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

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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	05/16/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on observation, interview and record review, the facility failed to accommodate residents needs and preferences and accommodation of needs, for 2 (Resident #13, Resident #14) of 19 residents reviewed for dignity. The facility failed to ensure Resident #13 and Resident #14 call lights were within reach. This failure could place residents at risk of a diminished quality of life and lead to a loss of self-esteem and isolation. Findings included: 1.Review of Resident #13's face sheet dated 05/16/2024 revealed a [AGE] year-old male admitted on [DATE] and most recently admitted on [DATE] with following diagnosis: Flaccid hemiplegia affecting right dominant side (inability to move muscles or muscle weakness on right side), sepsis (infection with inflammation throughout the body), aphasia (difficulty speaking), and dysphagia (difficulty swallowing). Review of Resident #13's significant change MDS dated [DATE] revealed: Resident #13 had no speech and rarely understood, sometimes understood others and BIMS not able to be performed. Section GG: Functional Abilities revealed Resident #13 had impaired range of motion to one side, he was dependent on staff for bed mobility and helper did all the effort with bed to chair transfer. Review of Resident #13's most recent Care plan last revised on 05/04/2024 revealed: Keep call light in reach at all times. During an observation on 05/14/2024 at 01:23 p.m. Resident #13 was lying in bed with his eyes closed and call light was sitting on nightstand to the right or resident's bed. During an observation on 05/15/2024 at 03:25 p.m. Resident #13 was lying in bed on his left side and his eyes closed. Call light was lying on nightstand to the right of resident's bed. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/2024 at 03:25 p.m. CNA B stated Resident #13 would be able to use call light if it was attached to his pillow. She stated that he was not able to reach if call light left on nightstand. CNA B stated that Resident #13 cannot use right arm so he uses left arm to grab things such as call light and mobility rail on right side of the bed. She did not know why call light was left out or Resident #14's reach. 2.Review of Resident #14's face sheet revealed a [AGE] year-old female admitted on [DATE] and most recently admitted on [DATE] with the following diagnosis: cervical disc degeneration (degeneration of the spine in the neck region), lack of coordination, weakness, abnormalities of gait and mobility, difficulty in walking, and unsteadiness on feet. Review of Resident #14's quarterly MDS dated [DATE] revealed Section C: Cognitive Patterns revealed a BIMS score of 07, which indicated her cognition was severely impaired; Section GG: Functional Abilities revealed Resident #14 she was dependent on staff for bed mobility and helper did all the effort with bed to chair transfer. Review of Resident #14's most recent care plan last revised on 05/08/2024 revealed : Keep call light in reach at all times. Encourage use of call light. During an observation on 05/14/2024 at 10:35 a.m. Resident #14 was lying in bed trying to find her cellphone and stated that it was in her pillowcase She was unable to find the cell phone and her Call light was sitting on the top of oxygen concentrator with a nightstand in between it and her bed out of resident's reach. She stated that she could not reach the call light. During an interview on 05/14/2024 at 10:39 a.m., CNA A stated Resident #14 was not able to reach the call light on the oxygen machine. He stated she would not be able to use call light if it was out of reach and had difficulty using it when it was in reach. He stated that he must have left it on oxygen machine earlier in the day when he was assisting resident with incontinent care. CNA A stated that call light should be in Resident #14's reach and then clipped it to her bed sheets. During an interview on 05/15/2024 at 04:06 p.m., the DON stated his expectation was for call lights to be in residents reach. He stated that Resident #13 and Resident #14 could not exit bed without assistance. He stated that Resident #14 would yell out or use her cell phone to call if she needed assistance when call light was out of reach. The DON stated Resident #13 would not use call light when it was in reach so staff check on him regularly when performing needs and did not feel any negative outcome to Resident #13 would have occurred. He stated that Resident #14's light not being in reach could possibly cause brief to not be changed timely. The DON stated charge nurse, ADON, and he were who monitored that the call lights were in reach of residents. He did not know why call lights were left out of reach. Review of facility policy titled Answering the Call Light revised date March 2021 revealed: Upon admission and periodically as needed, explain and demonstrate use of the call light to the resident. Ask the resident to return the demonstration .When a resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on interviews and record review, the facility failed to ensure resident right to formulate an advance directive for 2 of 5 residents (Resident #42 and #48) reviewed for advance directives. The facility failed to ensure that Resident #42 and #48's advanced directive consent, Out of Hospital Do Not Resuscitate (OOH-DNR) order, was signed by two witnesses. The facility failed to ensure that Resident #42 and #48's physician orders contained the most current code status. This failure could place residents at risk of receiving treatments that go against their personal preferences and does not allow them to make an informed decision about their care. Finding included: 1.Review of Resident #42's face sheet dated 05/16/2024 revealed a [AGE] year-old male admitted on [DATE] with the following diagnosis of unspecified psychosis not due to a substance or known physiological condition (condition were hallucinations or delusions may be present for unknown reason). Resident #42 had a code status of Do Not Resuscitate. Review of Resident #42's quarterly MDS dated [DATE] revealed: Resident #42 had a BIMS of 09 meaning moderate cognitive impairment. Review of Resident #42's physician orders reviewed on 05/16/2024 revealed no evidence of a physician order for DNR/ Do Not Attempt Resuscitation. Record review of Resident #42's OOH-DNR dated 02/05/2024 revealed no evidence of two witness' signatures. 