abuse/neglect, following doctor orders, and going over the meds and wound orders with the facility doctor, LVN C said wound care could not be complete without doctor orders. LVN C said when a resident returned from ER, she would ensure the resident was comfortable in bed, complete a head-to-toe assessment to include vital signs and skin assessments. LVN C said she would call the doctor and review the orders to let the doctor know the resident had returned to the facility. LVN C said she would clarify wound care orders to ensure products are available that were included in the ER or facility doctor's order. LVN C said she would notify the family and the administrator. LVN C said she was in-serviced to ensure skin assessment were completed at least weekly, but she would complete more frequently or as needed. During an interview on 06/08/2024 at 3:08 p.m., Housekeeping Q said she had been recently in-serviced on abuse/neglect prior to her shift on this date. Housekeeping Q said if she saw a call light on too long, she would get an aide. Housekeeping Q said examples of abuse included if she saw someone getting to rough or not being physically careful, or residents being mean to each other could be abuse. Housekeeping Q said she identified the categories of abuse as neglect, physical, emotional, or financial. Housekeeping Q said neglect could be a resident that was thirsty and had no water at his bedside. Housekeeping Q said if a resident was wet and had been laying wet for a long time could be neglect. During an interview on 06/08/2024 at 3:15p.m., CNA R said she worked a 6 p.m. to 6 a.m. rotation that included weekdays and weekends. CNA R said she was recently in-serviced on abuse/neglect prior to her shift that morning. CNA R said neglect was not providing resident proper care or not providing care when they needed it. CNA R said an example could be not answering a call light or not providing pain medication. During an interview on 06/08/2024 at 3:27 p.m., LVN A said she worked a 6 p.m. to 6 a.m. rotation that included weekdays and weekends. LVN A said she was in-serviced on 06/07/24 when she came on shift at 6 p.m. LVN A said the in-service covered documentation, abuse/neglect, which including a test, and what action to take when a resident returned from the ER. LVN A said she was to notify the facility doctor and family. LVN A said she was required to scan in the documents and if the discharge orders had new orders, she would enter the new orders into the eMar after she verified with the facility physician. LVN A said if a resident had a wound and no treatment orders, she was in-serviced to notify the facility doctor prior to completing wound care. LVN A said she could not do wound care without doctor orders. LVN A said she would do a head-to-toe assessment when a resident returned from the ER. During an interview on 06/06/2024 at 3:10pm, LVN H said when a resident returned from the hospital or ER, she would get the resident comfortable and ensure interventions were in place. LVN H said she would review the paperwork and place the paperwork in the DON's box. LVN H said she usually did not contact the doctor, family, or the DON. LVN H said if the resident had new orders, she would enter the new orders into the resident's clinical record and text the doctor or call the on-call service On 06/08/2024 at 2:17 p.m., received the Plan of Removal notebook which contained documentation for the action plan of the facility's POR, from the Administrator. Reviewed Resident #1's Doctor's Order History, which revealed wound care orders were initiated 06/02/2024. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/08/2024 at 2:34 p.m., reviewed the following in-services and signature sheets: - When do you notify the Attending Physician? Dated 06/02/2024 - Abuse & Neglect Inservice - dated 6/02/2024 for all staff - Wound Treatment Orders, How to input orders into the electronic record - dated 6/08/2024, signed by LVN A - When a resident returns from the ER: steps to take - dated 06/07/2024 - Resident Assessment: reviewed what steps were included - dated 6/02/2024 - Skin assessment and wound orders: when to be completed, who to notify - dated 6/02/2024 - Orders: directions and key points to remember - dated 6/02/2024 - Change in Condition, notifying proper parties - dated 6/03/2024 - Documentation - dated 6/02/2024 - Neglect test - nine (9) random employees included in sample - Resident returning from ER - four (4) nurses included in random sample - Ad Hoc QAPI Meeting Agenda dated [TRUNCATED]

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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** 45458 Based on observation, interview, and record review, the facility failed to maintain medical records, in accordance with accepted professional standards and practices, that were complete and accurately documented for 1 (Resident #1) of 5 residents reviewed for accuracy of medical records. The facility failed to accurately document Resident #1's had a bandaged area on his right elbow when he returned for the emergency roiagnom on [DATE] and accurately document an incident when Resident #1 had an open wound that was discovered infested with maggots. This failure could result in residents' records not accurately documenting interventions, monitoring, and inaccurate information provided to nursing staff and could lead to risk for