STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455915	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRANBURY CARE CENTER	**301 S PARK 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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the necessary services to maintain good grooming and personal hygiene for a resident who is unable to carry out activities of daily living for three (Resident #6, #7 and #9) of 8 residents reviewed for activities of daily living. The facility failed to ensure: 1. Residents #6 and #9 received baths and nail care. 2. Residents # 7 received baths. These failures placed residents at risk of poor hygiene and skin breakdown. Findings included: Review of Resident #6's MDS dated [DATE] revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. He was cognitively intact with a BIMS score of 15 (a score of 13-15 indicated cognitively intact. He had no behaviors but did reject care daily. He was totally dependent of two staff for bathing. He was always incontinent of bowel and bladder. He was at risk for pressure ulcers but had no skin issues. Review of Resident #6's Care Plan dated 06/12/20 revealed the resident required two staff participation in bathing and to check nail length, trim and clean on bath day and as necessary. Report any changes to the nurse, if diabetic the nurse will provide toenail care. The resident refused ADL care, at times, and the interventions included to educate the resident of the possible outcomes of not complying with treatment or care, if the resident resists ADL care, leave and try again. Review of Resident #6's Bath Documentation for June 2020 revealed the resident did not receive a bath from 06/07/20 - 06/12/20 (6 days) and from 06/14/20 - 06/19/20 (6 days). He received 6 out of 13 showers. The documentation indicated the bathing activity did not occur. Review of Resident #6's Progress Notes for June 2020 did not reveal any documentation regarding the resident's baths or nails. Review of Resident #6's Weekly Skin assessment dated [DATE] revealed the resident had redness to his peri-area and buttocks. In an observation and interview on 07/01/20 at 5:04 PM Resident #6's was in his room in bed. The fingernails on his left hand were long and had a brown substance under the nails. He said he needed his nails cut because he scratches himself. He said he could not remember the last time his nails were cut but he had his own nail clippers and just needed assistance. He said he was not sure when he was scheduled for a shower. In an observation and interview on 07/02/20 at 12:05 PM Resident #6 was in his room in bed. He said he had not gotten a shower in two weeks and had not been shaved for a week. The resident did have some facial hair. He said he had his own electric shaver but none of the staff will assist him. He said he asked for a shower last night and staff told him it was not his shower day. He said the day shift (6:30 AM - 6:30 PM) tell him they aren't supposed to shower him and the night shift (6:30 PM - 6:30 AM) tell him it's not his shower day. The nails on his left hand were still long with a brown substance underneath the nails. The resident said the nails on his right hand were not as long, but they still needed to be cut. The resident's right hand was contracted, and the nails were not long or soiled. In an interview on 07/02/20 at 12:10 PM CNA B said Resident #6 was showered on the night shift (6:30 PM - 6:30 AM). She said to her knowledge he did not refuse showers. In an interview on 07/02/20 at 1:33 PM LVN C, who worked the 6:30 PM - 6:30 AM shift, said she was not aware of Resident #6 refusing his showers. She said sometimes they did not have enough staff to get all the showers done but the staff did their best. In an interview on 07/02/20 at 3:38 PM Resident #6 said he wanted his nails clipped and he asked the CNAs but they told him a nurse had to clip them because he was diabetic. In an interview on 07/02/20 at 3:40 AM LVN D said a nurse had to clip Resident #6's nails because he was diabetic. She said she did not know the last time he had his nails cleaned and trimmed but he often refused care. She said he did scratch himself and his private area. She said she would try to do his nail care. In an observation and interview on 07/02/20 at 3:50 PM LVN C was in Resident #6's room cutting his nails. She said the ring fingernail of his left hand was about half an inch long. Review of Resident #9's MDS dated [DATE] revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. He was moderately cognitively impaired with a BIMS of 11 (a score of 8-12 indicated moderate cognitive impairment). He had no behaviors and did not reject care. He required physical help in part of the bathing from one staff. He was occasionally incontinent of bowel and bladder. He was at risk for pressure ulcers and had two Stage III pressure ulcers. Review of Resident #9's Care Plan dated 02/06/20 revealed the resident had an ADL Self Care Performance Deficit. The goal was for the resident to maintain or improve current level of function. Bathing: requires staff x1 for assistance. Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. If diabetic, the nurse will provide toenail care. Review of Resident #9's Bathing Documentation dated June 2020 revealed the resident did not get a bath from 06/01/20 - 06/09/20 (9 days), from 06/17/20 - 06/22/20 (6 days) and from 06/24/20 - 06/30/20 (7 days). In the month of June 2020, the resident received 4 baths in thirty days. Review of Resident #9's Progress Notes for the month of June 2020 did not reveal any documentation regarding his baths or nails. Review of Resident #9's Weekly Ulcer assessment dated [DATE] revealed the resident had a Stage II pressure ulcer on his coccyx that measured 1.0 x 0.5 x 0.1 cm. In an observation and interview on 07/02/20 at 11:15 AM Resident #9 was in his room wearing mismatched pajamas. He said he was not getting his showers and the care he needed. The fingernails on both his hands appeared long, some of them the nails were jagged. He said his fingernails had not been cut in a while and they needed to be. In a confidential staff interview, the staff member said all the residents' showers were not getting done because there was not enough staff on the 6:30 PM to 6:30 AM shift. The staff member said they normally had two CNAs but needed three to get all the showers done on the shift. Review of Resident #7's MDS dated [DATE] revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was severely cognitively impaired with a BIMS score of 4 (a score of 0-7 indicated severe cognitive impairment). She had no behaviors and no rejection of care. She was frequently incontinent of bowel and bladder. She was at risk for pressure ulcers but had no skin issues. She was totally dependent of one staff for bathing. Review of Resident #7's Care Plan dated 5/06/20 revealed the resident had a potential for pressure ulcer development and had a deficit with self-care of activities of daily living. The goal was for the resident to maintain or improve her current level of function in personal hygiene. She required one staff for assistance with bathing. Review of Resident #7's Bathing Documentation for June 2020 revealed the resident did not receive a bath from 06/06/20 - 06/10/20 (5 days). In an interview on 07/01/20 at 4:22 PM LVN A said there were 21 residents on the secure dementia unit. She said usually there was one CNA assigned to the hall on the 6:30 PM to 6:30 AM shift and one nurse who covered the unit and two other halls outside the unit. She said about thirty percent of the residents' showers were assigned to the 6:30 PM to 6:30 AM. She said if there was one CNA on the secure dementia unit and that CNA was in the shower room, if staffing permitted, another CNA might be able to go back to the unit to supervise the other residents. In an interview on 07/02/20 at 4:40 PM the Assistant Administrator said she reviewed Resident #7's clinical record and did not know why the resident did not have a bath from 06/06/20 - 06/10/06 (5 days). She said there was no documentation in the clinical record regarding the resident's baths. In an observation on 07/02/20 at 4:43 PM Resident #7 was on the secured dementia unit. She was unable to answer questions regarding her care. She was dressed appropriately. She was carrying a lot of random items and appeared somewhat disheveled. In an interview on 07/09/20 at 6:50 PM CNA E said

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455915	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRANBURY CARE CENTER	**301 S PARK 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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) she worked the secured dementia unit on the 6:30 PM - 6:30 AM shift. She said there was usually one CNA on the unit and 3-4 showers on her shift. She said one CNA could not do showers on the unit because all the residents required supervision. She said Resident #7's showers were schedule for the 6:30 PM - 6:30 AM shift and did not get done from 06/06/20 - 06/10/20 (5 days). In a confidential staff interview, the staff member said staff had been asking for a long time for additional assistance on the 6:30 PM to 6:30 AM shift because two CNAs could not get all 11 scheduled showers done. In a telephone interview on 07/02/20 at 10:46 AM the Ombudsman said she had received a recent complaint about the lack of ADL care at the facility from a resident's responsible party. In a confidential telephone interview, a resident's responsible party said it was not uncommon for a resident to go two weeks without a shower. In a confidential staff interview, the staff member said there were 5-6 showers on the hall and the staff member was lucky to get 1 or 2 showers done on the 6:30 PM to 6:30 AM shift. In an interview on 07/10/20 at 12:47 PM the Administrator said she was not aware residents' baths were not getting done. In an interview on 07/15/20 at 2:00 PM the DON said he was not aware the baths were not getting done, as scheduled, three times per week. In an interview on 07/02/20 at 5:07 PM the Assistant Administrator said there was not a specific policy related to baths or nail care.