2.Review of Resident #48's face sheet dated 05/16/2024 revealed a [AGE] year-old male admitted on [DATE] with an original admitted [DATE] with the following diagnosis of hypertension (high blood pressure), heart disease, kidney failure and Encephalopathy (disease affects brain/mental state). Resident #48 had a code status of Do Not Resuscitate. Review of Resident #48's Admission MDS dated [DATE] revealed: Resident #48 had a BIMS of 0 meaning a BIMS was not conducted due to resident is rarely/never understood. Review of Resident #48's physician orders reviewed on 05/16/2024 revealed no evidence of a physician order for DNR/ Do Not Attempt Resuscitation. Record review of Resident #48's OOH-DNR dated 03/04/2024 revealed no evidence of two witness' signatures. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #48's Care Plan dated 05/14/2024 revealed Resident #48 had a code status for Do Not Attempt Resuscitation. During an interview on 05/16/2024 at 11:12 AM the SW stated she was responsible for ensuring resident DNR's are completed. The SW stated for an OOH-DNR to be valid it needed be signed by two witnesses only when the resident was signing, and if family member was signing then you did not need witnesses. The SW stated she had retired and decided to come back to work. After the SW reviewed the directions on the back of the OOH-DNR, she stated things must have changed and she was not up to date on all the rules. The SW stated the OOH-DNR was not valid unless it had all the required signatures completed. During an interview on 05/16/24 at11:42 AM the DON stated the SW was responsible to ensure that OOH-DNR's were completed. The DON stated his expectation was that OOH-DNR's were completed correctly. The DON stated the effect on residents if OOH-DNR were not completed could be their wishes may not be met. The DON stated lack of education led to failure of the OOH-DNR's not being completed correctly. Record review of facility policy titled, Advanced Directives, dated 02/29/2024 revealed: It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance with these rights, the facility will implement procedure to communicate a resident's code status to those individuals who need to know this information .When an order is written pertaining to a resident's presences or absence of an Advance Directive, the directions will be clearly documented on the resident face sheet and banner of the medical record. Examples of directions to be documented include but are not limited to: a. Full Code b. Do Not Resuscitate . The attending physician must be informed of the resident's or surrogate's request to cease the DNR order and new order will be written reflecting the most current code status . The designated sections of the medical record include resident face sheet, resident banner and physician's orders. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of website titled Out of Hospital Do No Resuscitate Program located https://www.dshs.texas.gov/emstraumasystems/dnr.shtm accessed on 05/16/2024 revealed: An OOH DNR Order form must be properly executed in accordance with the instructions on the opposite side to be considered a valid form by emergency medical services personnel . IMPLEMENTATION: A competent adult person, at least [AGE] years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document existence of the Order in the person's permanent medical record . The OOH-DNR Order may be executed as follows: Section A - If an adult person is competent and at least [AGE] years of age, he/she will sign and date the Order in Section A. Section B - If an adult person is incompetent or otherwise mentally or physically incapable of communication and has either a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, the guardian, agent, or proxy may execute the OOH-DNR Order by signing and dating it in Section B. Section C - If the adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, or proxy, then a qualified relative may execute the OOH-DNR Order by signing and dating it in Section C. Section D - If the person is incompetent and his/her attending physician has seen evidence of the person's previously issued proper directive to physicians or observed the person competently issue an OOH-DNR Order in a nonwritten manner, the physician may execute the Order on behalf of the person by signing and dating it in Section D In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making an OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section. Optionally, a competent adult person or authorized declarant may sign the OOH-DNR Order in the presence of a notary public. However, a notary cannot acknowledge witnessing the issuance of an OOH-DNR in a nonwritten manner, which must be observed and only can be acknowledged by two qualified witnesses. Witness or notary signatures are not required when two physicians execute the OOH-DNR Order in section F. The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals. 48883

