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	08/15/2024

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on observation, interview, and record review, the facility failed to ensure the resident's right to be free from misappropriation of resident property for 1 of 16 residents (Resident #11), reviewed for drug diversion. The facility failed to prevent the misappropriation of an unknown number of Resident #11's Oxycodone tablets (Controlled Substance requiring double lock and count every shift on 08/03/2024 from the medication cart that was never found. This failure could place residents at risk of misappropriation, and could result in increased pain, and poor quality of life. Findings include: Resident #11 Review of Resident #11's face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of right foot fracture, chronic pain, arthritis, depression, and anxiety. Review of Resident 11's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated no cognitive impairment. Review of Section J: Pain management revealed received scheduled pain medication. Review of Resident #11's Comprehensive Care Plan last revised 01/03/24, revealed: Focus: Resident has chronic pain related to arthritis, chronic pain syndrome and neuropathy, she also has acute pain related to recent diagnosis of left lower extremity DVT. Goal: Will verbalize adequate relief of pain. Interventions: Administer analgesia as ordered. Anticipated residents need for pain relief and respond immediately to any complaint of pain and evaluate the effectiveness of pain intervention. Review of Resident #11's electronic physician orders revealed: Oxycodone-Acetaminophen Tablet 10-325 mg give 1 tablet by mouth every 6 hours for chronic pain, order date 02/21/24. Further review of physician orders revealed: Acetaminophen with Codeine Oral Tablet 300-30 mg give 2 tablets by mouth as needed for pain, ordered date 08/04/24. (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: 676185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Lakes Nursing and Rehabilitation Center	1300 2nd St 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #11's EMAR dated August 2024, revealed Resident #11 did not receive 11 scheduled doses of Oxycodone-Acetaminophen from 08/03/24-08/06/24. Further review of EMAR revealed Resident #11 received 9 doses of Acetaminophen with Codeine from 08/03/24-08/06/24 as a replacement. Review of the provider investigation report revealed facility investigation findings confirmed misappropriation of property and drug diversion. On 08/03/24 at 10:30 am, CMA C noticed Resident #11's Oxycodone and med count sheet was missing. Resident #11' was placed on a 4-hour pain check and assessed for pain. Facility called MD to notify and for pain medication adjustment until replacement medications arrived. It was determined CMA B miss placed and/or mishandled Resident #11's Oxycodone. Police were called and interviewed CMA B. Following the interview CMA B was terminated. Review of CMA B's employee file revealed CMA B's hire date was 04/03/24 and termination date of 08/04/24. Record review of CMA B's Record of Disciplinary Measure dated 05/23/24, revealed; Multiple med errors, did not follow proper policy for drug disposal. Any further med errors or failure to follow medication policy and procedure will result in termination. Further review of CMA B's Record of Disciplinary Measure dated 08/04/24, revealed CMA B did not count the medication cart when completing a shift. Previous write up stated any further med errors or failure to follow policy would result in termination. During an observation and interview on 08/13/24 at 11:34 AM, Resident #11 stated that her pain medication had been stolen. She stated it took the facility at least two and half days to replace her Oxycodone. She stated she was given an alternative pain medication, but it did not completely relieve her pain. She stated she was very upset and could not believe someone would steal her medication. During an interview on 08/15/24 at 01:50 PM, the DON stated CMA B had previously been written up for not having a witness when wasting narcotic medications which were a controlled substance requiring double lock and counted every shift. She stated CMA B and CMA C had admitted that they did not count the narcotics on the medication cart at shift change on 08/03/24. She stated CMA C was written up for failure to follow policies. The DON stated it was determined that CMA B had taken the medication after the facility and the police did a thorough search of the facility and the staff for the missing medication and none was found. She stated CMA B was the only staff member who had left the facility and returned. The DON stated both CMAs had been drug tested with negative results. She stated all staff had been in-serviced regarding drug diversion after the incident on 08/04/24. During an interview on 08/15/24 at 03:20 PM, the Administrator stated his expectation was to not have any medication errors and for staff to follow protocol and policies when administering medications. The Administrator stated his DON and ADON were in charge of overseeing medication errors and properly signing and counting narcotics. He stated he felt everything had been done properly by the facility to prevent drug diversion and you can't keep a thief from thieving. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Harbor Lakes Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 2nd St 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Controlled Substances policy revised December 2012 read in part, Policy Statements; The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. Policy Interpretation and Implementation: .5. Controlled substances must be stored in the medication room in a locked container separate from containers for any non-controlled medication. This container must remain locked at all times except when it's accessed to obtain medications for residents . 8. Unless otherwise instructed by the director of nursing services when a resident refuses a non-unit dose of medication, or it is not given, a resident received partial tablets or single dose and lose or it is not given, the medication shall be destroyed, witnessed by two licensed nurses, and may not be returned to the container. 9. Nursing staff must count controlled medications at the end of each shift the nurse coming on duty and the nurse doing off duty must make the count together they must document and report any discrepancies to the director of nursing services. Record review of the facility's Reporting Abuse to Facility Management policy revised December 2009 read in part, .Policy Interpretation and Implementation .2. To help with recognition of incidents of abuse, the following definitions of abuse are provided .h. Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of a resident's admission that included the instructions needed to provide effective and person-centered care plan and provide a summary of their baseline care plan to residents for 2 (Resident #81 and Resident #291) of 20 residents reviewed for care plan completion. 1. The facility failed to complete Resident #81's baseline care plan within the required 48-hour timeframe. 