errors in care and treatment. Findings included: Record review of Resident #1's Face Sheet, dated 06/04/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE], with of diagnoses Chronic (persisting) obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), unspecified, Unspecified dementia (impaired ability to remember, think, or make decisions that interfere with completing daily activities), Spinal stenosis (occurs when the space inside the backbone was to small and can put pressure on the spinal cord), Essential Hypertension (high blood pressure), and Dysphagia (difficulty swallowing), oropharyngeal phase (affects the oral and pharyngeal [swallowing food or liquid through the pharynx and esophagus] of swallowing). Record review of Resident #1's Doctor Visit Progress Note with Physician D, dated 05/17/2024, revealed Resident #1 had profound hearing impairment and he had an otoplasty (procedure to change the shape, position, or size of the ear using permanent sutures) in the past and had his right ear removed as part of his surgery. Record review revealed diagnoses included a cerebrovascular accident (a stroke) and Degenerative joint disease (another name for osteoarthritis). Record review revealed Physician D noted Resident #1 had no infections or acute issues over the past four to six weeks. Skin and integument was noted as no acute changes. Record review of Resident #1's Admission MDS Assessment, dated 04/14/2024, Section C- Cognitive Response Patterns revealed a BIMS score of 14, which indicated intact cognitive response. Section B - Hearing, Speech, and Vision, under B0200 - Hearing, revealed Resident #1 had moderate hearing difficulty in which the speaker had to increase volume and speak distinctly. Under B1000 - Vision, revealed Resident #1 was highly impaired with object identification in question, but eyes appeared to follow objects. Review of Section J1700 - History of Falls on Admission/Entry or Reentry revealed Resident #1 had no falls in the last two (2) to six (6) months prior to admission. Record review of Resident #1's Care Plan, dated 05/17/2024, revealed the plan was updated to identify Resident #1 had a fall with a laceration to the back of head of 5/17/24 and a fall on 5/25/24 with skin tear to rt elbow. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Progress Note, dated 05/25/2024 at 8:40 a.m., revealed LVN N was called to Resident #1's room when he was found on the floor on his back. LVN N noted bleeding to Resident #1's right elbow and Resident #1 was confused on how the fall occurred. Resident #1 was sent out by 911. Record review of Resident #1's Progress Note, dated 05/25/2024 at 2:15 p.m., revealed LVN N documented Resident #1 returned from the ER after a fall and LVN M notified the on-call for Physician G but there was no documentation to indicate Resident #1 had a bandage on his right elbow. Record review of Resident #1's Progress Notes, dated 05/15/2024 through 06/04/2024, revealed there was no documentation on or about 05/30/2024 that described or revealed Resident #1's wound on his right elbow was provided wound treatment after the wound was discovered by Resident #1's family member. Record review of Resident #1's Progress Note, dated 06/02/2024 at 10:05 p.m., revealed LVN A documented the date to be 05/30/2024 and noted small, white debris in dressing, smaller than a grain of rice. Review revealed note was edited by LVN A on 06/03/2024 at 4:05 a.m., due to incorrect data. Review revealed note was edited by DON on 06/05/2024 at 12:08 p.m., due to incorrect data. During an interview on 06/04/2024 at 6:58 a.m., LVN A said she was familiar with Resident #1 and was the nurse who found the bandage on Resident #1's right elbow covered with maggots on Saturday, 06/01/2024, at approximately 9:00 p.m. LVN A said she went into Resident #1's room to do his dressing change and noticed movement under the bandage. LVN A said she observed approximately 100 maggots in and around the bandage and in the gauze wrap. LVN A said the dressing was semi-saturated over the wound. LVN A described the bandage as wet with drainage and said blood had seeped through the gauze. LVN A said Resident #1 did not have doctor orders for wound care on 5/30/2024. LVN A said she cleaned and dressed the wound because she knew the area needed to be cleaned. During an observation on 06/04/2024 at 7:42 a.m., Resident #1 was observed with a gauze wrapped around his right elbow, with the gauze approximately an inch above and under the elbow. Observed a spot of bright red substance in the middle of the gauze about the size of a dime where the tape had come undone from the bandage and a spot of bright red substance on the tape, approximately 1/2 inch in length, that was unattached from the bandage. The bandage was dry. The skin on Resident #1's right arm around the outer edge of the bandage was extremely dry, flaking, and peeling from the mid-forearm, around the elbow, and upper arm. During an interview on 06/04/2024 at 7:46 a.m., Resident #1 said he did not remember who changed his bandage or seeing any type of bugs. Resident #1 said on Sunday (06/01/2024), he did not think he had white bugs on his bandage but Resident #1 said he could remember. Resident #1 said he had trouble seeing. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/05/2024 at 10:15 a.m., Resident #1's family member said she was at the facility with Resident #1 visiting at approximately 8:15 p.m., on 06/01/2024. Resident #1's family member said she was sitting to the left of Resident #1 and put her arm around his shoulders and Resident #1 said, ouch, that hurts. Resident #1's family member said she asked Resident #1 what hurt, and he told her his right elbow. Resident #1's family member said she looked at the bandage on Resident's elbow and saw movement of approximately 50 maggots on the outside of the bandage. Resident #1's family member said she moved the top layer of the bandage and under neither was approximately 100 to 150 baby maggots. Resident #1's family member said the bandage was saturated in bloody drainage. Resident #1's family member said immediately called LVN A who came in and changed and cleaned the bandage. Resident #1's family member said she watched while LVN A cleaned the area and she said she saw maggots on the wound. Review of photo evidence submitted by Resident #1's family member, dated 05/30/2024 at 6:17 p.m. and 6:23 p.m., revealed Resident #1's wound on his right elbow was uncovered and laid on white bandage that covered the wound. The bandage was saturated in black and thick, dark red drainage and the gauze was stuck to Resident #1 skin. The wound, which was approximately 1 1/2 inches by 1 1/2 inches, was pink, soft, and raw. The skin around the outer edge of the bandage was dry and cracked, with large scales of dry skin present. Based on the photo image, Resident #1's family member was contacted by phone. Review of video evidence submitted by Resident #1's family member, dated 06/01/2024 at 8:36 p.m., revealed an up-close view of the wound. Resident #1's arm laid on unwrapped cotton gauze and was wrapped in woven gauze bandage with small white larvae wiggling on the inside of the top layer of the gauze. The second layer of gauze had an area approximately 4 inches by 4 inches saturated in red blood with dark red colored drainage around the edges. The area was moist, the gauze was stretched, and small white larvae could be seen moving under the second layer. Review of video evidence submitted by Resident #1's family member, dated 06/01/2024 at 8:39 p.m., revealed an up-close view of the wound. Resident #1's arm laid on unwrapped cotton gauze and was wrapped in woven gauze bandage with small white larvae wiggling on the inside of the top layer of the gauze. The second layer of gauze had an area approximately 4 inches by 4 inches saturated in red blood with dark red colored drainage around the edges. The area was moist, the gauze was stretched, and small white larvae could be seen moving under the second layer. Review of photograph evidence provided by Resident #1's family member, dated 06/01/2024 at 8:40 p.m., revealed an up-close view of the wound of Resident #1's bandage on his right elbow. The area was covered in woven gauze that was stretch and small, white larvae was seen between the fibers of the gauze. The gauze was observed saturated in red drainage with dark edges. During a phone interview on 06/05/2024 at 11:58 a.m., Resident #1's family member said she was at the facility on 05/30/2024 at 6:00 p.m., and at approximately 6:15pm, noticed Resident #1's bandaged on his elbow had not been removed since he returned from theER on [DATE]. 05/30/2024 at 6:17pm and 6:23pm said she removed the dressing and saw the area was soaked in dark, black colored drainage and had a bad smell. Resident #1's family member said she reported the wound to the nurse who was in the hall outside Resident #1's door and was told that the facility was short staffed, and she would have to clean herself. Resident #1's family member said she gathered first aid supplies and cleaned and bandaged the wounds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675084	A. Building B. Wing	06/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Nursing and Rehab of Granbury	600 Reunion Court Granbury, TX 76048

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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	During an interview on 06/06/2024 at 12:01 p.m., the DON said Resident #1 returned from theER on [DATE] with a bandage on his arm and did not have orders to care for the wound until 06/02/2024. The DON said his expectation was the nurse on duty when Resident #1 returned to the facility on [DATE] would have been to clarify Resident #1's discharge orders with the facility physician. The DON said the progress note in Resident #1's clinical record indicated the doctor was notified upon return from ER but agreed the documentation was not clear what was discussed in the phone conversation with the doctor. The DON said; if the family provided evidence of Resident #1's wound and the bandage appeared in a state that lacked attention by the facility nursing staff, this he would be based the doctor's orders. The DON said he agreed were not put into place until 06/02/2024. Record review of the facility's policy, Charting and Documentation, dated 07/2017, revealed all services provided to the resident shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation of procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment; d. How the resident tolerated the procedure/treatment; e. Whether the resident refused the procedure/treatment; f. Notification of family, physician, or other staff, if indicated; and g. The signature and title of the individual documenting.