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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** 44722 Based on interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan with measurable objectives based on assessed needs with the ability to be evaluated or quantified to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 (Resident #3, and Resident #10) of 18 residents reviewed for comprehensive person-centered care plans. The facility failed to develop care plan that included Resident #3's current code status. The facility failed to develop care plan that included Resident #10's conditions of probation. The facility failed to develop a care plan that included measurable approach/frequency for Resident #10's wounds on both lower legs. These failures could affect the residents by placing them at risk for not receiving care and services to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. Findings include: 1.Review of Resident #3's face sheet dated 05/16/2024 revealed a [AGE] year-old male admitted on [DATE] with the following diagnosis of Heart failure, Senile degeneration of brain, presence of pacemaker, Atrial fibrillation, Chronic Kidney disease and Type 2 diabetes. Review of Resident #3's Admission MDS dated [DATE] revealed: Section C- Cognitive Patterns Resident #3 had a BIMS score of 8(meaning moderate cognitive impairment). Review of Resident #3's physician orders reviewed on 05/16/2024 revealed Code Status: Do Not Resuscitate (DNR) start date of 03/08/2024. Review of Resident #3's care plan dated 3/15/2024 revealed the following: Problem start date: 03/06/2024 Category: Code Status My code status: no code Long term goal target date: 06/06/2024 The resident and/or responsibly party will communicate their wishes regarding code status. Facility staff will honor their stated preferences. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Approach: Will review on admission, quarterly and PRN. 2.Review of Resident #10's face sheet dated 05/15/2024 revealed a [AGE] year-old male admitted on [DATE] and most recently admitted on [DATE] with following diagnosis: encephalopathy (swelling of the brain), abnormalities of gait and mobility, unsteadiness of feet, soft tissue disorder, non-pressure chronic ulcer of unspecified part of lower leg. Further review of face sheet revealed Probation officer call when leaving building. Review of Resident #10's quarterly MDS dated [DATE] Section C - Cognitive Patterns revealed BIMS score of 13 meaning cognitively intact. Review of Resident #10's most recent Care plan reviewed on 05/15/2024 revealed the residents care plan did not address notifying the residents probation officer. During an interview on 05/15/2024 at 9:11 AM Resident #10's probation officer stated that Resident#10 was on probation. The probation officer stated that resident was not allowed to have access to any electronic devices that had internet capable devices. The probation officer stated the facility was to contact him if Resident #10 was to leave the facility. During an interview on 05/16/2024 at 8:35 AM the Clinical Resource Nurse stated she would expect stipulations of resident's probation be on his care plan. During an interview on 05/16/2024 at 3:15 PM the DON stated his expectation was that care plans be accurate, person specific, measurable, and attainable. The DON stated he was responsible to monitor care plans. The DON stated the code status of Residents should have been incorporated in the care plan. The DON stated not having a person-centered measurable care plan could affect residents' specific needs not being met. The DON stated oversight during the auditing process led to failure. Record review of facility policy titled, Comprehensive Care Plans, dated 01/26/2024 revealed: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the resident's comprehensive assessment .The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Record review of facility policy titled, Advanced Directives, dated 02/29/2024 revealed: Additional means of communication of code status will be the are plan. 48883

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on interview and record review, the facility failed to ensure residents had a discharge summary that included a recapitulation of the resident's stay, medication reconciliation, and a discharge plan of care for 1 of 3 resident (Resident #50) reviewed for discharge summaries. The facility failed to complete a discharge summary with necessary medical information that the facility must furnish prior to discharge for Resident #50. The facility failed to complete a post-discharge plan of care with the participation of the Interdisciplinary team, the resident and with the resident's consent, and the resident's representative. This failure could place residents discharged from the facility at risk for incorrect, incomplete, or misleading information regarding discharge. Findings included: Review of Resident #50's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnosis that included: bacterial infection, heart failure, dementia, and kidney disease. Further review of electronic face sheet revealed Resident #50 was discharged home on 04/05/2024. Review of Resident #50's Discharge MDS assessment dated [DATE], revealed BIMS score 12 (indicates no cognitive impairment). Further review of Discharge MDS Assessment planned discharge home return not anticipated on 04/05/2024. Review of Resident #50's Care Plan last revised 02/23/2024 revealed no evidence discharge plan with goals and interventions defined. Further review revealed no evidence of discharge care plan or care plan conference with Resident #50 or family member. Review of Resident #50's electronic physicians orders revealed no evidence of discharge order. Review of Resident #50's electronic record revealed no evidence of discharge paperwork including an evaluation of the resident's discharge needs, a discharge summary, or post-discharge plan. Review of Resident #50's electronic progress notes revealed: Discharge to Home/Community Progress Note (Nursing): Resident discharged Assisted Living Community Discharge Order obtained from medical provider and entered into medical records. Discharge instruction provided to resident. Discharge instruction provided on: Other. Document sent with resident: Transition of care/discharge summary, list of medications, Immunization record. Report provided to Receiving Facility. Resident left the facility by ambulation. Resident left facility via facility van. Time resident left facility 04/05/2024 at 3:00 PM. Medications sent with resident. Dated 04/05/2024 at 5:18 PM. Signed by LVN C. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/16/2024 at 11:15 AM, LVN C stated she did not remember if she had done Resident #50's discharge or not. She stated when she discharged residents, she completed the discharge progress note and printed out a list of the residents' medications. She stated that was all she was told in her training to do involved with the discharge process. During an interview on 05/16/24 at 11:38 AM, the DON stated the social worker should do a discharge assessment and plan and there should have been a document with this information. He stated the Discharge summary should have been completed and it was not done. He stated he was ultimately responsible for ensuring the discharge process was done accurately. He stated he did not know why this was not done. During an interview on 05/16/24 at 11:52 AM, the SW stated she would document in the resident's progress notes any assessments or planning she had performed. She stated when a resident discharged or transferred to another facility there was not much that she was involved in. She stated if it was not documented in the progress notes then she was not involved. The SW could not remember any details related to Resident #50's discharge. She stated a normal discharge would include planning with the resident and family member and a post-discharge plan. Attempted interview on 05/16/24 at 12:00, with Resident #50 and resident family member via phone call with no answer. Review of facility policy titled, Discharge Summary and Plan, revised December 2016, revealed: Policy Statement: When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. Policy Interpretation and Implementation: 1. When the facility anticipated a resident's discharge to a private residence, another nursing care facility, a discharge summary, and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment. 2. The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of discharge in accordance with the established regulations governing release of resident information and as permitted by the resident .4. Every resident will be evaluated for his or her discharge needs and will have an individual post-discharge plan. 5. The post-discharge plan will be developed by the care planning/interdisciplinary team with assistance of the resident and his or her family and will include: a. where the individual plans to reside; b. arrangements that have been made for follow-up care and services; c. a description of the resident's stated discharge goals; d. the degree of caregiver/support person availability, capacity, and capability to perform required care; e how the interdisciplinary team will support the resident or representative in the transition to post-discharge care; f. what factors may make the resident vulnerable to preventable readmission; and g. how those factors will be addressed .13. A copy of the following will be provided to the resident and receiving facility and a copy will be filled in the resident's medical records: a. An evaluation of the resident's discharge needs; b. the post-discharge plan; and c. the discharge summary.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 44722 Based on record review and interviews, the facility failed to ensure the use of the services of a registered nurse for at least 8 consecutive hours a day, seven days a week for 8(10/07/2023, 10/08/2023, 10/21/2023, 10/22/2023, 10/28/2023, 10/29/2023, 11/04/2023 and 11/05/2023) of 90 days reviewed for RN coverage. The facility failed to provide evidence that a Registered Nurse (RN) worked 8 consecutive hours a day, seven days a week on 10/07/2023, 10/08/2023, 10/21/2023, 10/22/2023, 10/28/2023, 10/29/2023, 11/04/2023 and 11/05/2023. This failure placed the residents at risk for not having decisions made that would have required an RN to make in the management of the residents' healthcare needs and in managing and monitoring of the direct care staff. Findings included: Review of facility's Direct Care Staff Daily Report from 10/01/2023 to 12/31/2023, revealed on 10/07/2023, 10/08/2023, 10/21/2023, 10/22/2023, 10/28/2023, 10/29/2023, 11/04/2023 and 11/05/2023 there was no evidence of RN coverage. During an interview on 05/16/2024 at 3:15 PM the DON stated his expectation was to have RN coverage 8 hours a day. The DON stated he started at the end of October 2023 and inherited the issue of not having RN coverage on the weekends. During an interview on 05/16/20024 at 3:30 PM the ADMN stated her expectation was to follow policy and have RN coverage 8 hours a day. The ADMN stated what led to failure of not having 8 hours of RN coverage was the inability to hire a RN due to facility location. The ADMN did not provide a response to how not having a RN would have affected residents. Record review of facility policy, titled Staffing, dated 09/28/2023 revealed: The facility utilizes the services of registered nurse for at least 8 consecutive hours a day, 7 days per week.