2. The facility failed to provide Resident #81 & Resident #291 a summary of their baseline care plan after completion. This failure could place residents who were newly admitted at risk for not receiving necessary care and services or having important care needs identified. Findings included: Resident #81 Record review of Resident #81's electronic face sheet dated 08/15/2024 revealed resident was a [AGE] year-old female admitted on [DATE]. Record review of Resident #81's baseline care plan revealed RN signed date of 07/16/2024 (more than 48 hours after admission). No evidence that summary of baseline care plan was given to Resident #81 or her representative. Record review of Resident #81's comprehensive care plan revealed comprehensive care plan was completed on 07/19/2024. Resident #291 Record review of Resident #291's electronic face sheet dated 08/14/2024 revealed resident was a [AGE] year-old female admitted on [DATE]. Record review of Resident #291's baseline care plan revealed LVN L signed date of 07/24/2024. No evidence that the summary of the baseline care plan was given to Resident #291 or her representative. During an interview on 08/15/2024 at 11:10 a.m., the MDS Coordinator stated the baseline care plan was documented in the medical record under assessments tab labeled Interim Plan of Care. She stated the facility would have a meeting with resident and their representative to go over the information on the baseline care plan. She stated the meeting would be documented under assessments tab labeled care conference. She stated information from the baseline care plan was not provided to resident or their representative. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER: Harbor Lakes Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1300 2nd St 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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 08/15/2024 at 2:57 p.m., the MDS Coordinator stated baseline care plans should be completed within 48 hours of admission. She stated Resident #81's baseline care plan was not completed within that time frame. She did not know why the baseline care plan was not completed within 48 hours for Resident #81. During an interview on 08/15/2024 at 3:14 p.m., the Social Worker stated she performed care conferences with residents and their representatives after the baseline care plan had been completed by nurse. She stated she was not opposed to provide residents' documentation about baseline care plans, but she had never been asked to provide it. During a follow up interview on 08/15/2024 at 3:43 p.m., the DON stated she expected baseline care plans to be done within 48 hours of a resident's admission. She stated she was not aware that information from care plan was to be given to resident or their representative. She stated she did not know why Resident #81's care plan was not completed within 48 hours. She stated charge nurses are responsible for completing baseline care plans. She stated she monitored that baseline care plans were done and would complete them if she found the baseline care plan was incomplete. She stated she felt the facility's process led to the failure of not providing the baseline care plan summary to the residents or their representatives. The DON stated the effect of not completing baseline within 48 hours could lead to resident's care needs not being followed and goals not being met. Record review of facility policy titled Care Plans - Baseline revised date December 2016 revealed: A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission .The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to: a. The initial goals of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel actine on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 48883 Based on observation, interview, and record review, the facility failed to review and revise resident's comprehensive care plans by the interdisciplinary team after each assessment for 3 (Resident #9, Resident #15, and Resident #75) of 20 residents reviewed for comprehensive care plans. 1. The facility failed to ensure the interdisciplinary team reviewed and revised the plan of care quarterly for Residents #9 between 11/22/2023 & 06/19/2024. 2.The facility failed to ensure the interdisciplinary team updated the care plan after Resident #9's foley catheter was ordered on 07/16/2024. 3. The facility failed to ensure the interdisciplinary team reviewed and revised the plan of care quarterly for Resident #15 between 11/08/2023 & 07/17/2024. 4. The facility failed to ensure the interdisciplinary team updated care plan after Resident #15 hit another resident on 07/23/2024. 5. The facility failed to ensure the interdisciplinary team reviewed and revised the plan of care quarterly for Resident #75 between 12/05/2023 & 05/31/2024. These failures could affect residents by placing them at risk for not having their current individual needs met. Findings included: Resident #9 Record review of Resident #9's electronic face sheet dated 08/15/2024 revealed a [AGE] year-old female with an initial admission on 08/08/2023 and most recent admission on 07/14/2024 with diagnoses that included: anemia (low iron in blood), muscle weakness, lack of coordination, difficulty in walking, dysarthria (weakness of speech muscles), dysphagia (difficulty swallowing), cognitive communication deficit, neuromuscular dysfunction of bladder (a disease that interferes with nervous system and bladder function that can lead to voiding difficulties), and weakness. Record review of Resident #9's MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated her cognition was intact. Further review of the MDS Section H - Bladder and Bowel revealed resident was not on a toileting program or trial. Record review of Resident #9's Care Plan with the last review dated 07/25/2024 revealed, no evidence of foley catheter. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9's Physician orders dated 07/16/2024 revealed: Foley catheter to bedside drainage, diagnosis: Urinary retention. Record review of Resident #9's electronic medical record revealed no care plans were completed between 11/22/2023 - 06/19/2024. During an observation on 08/14/2024 at 8:31 a.m., Resident #9 had an indwelling catheter in place. Resident #15 Record review of Resident #15's electronic face sheet dated 08/15/2024 revealed a [AGE] year-old female with an initial admitted on 04/05/2017 with diagnoses that included: seizures, weakness, lack of coordination, insomnia, generalized anxiety disorder, dementia, and mild cognitive impairment. Record review of Resident #15's MDS dated [DATE] revealed: a BIMS score of 13 which indicated cognition was intact. Further review of the MDS Section E - Behavior revealed resident had not exhibited physical behavioral symptoms directed toward others. Record review of Resident #15's Care Plan with the last review date 08/15/2024 revealed no evidence that care plan was updated with aggressive behavior after encounter. Record review of Resident #15's progress note dated 07/23/2024 revealed: Resident had an encounter with another resident. Hit resident on her arm. Reported to DON. Record review of Resident #15's electronic medical record revealed no care plans were completed between 1/30/2023 - 11/08/2023 and 11/08/2023 - 07/17/2024. Resident #75 Record review of Resident #75's electronic face sheet dated 08/15/2024 revealed an [AGE] year-old female with an initial admitted on 11/15/2023 with diagnoses that included: hypothyroidism (decreased production of thyroid hormones), muscle weakness, unsteadiness on feet, depressive disorders, tachycardia (fast heartbeat), cognitive communication deficit, and history of falling. Record review of Resident #75's MDS dated [DATE] revealed a BIMS score of 14 which indicated cognition was intact. Record review of Resident #75's electronic medical record revealed no care plans were completed between 12/05/2023 - 05/31/2024. During an interview on 08/15/2024 at 2:57 p.m., the MDS Coordinator stated comprehensive care plans should be performed quarterly. She stated aggressive behaviors should be care planned. The MDS Coordinator stated a foley catheter should be care planned. She stated that care plan meetings were performed quarterly, and she hit the edit button instead of new review button on the care plan screen which let her update the care plan but did not show that quarterly review had occurred. She stated there was no way of proving that comprehensive care plans had been performed. She did not know why behaviors and foley catheter were not included on care plan and stated that she reviewed care plans frequently. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/15/2024 at 3:43 p.m., the DON stated her expectation was for comprehensive care plans to be reviewed quarterly. She stated behaviors and a foley catheter should be included in the care plan. She did not know why care plan reviews were not documented in electronic medical records. She stated she and the ADONs monitored care plans. She stated the effect of not performing care plan reviews could lead to resident's care needs not being followed and goals not being met. Review of facility's policy titled Care Plans - Comprehensive dated December 2009 revealed: Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain .The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). The Care Planning/Interdisciplinary Team is responsible for the periodic review and updating of care plans: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. When the resident has been readmitted to the facility from a hospital stay; and d. At least quarterly.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not five percent (%) or greater. The facility had a medication error rate of 16% based on 4 errors out of 25 opportunities, which involved 1 of 5 residents (Resident #67) reviewed for medication errors. 1. The facility failed to ensure LVN A administered the correct dose of Tylenol (given for pain) to Resident #67 according to physician orders. 2. LVN A failed to administer famotidine (given for GERD), multivitamin, and magnesium oxide to Resident #67 according to physician orders. These failures could place residents at risk of inadequate therapeutic outcomes. Findings include: Review of Resident #67's electronic face sheet revealed a [AGE] year-old female admitted on [DATE] with diagnoses to include: diabetes, Gastro-esophageal Reflux (GERD- acid indigestion), and pain to left and right shoulder. Review of Resident #67's Quarterly MDS assessment dated [DATE] revealed a BIMS score 14 which indicated no cognitive impairment. Review of Resident #67's comprehensive care plan last revised 06/20/24 revealed; Focus: Resident has potential for pain related to general discomfort and disease process. Goal: Will verbalize adequate relief of pain, Will not have discomfort related to side effects of analgesia, and will voice a level of comfort. Interventions: Administer analgesia as per orders, evaluate effectiveness of pain interventions, and report to nurse if resident complains of pain or request pain treatment. Focus: Resident has the potential for discomfort, complications or s/sx related to diagnosis of GERD. Goal: Will remain free from discomfort, complications or s/sx related to diagnosis of GERD. Interventions: Give medications as ordered. Review of Resident #67's electronic Physician Orders revealed the following orders: Tylenol extra strength oral tablet 500 mg give 2 tablets by mouth two times a day for pain, order date 06/21/24, Famotidine tablet 20 mg give 1 tablet by mouth 2 times a day for acid indigestion, order date 03/29/23, Magnesium oxide oral tablet 400 mg give 1 tablet by mouth on time a day for supplement, order date 02/28/23, and Multivitamin tablet give 1 tablet by mouth one time a day for supplement, order date 01/02/23. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 08/13/24 at 10:45 AM, LVN A had 3 pills in medication cup pulled for Resident #67. LVN A stated they were Tylenol 500 mg and she accidently pulled 3 pills instead of 2 pills. LVN A stated the Tylenol bottle she had pulled the medication from was in the trash because she had used the last 500 mg pill. LVN A then pulled the Tylenol 325 mg bottle and stated she had pulled the 325 mg pills instead. LVN A then discarded one tablet and administered the two 325mg tablets along with resident's other medications. LVN A did not administer Famotidine, multivitamin, and magnesium oxide. During an interview on 08/13/24 at 03:48 PM, LVN A stated she must have just missed the 3 medications for Resident #67. She stated she didn't know why she signed them off without giving them, but she knew she should not sign medications without giving them. She stated the error could lead to ineffective pain management. LVN A said she had given Resident #67 the two 325 mg Tylenol instead of 500 mg. She stated she had gotten behind while training a new medication aide and that she had gotten nervous while being monitored by surveyor. During an interview on 08/13/24 at 04:00 PM, Resident #67 stated she was always in pain. She stated she had not noticed being in any more pain than her usual. She stated she was not even aware that she was receiving Tylenol two times a day. During an interview on 08/13/24 at 04:14 PM, the DON stated her expectation was no medication errors. She stated no medications should have been signed out for if they were not given. The DON stated if the appropriate dosage of Tylenol was not on the medication cart, then the nurse should have gotten the appropriate dosage from the medication storage room or notified the DON. The DON stated it was unacceptable to knowingly give the wrong dose of medication. She stated the medication error could have led to uncontrolled pain or ineffective medication management. She stated nurses should not have to be trained on medication pass because they were licensed and should know what they were doing. She stated when nurses were hired, they were orientated for 2-3 shifts on medication pass. During an interview on 08/15/24 at 03:20 PM, the Administrator stated his expectation was to not have any medication errors and for staff to follow protocol and policies when administering medications. The Administrator stated his DON and ADON were in charge of overseeing and preventing medication errors. Record review of the facility's Administering Oral Medications policy revised October 2010 read in part, Purpose: The purpose of this procedure is to provide guidelines for the safe administration of oral medications .Steps in the Procedure .2. Move the medication cart outside the resident's room and make sure your resident is somewhere you can give the meds.3. Place the MAR within easy viewing distance .6. Check the label on the medication and confirm the medication name and dose with the MAR .8. Check the medication dose. Re-check to confirm the proper dose.