F 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly notify the physician or physician's representative when laboratory results fell outside of the clinical reference range in accordance with facility policies and procedures for 1 (Resident #8) of 9 residents reviewed for lab services. The facility failed to ensure Resident #8's COVID-19 test was followed up on and the positive lab test results were not relayed to the physician or the residents accepting facility. The failure placed residents at risk of COVID-19 infection. Findings included: Review of Resident #8's Admission Record dated 07/09/20 revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. In a telephone interview on 07/07/20 at 2:00 PM the DON said the facility discovered Resident #8's positive COVID-19 lab on 07/06/20. He said Resident #8 did not have a roommate and was asymptomatic. He said the resident wanted to discharge to an assisted living and the assisted living required a COVID-19 test prior to admission but the resident ended up discharging to a different assisted living that did not require a COVID-19 test prior to admission. He said he administered the test on 06/19/20. He said the results were available on 06/23/20 but the lab did not call the facility regarding the positive test result or fax the test result, which was the usual practice if a test result was critical. He said he phoned the lab and the company said the lab considered it abnormal but not critical and therefore did not call or fax the results. He said the procedure was for the nurses to check the lab portal during their shift for any test results. He said the test results were on the lab portal but the portal was not checked and the lab was missed. Review of Resident #8's Lab Report dated 07/09/20 revealed on 06/19/20 at 4:30 PM a COVID-19 specimen was collected. On 06/23/20 at 11:36 PM the results were positive for COVID-19. Review of Resident #8's Progress Note dated 06/25/20 revealed the resident discharged to an assisted living facility on 06/25/20. Review of Resident #8's Progress Notes and Vital Signs for June 2020 did not reveal any signs or symptoms of COVID-19. In an interview on 07/10/20 at 12:47 PM the Administrator said Resident #8's lab result was not followed up on and it just got missed but she reported the results to the resident, physician and the State as soon as she found out about it on 07/06/20. She said the procedure was for the nurses to check the lab portal for results and notify the physician. She said the lab results were received on 06/23/20 but the portal was not checked and then the resident discharged to the assisted living two days later on 06/25/20. She said it was only discovered because the facility was checking on other residents' COVID-19 test results.
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** Based on interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices for one (Resident #6) of 9 residents whose clinical records were reviewed. The facility failed to ensure Resident #6's insulin administration was documented accurately and completely. This failure placed residents at risk for inaccurate or incomplete clinical records. Findings included: Review of Resident #6's MDS dated [DATE] revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. He was cognitively intact with a BIMS score of 15 (a score of 13-15 indicated cognitively intact. He had no behaviors but did reject care daily. Review of Resident #6's Care Plan dated 06/12/20 revealed the resident was diabetic and refused medications. The interventions included to educate the resident of the possible outcome of not complying with his treatment or care. Review of Resident #6's Treatment Administration Record Dated June 2020 revealed the resident was to receive the follow sliding scale insulin: [MEDICATION NAME] Solution 100 Unit/ML at 8:00 PM, 70-180 = 0 units, 181-240 = 2 units, 241-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, 401+ = 6 units. Higher than 400 give 6 units. On 06/26/20 the resident refused to have his blood sugar checked or insulin administered. On 06/27/20 the record was blank. On 06/28/20 the resident refused to have his blood sugar checked or insulin administered. On 06/29/20 the record was blank. On 06/30/20 the resident refused to have his blood sugar checked or insulin administered. The resident did not receive his sliding scale insulin, as ordered at 8:00 PM for five days from 06/26/20 - 06/30/20. Review of Resident #6's Progress Notes for June 2020 did not reveal any documentation regarding the scheduled blood sugar check and insulin administration on 06/27/20 or 06/29/20, or refusal of insulin on 06/26/20. The notes did not document the resident's physician or responsible party were notified the resident's refusals. Review of Resident #6's Progress Note dated 06/28/20 documented refused. Review of Resident #6's progress note dated 06/30/20 revealed the resident was sleeping and refused his medications and blood sugar check. There was no documentation regarding the Care Plan intervention to educate the resident of the possible outcome of not complying with his treatment or care. In an interview on 07/02/20 at 12:05 PM Resident #6 said he does refuse medications, at times. In a telephone interview on 07/10/20 at 2:18 PM Resident #6's responsible party said she and his physician were aware of his medication refusals, but she was not always notified each time he refused. In a telephone interview on 07/10/20 at 4:08 PM LVN F said Resident #6 often refuses his blood sugar checks and insulin on the evening shift because he is sleeping. She said the blanks on the record were refusals. She said she notified his responsible party and his physician but failed to document. In an interview on 07/15/20 at 2:00 PM the DON said he spoke with Resident #6's nurses and he feels the blank on the record were refusals, but the nurses should not have left the record blank and should have charted. He said it is his expectation that if a resident refuses medications that the nurses should chart it in the clinical record. Review of the facility's Documentation Policy dated 2003 revealed the facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.