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on observation, interview and record review, the facility failed to ensure the menu was followed for 3 of 4 (Residents #12, #36, #37) residents who received a pureed meal reviewed during one lunch meal observed. The facility failed to ensure residents receiving a pureed texture diet were provided the food according to the menu, including a roll. This failure could place residents that eat food from the kitchen at risk of poor intake, chemical imbalance and/or weight loss. Findings included: 1. Resident #12 Record review of the resident #12's face sheet dated 05/16/2024 revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: hypertension (high blood pressure) and depression. Record review of Resident #12's quarterly MDS dated [DATE] revealed: no BIMS score related to resident was rarely or never understood. Further review of the MDS Section K- Swallowing / Nutritional Status revealed Resident #12 had been on a mechanically altered diet while a resident. 2. Resident #36 Record review of the resident #36's face sheet dated 05/16/2024 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: diabetes, aphasia (difficulty speaking), and cerebrovascular accident (stroke). Record review of Resident #36's significant change MDS dated [DATE] revealed: no BIMS score related to resident was rarely or never understood. Further review of the MDS Section K- Swallowing / Nutritional Status revealed Resident #36 had been on a mechanically altered diet while a resident. 3. Resident #37 Record review of the resident #37's face sheet dated 05/16/2024 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: hypertension (high blood pressure), dementia, and malnutrition. Record review of Resident #37's significant change MDS dated [DATE] revealed: no BIMS score related to resident was rarely or never understood. Further review of the MDS Section K- Swallowing / Nutritional Status revealed Resident #37 had been on a mechanically altered diet while a resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER: Trinity Nursing and Rehab of Granbury		STREET ADDRESS, CITY, STATE, ZIP CODE: 600 Reunion Court Granbury, TX 76048	

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #37's lunch meal ticket dated 05/13/2024 revealed she was to receive 1/4 cup of pureed dinner roll. During an observation on 03/13/2024 at 11:15 a.m., a daily posted menu that reflected chicken fried chicken, cream gravy, mashed potatoes, parslied carrots, dinner roll and a frosted cake. The DA and the [NAME] were pureeing menu items in the kitchen and did not observe them include roll in pureed items that were ready to serve. During an observation on 05/13/2024 at 12:19 p.m., trays for residents who received a pureed diet sitting in dining room did not receive a pureed roll. During an interview on 05/14/2024 at 09:18 a.m., the Dietician stated her expectation would be that menus be followed. She stated that residents on pureed diet should receive one item per food group per the resident's preference. The effect on the resident would be missing out on the food groups and calories that could potentially cause weight loss in the future and not being served food that were on another resident's tray. The Dietician stated the cook monitors menus are followed and should follow the menu. The DM would monitor that menus are followed if DM was available, and Dietician monitor that menus are followed when in the building. She stated she did not know why pureed diet residents were not offered a roll. During an interview on 05/15/2024 at 02:32 p.m. the DM stated her expectation would be for pureed diet residents to receive a pureed roll. She stated that all menu items should have been provided to residents. She stated that she monitors that menus are followed. She did not know why the [NAME] did not prepare pureed roll during meal preparation. She stated the effect of not providing all menu items would be residents not getting proper nutrition. She stated she felt that kitchen staff being nervous led to pureed diet residents not offered roll. During an interview on 05/16/2024 at 03:07 p.m., the ADMN stated her expectation would be for all residents offered all menu items including rolls. She stated the effect of residents not receiving all menu items could cause weight loss. She stated that it was a joint effort of staff to monitor that all menu items are provided but mostly nurses monitor when they check the trays. She did not know why pureed diet residents were not offered a roll. Record review of facility provided list of residents with Pureed diets revealed: Resident #12, Resident #36 and Resident #37 received a pureed diet. Review of pureed dinner roll recipe dated November 17, 2023, revealed: Ingredients (Prep Method) .Mild Whole .Dinner Roll .Place prepared recipe portions along with liquid into a blender or food processor; blend until smooth, adding additional liquid/thickener as needed to obtain a pudding-like consistency. Hot Service: CCP Reheat to an internal temperature of > 165F held for 15 seconds. Serve: #16 dipper. CCP Maintain at an internal temperature of > 140F for only 4 hours. Discard unused portion(s). Cold Service: CCP Chill to an internal temperature of <41F. Serve: #16 dipper CCP Maintain at an internal temperature of < 41F. Discard unused portion(s). (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility polity titled, Menu Planning dated June 1, 2019, revealed The facility believes that nutrition is an important part of maintaining the well-being and health of its residents and is committed to providing a menu that is well-balanced, nutritious and meets the preferences of the resident population. A standardized menu which meets the nutritional recommendations of the residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences will be used. Modifications for resident population and preferences may be made as appropriate.