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45732

Based on observations, interviews, and record review, the facility failed to ensure that drugs and biologicals were properly secured for 1 of 9 (CMA Medication cart Hall 400) medication carts reviewed for proper medication storage.

The facility failed to store Resident #16's Tramadol (Controlled Substance requiring double lock and count every shift) properly, when 2 pills were left in a medication cup in the top drawer of a medication cart, not labeled and not double locked on 08/13/2024.

These failures could place residents at risk of having access to unauthorized medications and/or lead to possible harm, drug overdose, or drug diversions.

Findings include:

Review of Resident #16's face sheet revealed an [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of back disk degeneration, spinal stenosis, lung disease, and diabetes.

Review of Resident 16's Quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated no cognitive impairment. Review of Section J: Pain management revealed received scheduled pain medication.

Review of Resident #16's Comprehensive Care Plan last revised 07/18/24, revealed: Focus: Resident has chronic pain related to arthritis. Goal: Will verbalize adequate relief of pain or ability to cope incompletely relieved pain. Interventions: Monitor/record pain characteristics and observe/record/report to nurse any signs and symptoms of non-verbal pain.

Review of Resident #16's electronic physician orders revealed: Tramadol Oral Tablet 50 mg give 2 tablets by mouth every 8 hours for pain.

Review of Resident #16's EMAR dated August 2024, revealed Resident #16 was given Tramadol 50 mg 2 tablets on 08/13/24 at 2:10 pm by LVN A.

