STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676185	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Lakes Nursing and Rehabilitation Center	1300 2nd St Granbury, TX 76048

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 44722 Based on interview and record review, the facility failed to maintain medical records on each resident, in accordance with accepted professional standards and practice, that were complete and accurate for 1 of 8(Resident #5) residents reviewed for resident records. The facility failed to ensure physician orders were followed and documented for Resident #5. This failure could place residents at risk of having errors with their care and treatment. Findings included: Record review of Resident #5's face sheet dated 06/26/2024 revealed a [AGE] year-old female admitted on [DATE] and discharged on [DATE] with the following diagnosis hydronephrosis (kidney swells and cannot get rid of pee), difficulty walking, obstructive and reflux uropathy (urine cannot flow normally through urinary tract due to a blockage) and hypertension (high blood pressure). Record review of Resident #5's Admission MDS dated [DATE] revealed Section-C Cognitive Patterns Resident #5 had a BIMS score of 14, meaning cognitively intact; Section H- Bladder and Bowel revealed Resident #5 had intermittent catheterization. Record review of Resident #5's physician orders revealed start date 02/17/2024 Nurse to straight cath patient if patient unable to void every 3 hours as needed for urinary retention. Record review of Resident #5's MAR for February 2024 revealed no evidence of urine output or monitoring every 3 hours. Record review of Resident #5's progress notes revealed no evidence of urine output or monitoring every 3 hours per physician order on 02/18/2024, 02/19/2024, and 02/20/2024. During an interview on 06/26/2024 at 3:15 PM the ADON stated she was educated on how to document when she was received her education for her license. The ADON stated she expected that nurses had been trained in school and they were also trained during orientation and provided in-service per facility need. The ADON stated her expectation would have been that staff document every 3 hours that Resident #5 had voided or needed to have been cathed, and the urine output should have been recorded. The affect on resident could have been resident not receiving the assistance/care needed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/03/2024 at 10:25 AM the DON stated her expectation was that nurses follow physician orders and document their actions in residents electronic chart in the MAR and/or the progress notes. The DON stated if an order stated, Nurse to straight cath patient, if patient unable to void every 3 hours as needed for Urinary Retention, the nurse should have been monitoring the resident every 3 hours and documenting in the resident's electronic chart. The DON stated resident's output should have been documented in the MAR and/or the progress notes. The DON stated the failure to could have caused resident to have a negative outcome. The DON stated what led to failure was learning the system on what reports the facility were able to run to review daily. The DON stated herself and the ADONs were responsible to monitor. Record review of facility policy titled, Charting and Documentation dated July 2017 revealed, The following information is to be documented in the resident medical record: Objective observations .treatments or services performed; changed in the resident's condition .Documentation in the medical record will be objective(not opinionated or speculative), complete, and accurate . documentation of procedures and treatments will include care-specific details, including: The date and time the procedure/treatment was provided; the name and title of the individual who provided the care; The assessment data and/or any unusual findings obtained during the procedure/treatment; how resident tolerated the procedure/treatment; whether the resident refused the procedure/treatment