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	675084	A. Building B. Wing	05/16/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on observations, interviews, and record reviews the facility failed to properly store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure foods were sealed and/or labeled properly in dry food storage and refrigerator. The facility failed to ensure that food items were discarded when it reached expiration date. The facility failed to ensure that meat was thawed properly. The facility failed to ensure food temperatures were taken properly. These failures could place residents that eat out of the kitchen at risk for food borne illnesses. The findings included: During an observation and interview on [DATE] between at 09:50 a.m. to 10:15 a.m. of the kitchen revealed: Refrigerator 1. 1 plastic container of sliced cheese with lid not secured on right front corner. 2. 1 plastic container of chicken noodle soup with foil lid not covering front of container. 3. 1 individual see through plastic container with lid and what appeared to be chopped onion without a label identifying the item and date. Dry Storage 1. 3 packages of what appeared to be coconut flakes in sealed plastic bags outside of original box, not labeled with an item description, with open date of [DATE] written on bag. Some of the white flakes had pink discoloration. 2. 10 cans of evaporated milk with best by date of [DATE]. Sink (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. 1 aluminum pan with package of hamburger meat thawing. Half of hamburger meat package was above water line in aluminum pan (not submerged) and water was running down one side of package. At 10:11 a.m. , the DM stated she did not have a pan large enough to thaw meat another way. She stated that she would turn package over halfway through thawing to start thawing the other end. She stated that she expected for foods in the refrigerator to have lid secured, have item description and date written on container. During an observation on [DATE] between 11:15 a.m. to 12:15 a.m. of kitchen revealed: 1. The [NAME] and DA observed making pureed chicken fried chicken. 2 scoops of cream gravy added to blender with 3 skinned chicken breasts removed from bone. The [NAME] used spatula to push down food from side of blender and proceeded to add cold milk to blender then blended some more. The pureed chicken fried chicken temperature was not taken prior to placing in aluminum pan and then sat on top of other pans in the steam table. 2. Observed hamburger meat still thawing in aluminum pan in sink with half of meat sticking out of pan and not fully submerged with cold water running down the side. 3. Temperatures of food taken with thermometer of hamburger patties, chicken fried chicken and mechanical soft chicken fried chicken without wiping thermometer in between. Temperatures taken of pureed carrots, mashed potato, pureed chicken and wiped thermometer with paper towel in between temperatures but did not sanitize. 4. Pureed chicken temp taken at 12:03 by DA and temperature was 120 ?. Meal service started. At 12:07 p. m. the [NAME] took temperature of pureed chicken, and it was 123 ? after being asked questions about what temperature should be prior to serving food. He then heated food in microwave to appropriate temperature. During an interview on [DATE] at 11:21 a.m., the [NAME] stated that he knew pureed diet recipes and usually had them sitting next to him when he was preparing food. Today the DM needed to make the food order, so they were not present. He stated that it was okay to use cold milk to thin chicken fried chicken. The [NAME] stated that there was not enough room in the steam table to sit all the prepared food in it so he would sit aluminum pans on top of other pans in the steam table to attempt to keep them warm. During an interview on [DATE] at 12:07 p.m., the [NAME] stated that chicken needed to be at least 140 ? prior to being served. He stated that he felt the chicken temperature could be low because he used cold milk to thin out the pureed chicken. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 09:18 a.m., the Dietician stated she expected kitchen staff to follow facility policy on storing food items. She stated that if anything was expired then item should be discarded. If items are taken out of original container there should be received date written and items would need to be identified. She stated that guidelines for coconut package should be stored for 6 months, and I would expect for it to be discarded after 6 months. She expected that onion would need to be labeled per policy if it was not being used for the next meal. She stated that foods stored in fridge with lid should be sealed with lid or foil. The Dietician stated the DM, corporate staff and herself monitor that food items are being stored appropriately. She stated that not storing food properly could affect quality of food. Expired food runs risk for bacterial growth and causing sickness. Food not being sealed could cause potential for another food product entering that product and contaminating it that could potentially cause bacterial growth and