During an observation and interview on 08/13/24 at 03:48 PM, 2 oval shaped white pills were observed in a medication cup in the top drawer of the CMA medication cart for hall 400. LVN A stated the 2 pills where tramadol (which are a controlled substance requiring double lock and counted every shift) for Resident #16. She stated she pulled the pills and then the resident was not in his room. LVN A stated she should have gone and found the resident to administer the medications, or she should have wasted and discarded the medications. LVN A then went and found Resident #16 and administered the medications. LVN A stated she had been trained and in-serviced on medication administration policies, drug diversion, and misappropriation of property.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Lakes Nursing and Rehabilitation Center	1300 2nd St 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/13/24 at 04:00 PM, Resident #16 stated he was always in some sort of pain, but it was manageable. He stated he sometimes received his medication late, but he always received it. During an interview on 08/13/24 at 04:14 PM, the DON stated nurses should not have to be trained on medication pass because they were licensed and should know what they were doing. She stated when nurses were hired, they were orientated for 2-3 shifts on medication pass. The DON stated there should never have been a medication left in a medication cup unlabeled. She stated a medication should never have been pulled unless the resident was present. She stated the Tramadol was a controlled substance requiring double lock and counted every shift and should have been wasted or discarded immediately if the resident was not present. She stated no medications should have been signed out for if they were not given. She stated this error could lead to drug diversion. The DON verified that Tramadol was signed on the EMAR as given at 2:10 PM on 08/13/24 by LVN A. During an interview on 08/15/24 at 03:20 PM, the Administrator stated his expectation was to not have any medication errors and for staff to follow protocol and policies when administering medications. He stated that having narcotics, such as Tramadol, unlabeled should not have happened and the medication should have either been given or discarded. The Administrator stated his DON and ADON were in charge of overseeing medication errors and properly signing and counting narcotics. The Administrator stated he did not feel that there was a risk for drug diversion or any harm to the resident. He stated he felt everything had been done properly by the facility to prevent drug diversion and you can't keep a thief from thieving. Review of LVN A's employee file and in-services verified LVN A had been trained on administering pain medications, controlled substances, and misappropriation of property on 05/23/24. Record review of the facility's Administering Oral Medications policy revised October 2010 read in part, Purpose: The purpose of this procedure is to provide guidelines for the safe administration of oral medications .Steps in the Procedure .2. Move the medication cart outside the resident's room and make sure your resident is somewhere you can give the meds.3. Place the MAR within easy viewing distance .6. Check the label on the medication and confirm the medication name and dose with the MAR .8. Check the medication dose. Re-check to confirm the proper dose. Record review of the facility's Controlled Substances policy revised December 2012 read in part, Policy Statements; The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. Policy Interpretation and Implementation: .5. Controlled substances must be stored in the medication room in a locked container separate from containers for any non-controlled medication. This container must remain locked at all times except when it's accessed to obtain medications for residents . 8. Unless otherwise instructed by the director of nursing services when a resident refuses a non-unit dose of medication, or it is not given, a resident received partial tablets or single dose and lose or it is not given, the medication shall be destroyed, witnessed by two licensed nurses, and may not be returned to the container. 9. Nursing staff must count controlled medications at the end of each shift the nurse coming on duty and the nurse doing off duty must make the count together they must document and report any discrepancies to the director of nursing services.

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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 0802 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 Based on observation, interview, and record review, the facility failed to employ sufficient staff with the appropriate competencies, skills set and accreditations to carry out the functions of the food and nutrition service department for 1 of 4 dietary staff (DA-D) reviewed for dietary support personnel. The facility failed to ensure that dietary staff (DA-D) serving in kitchen were working with a current Food Handler Certificate. This failure could place residents at risk of not having their nutritional needs met and food borne illnesses due to lack of dietary staff training. Findings include: During an observation on [DATE] at 9:51 AM of the kitchen, DA-D was in the kitchen preparing the lunch meal. Record review on [DATE] at 11:30 AM of DA-D's employee file revealed a Food Handler certificate that expired ,d+[DATE]. During an interview on [DATE] at 11:30 AM, the CDM stated DA-D had previously updated her certificate and did not know why it was not provided in the food handlers binder. The CDM stated on [DATE] at 3:29 PM she was unable to locate DA-D's food handlers' certificate and had her retake it. During an interview [DATE] at 3:21 PM, the DM stated he was to monitor the trainings and certifications for his dietary staff. He stated he looked at DA-D's certification and saw the year 2024 and had assumed it was up to date. The DM stated the CDM spoke to DA-D and asked her to come into the facility and take the food handlers certification. He stated the negative impact to residents was the possibility of unsafe food not being delivered to them during mealtime. The DM stated the reasoning behind having their certification up to date was to learn new techniques or any updated information such as handling food, how hot or cold, cross contamination and infection control. The DM stated if staff missed their certification and did not follow regulations of how to prepare food, it could have made the residents sick. He stated the failure occurred, with him needing glasses and assumed the date was good. The DM's expectations were for staff to have their food handler's certification prior to coming to work or have it updated prior to the expired date. During an interview on [DATE] at 3:36 PM, the ADMN stated it was the CDM's responsibility to have monitored the DM and dietary staff. He stated he looked at the Food Handlers certificates earlier in the year, but not recently. He stated the failure occurred with the DM since he had not monitored correctly. The ADMN stated they did not feel there was a negative impact for the residents since it had only been expired a month. His expectations were for the Dietary staff Food Handlers certificates to be renewed on time without being lapsed. Record Review of DA-D's Food Handlers Certificate revealed it was completed and dated on [DATE]. (continued on next page)