sickness to the residents. She did not know why foods were not stored properly. The Dietician stated the process for taking food temperatures would be to take temperature after cooking and prior to serving the food. She expected mechanically altered food have a temperature taken after alteration and expected it to be heated to 165 ? if not above 165 ? already. She stated that she expected staff to clean and sanitize thermometer per policy before taking food temperatures and in between food items. She stated that wiping with paper towel would clean thermometer but not sanitize it. Her expectation would be that food temperature be maintained to over 135 ? and that if holding temperature drops below 135? then food be reheated to above 165?. The Dietician stated that cold mild could be used in pureed chicken fried chicken if it was reheated to 165 ?. The Dietician stated she expected for kitchen staff to thaw meat per policy which included in refrigerator, completely submerged in cold water, or in microwave. She stated completely submerged would mean all food surface would be in the water. She said that the effect of not preparing foods correctly could run the risk of bacterial growth if food was in temperature danger zone. She felt that staff education may have caused some of the issues. She stated that both the DM and she monitored that kitchen staff prepare food properly when she was in the building. During a follow up interview on [DATE] at 02:32 p.m., the DM stated her expectation would be for food to be discarded when past expiration or best use by date. She expected items stored outside of original container then the date it was received, the date that it was opened and if there was a used by date then that should be written on package. She stated that she monitored foods were stored appropriately and did not know why they were not. She stated that storing food improperly could cause residents to become sick from cross contamination. The DM stated she expected for temperatures to be taken after food was cooked and then before being served. She expects that thermometer be sanitized prior to temperatures being taken. The DM stated if food were not above proper temperature, then she expected for it to be heated to correct temperate. She felt that using cold milk when pureeing could have caused temperature to be below 135 ? and would have expected hot liquid be used. She stated that the cooks and her monitor that temperatures are taken correctly, and that equipment sanitized. Not performing correctly could cause residents to not eat food or become sick from bacterial growth. The DM stated meat should be submerged into cold water when thawing. She stated that she was thawing the way she was taught and did not know it was incorrect. She stated that she and the ADMN monitor meat thawed correctly and performing wrong could affect the texture of food or cause residents to become sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 03:07 p.m., the ADMN stated that she expected food to be stored appropriately and food should have been discarded when past use by date. She felt that coconut flakes and evaporated mild were forgotten about since the facility has not used them in any recipes recently. She stated that she expected for food temperatures to be taken and thermometer to be wiped with alcohol wipes in between thermometer use. She stated that it was the third day that the DA had worked and felt that led to the failure to sanitize and take temperatures appropriately. The ADMN stated meat should have been submerged in water when thawing. She stated the DM, the Dietician, the Cook, and herself monitor that food was stored and prepared properly. She stated the effect of not preparing and storing food appropriately could cause sickness from food borne illness. Review of puree chicken fried chicken recipe dated [DATE], revealed: Ingredients (Prep Method) Chicken Fried Chicken and Cream Gravy (Prepared) .Place portions to be pureed into blender or food processor. Add adequate amount of liquid needed to achieve the consistency as appropriate for resident(s) and puree until smooth. CCP Reheat to an internal temperature of > 165F held for 15 seconds. Measure the resulting total amount of pureed product prepared. Serve: ,d+[DATE] cup (#8 scoop). CCP Maintain at an internal temperature of > 140F for only 4 hours. Discard unused portion(s). Record review of facility policy titled, Food Storage revised date [DATE], revealed: To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated . Refrigerators: Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. Record review of facility policy titled Food Preparation and Handling revied date [DATE], revealed: Use clean, sanitized surfaces, equipment, and utensils . Foods may also be thawed using the following procedures: Completely submerged under running water at a temperature of 70?or below with sufficient water velocity to agitate and float off loosened food particles into the overflow; .Food Preparation: Take temperatures throughout the preparation process to ensure that food is safe .Hot Food Temperatures: [NAME] poultry, stuffed fish or meat, stuffed pasta or stuffing