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F 0802 Level of Harm - Potential for minimal harm Residents Affected - Some	Record Review of facility's policy Education and Training with a revised date of ,d+[DATE] revealed; Policy Statement All employees will be provided education and training upon hire and ongoing to ensure that they have the appropriate competencies and skill sets to carry out the functions of the food and nutrition services, taking into consideration the needs of the resident population. Procedures 1. All employees will be provided with education, training, and tools to perform their roles. Training shall include, but not be limited to, the following: HCSG policies and procedures Facility policies and procedures, where applicable Job responsibilities and duties 2. All employees will receive education and training on federally mandated topics and ZHCSG required Human Resources topics upon hire and annually. 3. The Dining Services Director will ensure that all employees complete the required monthly education modules as outlined in the corporate training program

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 44728 Based on observation, interview, and record review, the facility failed to ensure that each resident received food that is palatable, attractive, and at a safe and appetizing temperature for 1 of 1 lunch meal tested for nutritive value, flavor, and appearance: The facility failed to provide palatable food served at an appetizing temperature as evidenced by a sample tray tested on [DATE]. This failure could affect the residents who ate food from the facility's kitchen by placing them at risk of poor food intake and/or dissatisfaction of the meals served. The findings included: During an observation and interview on 08/13/2024 at 12:46 PM, the test tray was placed on the hall cart for transport. The [NAME] told DA-D to take the test tray directly to the conference room or the food would be cold. The test tray continued with hall cart until all food trays were observed being delivered to the residents. When finished the test tray was observed being placed in the conference room for temping at 12:52 PM with the DM. During an observation on 08/13/2024 at 12:52 PM, the test tray temperatures revealed: Spaghetti with meat sauce tested at 106.8 degrees F. Breadsticks tested at 94 degrees F and were unable to be cut with a knife or pull apart easily. During an interview on 08/13/2024 at 12:56 AM, the DM stated the spaghetti and meat sauce was supposed to have temped at 135 degrees F with that being the proper temperature when the residents received their meal tray. The DM stated the spaghetti and meat sauce should have been warmer and agreed that the bread was tough. He stated there could have been a negative impact for residents who wore dentures if the bread was too tough which could have resulted with them not being able to eat them. The DM stated if the food were not palatable the residents would not have wanted to eat it with the possibility of losing weight. During an interview on 08/15/2024 at 3:41 PM, the ADMN stated the facility had plenty of staff to deliver trays. He stated the charge nurses monitored the trays as they passed them to residents within the allotted time given. The ADMN stated the negative impact to residents would have been that it was not the resident's preference to have cold food, and in getting that, could have caused them to lose weight. He stated he could not comment on what led to the failure. He stated his expectations for the residents were for them to let staff know if their food was cold and they would warm it up. The ADMN stated he did not feel the trays being cold when delivered to the residents was not due to staff taking too long. Record review of facility policy Food Preparation, HCSG Policy 016 undated, revealed; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Statement All foods are prepared in accordance with the FDA food Code. Procedures 4. The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 degrees F and/or less than 135 degrees F, or per stated regulation. 13. All foods will be held at appropriate temperatures, greater than 135 degrees F (or as state regulation requires) for hot holding 48883

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44728 Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed, in that: The facility failed to ensure kitchen staff followed proper hand hygiene during meal preparations. This failure could place residents that eat out of the kitchen at risk for food borne illness and cross-contamination. Findings include: During an observation and interview on 08/13/2024 at 11:02 AM, DA-D was observed chopping lettuce and placing it into the plastic bag with her bare hands. DA-D stated she was supposed to have had gloves on when handling food. She stated in not doing so, could have possibly contaminated residents' food and made them sick. During an interview on 08/13/2024 at 11:10 AM, the CDM stated the staff was supposed to have gloves on when handling food as well as when handling ice. During an interview on 08/14/24 at 3:17 PM, the CDM stated the in-services were rotated, with the DM taking the video trainings prior to the Dietary Aides. She stated that touching the food, ice, and the tops of cups with their bare hands, while preparing food, was unacceptable. She stated it was the DM's responsibility to monitor infection control in the kitchen. She stated with nurses touching the ice, while preparing resident drinks, was not a dietary problem, but a nursing problem. During an interview on 08/15/24 at 3:48 PM the ADMN stated it was never acceptable for dietary staff to have touched food with their bare hands, but it depended on the situation and regulations. He stated if it were raw food it was going to be washed anyway. The ADMN stated the DM monitored the food preparation. He stated he did not feel there was a failure to having been caught prior to it happening. The ADMN stated the negative impact was that the residents' food could possibly have caused contamination. The ADMN stated the failures were not given proper and timely education to staff. He also stated the dietary manager should have monitored his staff and their trainings. The ADMN stated his expectations would have been for staff to follow the regulations for all infection control purposes to aid in the prevention of cross contamination. Record Review of facility Matrix 807 dated 08/13/2024 revealed all residents (80 of 80) ate out of the kitchen. Record review of facility policy Food Preparation, HCSG Policy 016 undated, revealed; Policy Statement All foods are prepared in accordance with the FDA food Code. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procedures 1. All staff will practice proper hand washing techniques and glove use. 2. Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. Record Review of S228.65 page 49, Preventing Contamination by Employees (provided by facility) revealed; a. Preventing contamination from hands. (1) Food employees shall wash their hands as specified under S228.38 of this title (relating to Management and Personnel). (2) Except when washing fruits and vegetables as specified under S228.66 (f) of this title or as specified in paragraphs (4) and (5) of this subsection, food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. According to the FDA (Food and Drug Administration) Food Code (https://www.fda.gov/food/retail-food-protection/fda-food-code accessed 08/15/2024), FOOD EMPLOYEES shall clean their hands and exposed portions of their arms . immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLESERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; . (D) . after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; . (E) After handling soiled EQUIPMENT or UTENSILS; . (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; . (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD. (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45732 48883 Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for staff members (CMA H, LVN A, CNA J, & CNA K) observed for infection control. 1. The facility failed to ensure CMA H performed hand hygiene prior to putting on gloves and after taking off gloves during incontinent care. 2. The facility failed to ensure LVN A sanitized the blood pressure cuff in between using it on different residents. 3. The facility failed to ensure CNA J performed hand hygiene after taking off gloves. 4. The facility failed to ensure CNA J did not reuse disposable incontinent wipes during incontinent care. 4. The facility failed to ensure CNA K performed hand hygiene in between assisting two residents while feeding. 5. The facility failed to ensure CNA F and LVN-G touched ice in resident's cup without gloves. These failures place residents at risk for unnecessary infections while in the facility. Findings include: During an observation of medication administration on 08/13/2024 at 10:50 a.m., LVN A took pulse oxygen level of one resident and returned to medication cart without sanitizing her hands. LVN A took blood pressure on a resident with an un-sanitized blood pressure cuff and returned it to medication cart without sanitizing blood pressure cuff or hands. During an observation of medication administration on 08/13/2024 at 11:00 a.m., CMA H put on gloves after preparing medication and did not sanitize hands prior to placing gloves. CMA H administered eye drops to a resident then removed gloves without performing hand hygiene and administered oral medications. During an observation and interview on 08/13/2024 at 11:30 AM, CNA-F was observed placing cups upright on a tray and filling with ice, touching the ice as she filled the cups, with no gloves on. The CDM was then observed taking the tray of ice filled cups then discarding them in the sink due to CNA-F being ungloved and touching the ice. CNA-F stated she should not be touching the ice and/or the top of resident cups with her bare hands which could have possibly contaminated the resident's ice. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 08/13/2024 at 11:44 AM, LVN-G was observed with a resident's cup and filled it with ice, ungloved. She stated she was in a hurry and rushed due to a resident that needed his cup filled with ice immediately. LVN-G stated she knew she was supposed to have gloves on while getting ice, and she should have used proper hand hygiene while handling any resident food and it included the ice. + During an interview on 08/13/2024 at 11:10 AM, the CDM stated the staff was supposed to have gloves on when handling ice. During an interview on 08/14/24 at 3:17 PM, the CDM stated the in-services were rotated, with the DM taking the video trainings prior to the Dietary Aides. She stated that touching ice, and the tops of cups with their bare hands, while preparing food, was unacceptable. She stated it was the DM's responsibility to monitor infection control in the kitchen. She stated with nurses touching the ice, while preparing resident drinks, was not a dietary problem, but a nursing problem. During an interview on 08/13/2024 at 3:48 p.m., LVN A stated blood pressure cuffs and other equipment should have been cleaned between each resident. She stated not cleaning the equipment could spread germs and cause infection. LVN A stated she had been trained on infection control and she did not know why she forgot to clean the equipment. During an observation of dining room on 08/13/2024 at 12:35 p.m., CNA K sat between two residents and assisted them with feeding. She did not perform hand hygiene in between touching soiled utensils and glasses from one resident to the other. During an interview on 08/13/2024 at 1:30 p.m., CNA K stated it was inappropriate to feed 2 different residents at the same time without sanitizing hands in between. She stated she needed to ask a nurse before answering any more questions. During a follow up interview on 08/13/2024 at 1:40 p.m., CNA K stated she was not expecting to have to assist two different residents at lunch. She sat down to assist one and then the other resident needed assistance. She stated she should have sanitized her hands in between the two residents and that could cause infection. During an observation on 08/14/2024 at 9:25 a.m., CNA J performed incontinent care to a female resident. She sanitized hands and placed gloves. She took 3 disposable incontinent wipes out of container and wiped residents right crease then folded the wipes. She wiped left crease then folded the wipes. She wiped down the middle with folded wipes over labia then disposed of the wipes. After resident rolled onto right side, CNA J took 3 more disposable incontinent wipes out of container and wiped around rectum, folded wipes, then wiped again 2 more times with same folded wipe then disposed of wipe. She placed clean brief under the resident and helped her roll onto her back and secured the brief. CNA J removed her gloves and disposed of them into trash without performing hand hygiene. She pulled up sheets and cover and positioned bed using bed control. She then went into restroom and washed her hands. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an interview on 08/14/2024 at 9:36 a.m., CNA J stated she should have changed gloves after cleaning stool with disposable wipe before placing new brief under resident. She stated she should have performed hand hygiene after removing her gloves. CNA J stated she should not have folded incontinent wipes and reused. She stated being nervous from being observed caused her to not perform incontinent care correctly.