containing fish, meat or poultry to 165 ?or above for 15 seconds. Review of the FDA Food Code 2022 https://www.fda.gov/food/retail-food-protection/fda-food-code accessed [DATE] revealed: ,d+[DATE].11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement; (2) If made from two or more ingredients, a list of ingredients and sub-ingredients in descending order of predominance by weight, including a declaration of artificial colors, artificial flavors and chemical preservatives, if contained in the FOOD; (3) An accurate declaration of the net quantity of contents; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(4) The name and place of business of the manufacturer, [NAME], or distributor; and (5) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or usual name of the respective ingredient. Pf (6) Except as exempted in the Federal Food, Drug, and Cosmetic Act S 403(q)(3) - (5), nutrition labeling as specified in 21 CFR 101 - Food Labeling and 9 CFR 317 Subpart B Nutrition Labeling. (7) For any salmonid FISH containing canthaxanthin or astaxanthin as a COLOR ADDITIVE, the labeling of the bulk FISH container, including a list of ingredients, displayed on the retail container or by other written means, such as a counter card, that discloses the use of canthaxanthin or astaxanthin. Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date. ,d+[DATE].13 Thawing. Except as specified in (D) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be thawed: (A) Under refrigeration that maintains the FOOD temperature at 5oC (41oF) or less Pf; or (B) Completely submerged under running water: (1) At a water temperature of 21oC (70oF) or below Pf, (2) With sufficient water velocity to agitate and float off loose particles in an overflow Pf, and (3) For a period of time that does not allow thawed portions of READY-TO-EAT FOOD to rise above 5oC (41oF) Pf, or (4) For a period of time that does not allow thawed portions of a raw animal FOOD requiring cooking as specified under ,d+[DATE].11(A) or (B) to be above 5oC (41oF), for more than 4 hours including: (a) The time the FOOD is exposed to the running water and the time needed for preparation for cooking Pf, or (b) The time it takes under refrigeration to lower the FOOD temperature to 5oC (41oF) Pf; (C) As part of a cooking process if the FOOD that is frozen is: (1) Cooked as specified under ,d+[DATE].11(A) or (B), S,d+[DATE].12, or S ,d+[DATE].15 Pf, or.

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F 0910 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms meet each resident's needs. 44722 Based on observation and record review, the facility failed to have certified resident rooms equipped for adequate nursing care, comfort, and privacy for 14 (#45W, #45D, #46W, #46D, #47W, #47D, #48W, #48D 49W, #49D, #52W, #52D, #53W, #53D) of 104 certified beds. 1. The facility failed to ensure rooms #45 and #46 were certified for two Title 18 resident beds each and were not resident ready and could not easily be transitioned into resident ready rooms. The rooms were being used for activities, the shared wall between the two rooms had been knocked out to make one large room. 2. The facility failed to ensure rooms #47, #48 and #49 were certified for two Title 18 resident beds each and were not resident ready and could not easily be transitioned into resident ready rooms. The rooms were being used as a theater, the shared walls between the three rooms had been knocked out to make one large room. 3. The facility failed to ensure rooms #52 and #53 were certified for two Title 18 resident beds each and were not resident ready and could not easily be transitioned into resident ready rooms. The rooms were being used for therapy, the shared wall between the two rooms had been knocked out to make one large room. These failures could affect residents by placing them at risk of being placed in rooms without proper furnishings and privacy. The findings include: During observations on 05/13/2024 between 1:45 PM and 2:00 PM of North Hall revealed: Room's #45 and 46 had a wall knocked out to make one large room and was being used for activities. Room #'s 47,48, and 49 had the walls knocked out of the rooms to make one large room and was being used as the theater room. Room #'s 52 and 53 had a wall knocked out between the rooms to make one large room and was being used for therapy. During an interview on 05/15/2024 at 4:00 PM the ADMN stated she did not have a reason to why the beds were not decertified. The ADMN stated she had been here over a year and a half and the theater room, the activities room and therapy rooms were set up. The ADMN stated she never really thought about the rooms needing to be decertified, that if they needed the rooms, they could have just built a wall. The ADMN stated she did not have a policy to provide regarding bed class/certification. Review of the Bed Classification Form 3740 dated 05/13/2024 the facility identified rooms: #45, #46, #47, #48, #49, #52, and #53 were certified for two Title 18 resident beds each. Review of the CMS-671 dated 050/13/2024 the facility identified the census of 51 residents who were currently residing in the facility.