During an interview on 08/15/2024 at 3:11 p.m., the IP stated her expectation was for blood pressure equipment to be sanitized between residents. She stated hands should be sanitized each time gloves were placed or removed. She stated it was not appropriate to fold and reuse incontinent wipes during incontinent care. The IP stated hands should be sanitized in between residents when assisting with feeding. She stated the effect of not following infection control could lead to potential cross contamination causing infection. She stated all management and nurses should be watching CMAs and CNAs to ensure they are sanitizing hands, equipment and not reusing disposable wipes. She did not know why staff did not follow infection control and stated that they had been trained in infection control.

During an interview on 08/15/2024 at 3:43 p.m., the DON stated her expectation would be for equipment and hands to be sanitized in between residents. She stated that hands should be sanitized prior to putting on and taking off gloves. She stated it was appropriate to fold and reuse incontinent wipe as long as not using to wipe labia or urethra. She stated failure of folding and reusing wipes may be due to education the CNAs have been given and will review incontinent care checkoff sheets. She stated that all nurses and management monitor staff were following infection control. She stated she felt being observed caused staff to be nervous which led to staff forgetting to not sanitize equipment and hands. The DON stated not following infection control procedures could cause to residents getting infections.

During an interview on 08/15/24 at 3:48 PM the ADMN stated it was never acceptable for staff to have touched ice with their bare hands. The ADMN stated his expectations would have been for staff to follow the regulations for all infection control purposes to aid in the prevention of cross contamination.

Record Review of S228.65 page 49, Preventing Contamination by Employees (provided by facility) revealed;

a. Preventing contamination from hands.

(1) Food employees shall wash their hands as specified under S228.38 of this title (relating to Management and Personnel).

(2) Except when washing fruits and vegetables as specified under S228.66 (f) of this title or as specified in paragraphs (4) and (5) of this subsection, food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment.

According to the FDA (Food and Drug Administration) Food Code (https://www.fda.gov/food/retail-food-protection/fda-food-code accessed 08/15/2024), FOOD EMPLOYEES shall clean their hands and exposed portions of their arms . immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLESERVICE and SINGLE-USE ARTICLES and:

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; . (D) . after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; . (E) After handling soiled EQUIPMENT or UTENSILS; . (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; . (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD. (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands. Record Review of the facility's policy titled Handwashing/Hand Hygiene dated August 2015 revealed All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty; b. Before and after direct contact with residents; c. Before preparing or handling medications; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin; k. After handling used dressings, contaminated equipment, etc.; l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; m. After removing gloves; o. Before and after eating or handling food; p. Before and after assisting a resident with meals . The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. (continued on next page)

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	08/15/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of the facility's policy titled Perineal Care dated December 2011 revealed: For a female resident: Using a pre-moisten disposable wipe or wet washcloth and apply soap or skin cleansing agent. Wash perineal area, wiping from front to back. Separate labia and wash area downward from front to back. (Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area.) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. Do not reuse the same disposable wipe/washcloth or water to clean the urethra or labia.