STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455915	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on interview and record review the facility failed to ensure residents/resident's representative had the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he/ she preferred for 2 of 26 residents (Resident #50 and Resident #114) reviewed for antipsychotic consents. 1. The facility failed to ensure Resident #50's HHSC Form 3713 for Ziprasidone (also known as Geodon an antipsychotic medication used to treat bipolar 1 disorder and schizophrenia) was signed by Resident #50 or Resident 50'ss responsible party. 2. The facility failed to ensure Resident #114's HHSC Form 3713 for Seroquel (an antipsychotic medication used to treat mental health disorders, such as schizophrenia) was signed by Resident #114 or Resident #114's responsible party. This failure could affect residents who received antipsychotics by placing them at risk of not being informed of their health status, to make informed decisions regarding their care. Findings included: Record review of Resident #50's electronic face sheet dated 12/04/2024 revealed a [AGE] year-old male admitted on [DATE] with the following diagnosis senile degeneration of (brain group of symptoms affecting memory, thinking and social abilities) schizoaffective disorder (mental health condition that includes hallucinations and delusions, depression and , mania), psychosis, and anxiety disorder. Record review of Resident #50's MDS assessment dated [DATE] revealed Section C- Cognitive Patterns: Resident #50 had a BIMS of 10 (meaning moderate cognitive impairment); Section N-Medications: Resident #50 had received antipsychotic medications during the previous 7-day period. Record review of Resident #50's physician order revealed: Ziprasidone HCL Oral Capsule 60 MG Give 1capsule by mouth two time a day related to schizoaffective disorder with a start date of 12/28/2023. Record review of Resident #50's December Medical Administration Record dated December 2024 revealed Resident #50 received Ziprasidone on 12/01/2024, 12/02/2024, 12/03/2024 and 12/04/2024. (continued on next page)

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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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #50's HHSC Form 3713 for Ziprasidone revealed no evidcnce of a signature by Resident #50 or their representative. Record review of Resident #114's electronic face sheet dated 12/04/2024 revealed [AGE] year-old male admitted on [DATE] with the following diagnosis unspecified Dementia, and insomnia. Record review of Resident #114's MDS assessment dated [DATE] revealed Section C- Cognitive Patterns: Resident #114 had a BIMS of 3 (meaning severe cognitive impairment); Section N-Medications: Resident #114 had received antipsychotic medications during the previous 7-day period. Record review of Resident #114's physician orders revealed: Seroquel Oral Tablet 25 MG Give 0.5 tablet by mouth one time a day related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (f03.90) give half of tablet to equal 12.5m . Seroquel oral tablet 25 mg (quetiapine fumarate) give 1 tablet by mouth one time a day related to unspecified, dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (f03.90) with a start date of 11/14/2024. Record review of Resident #114's December Medical Administration Record dated December 2024 revealed Resident #114 received Seroquel on 12/01/2024, 12/02/2024, 12/03/2024 and 12/04/2024. Record review of Resident #114's HHSC Form 3713 for Seroquel revealed no evidence of a signature by Resident #114 or their representative. During an interview on 12/04/24 at 5:02 PM, the DON stated her expectation was that the antipsychotic consent should have been signed by the resident or resident's representative prior to Resident # 50 and Resident #114 were given and antipsychotic medication. The DON stated she was responsible to monitor the completion of resident's HHSC Form 3713, and she monitored during their weekly team meetings. The DON stated the effect on residents could have been residents and their representatives were not made aware of what medication residents were on and the side effects of the medications. The DON stated what led to the failure was the lack oversight by staff and staff turnover. Record review of facility policy titled Psychotropic Drugs dated 10/25/17 revealed A psychotropic consent from explains the risks and benefits of psychotropic medication. The resident or their representative must provide documented consent prior to administration of a newly offered psychotropic medication . Consent for antipsychotics must be in a written from. Phone o Seroquel r verbal consent is not allowed. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of LTCR Provider letter titled Consent for Antipsychotic and Neuroleptic Medications dated May 5, 2022, accessed on 08/30/2024 at https://www.hhs.texas.gov/sites/default/files/documents/pl2022-11.pdf, revealed The prescriber of the medication, the prescriber's designee, or the NF' s medical director must complete Section I of Form 3713. HHSC cannot specify who can be the designee for the prescriber. Prescribers should consult their own board, such as the Texas Medical Board, to determine who can act as their designee. A prescriber can delegate the completion of Form 3713, Section I, if the prescriber's license permits it . The resident or the resident's legally authorized representative must sign Section II of Form 3713 (Consent for Antipsychotic or Neuroleptic Medication Treatment). The rule requires consent in writing by the resident or by a person authorized by law to consent on behalf of the resident. Verbal consent does not meet the rule requirements. NF staff cannot sign on behalf of the resident. Review of drugs.com accessed on 12/04/2024 at https://www.drugs.com, revealed Seroquel and Ziprasidone (Geodon) were Drug class: Atypical antipsychotics. Review of [NAME]-Term Care Regulatory Provider Letter date issued 05/05/2022 revealed: Under 26 TAC S554.1207, a resident receiving antipsychotic or neuroleptic medications must provide written consent. Written consent can also be given by a person authorized by law to consent on the resident ' s behalf. Consent for antipsychotic and neuroleptic medications must be documented on Texas Health and Human Services Commission (HHSC) Form 3713.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45458 Based on observation, interviews, and record review, the facility failed to refer residents for PASRR screening and evaluation, with a newly evident mental disorder or related condition for level II PASRR review, 1 of 3 residents (Resident #107) in that: Resident #107 was not referred to the state-designated authority for PASRR re-evaluation upon evidence of past history significant for depression, anxiety, and PTSD when admitted to the facility on [DATE] with a negative PL1. This failure placed residents at risk of not receiving adequate services or care related to mental illnesses. Finding include: Record review of Resident #107's Facesheet, dated 12/03/2024, revealed Resident #107 was a [AGE] year-old male, with an admitted into the facility on [DATE]. Record review of Resident #107's Diagnosis Report, dated 12/03/2024, revealed Resident #107's admission primary diagnosis was Bipolar disorder, unspecified, effective 09/12/2023. Other diagnoses included Generalized Anxiety Disorder, which was dated 12/12/2023, and Post-traumatic stress disorder and major depressive disorder, dated effective 12/13/2023. Record review of Resident #107's Annual Minimum Data Set (MDS) assessment, dated 09/17/2024, indicated Resident #107 had a BIMS score of 15, which indicated intact cognitive response. Section I - Active Diagnoses revealed Resident #107 was coded a 13 which identified medically complex conditions. Active diagnoses identified were Anxiety disorder, depression, bipolar disorder, and post-traumatic stress disorder. Record review of Resident #107's PL1, dated 09/11/2023, revealed the referring entity documented Resident #107 had no previous history of mental illness by answering C0100 Is there evidence or an indicator this is an individual that has a Mental Illness? as no. Record review of Resident #107's progress note, dated 09/13/2023, completed by the PCP, revealed Resident #107 had a past history significant for depression, anxiety, and PTSD. Record review of Resident #107's Care Plan, dated initiated on 09/15/2023, revealed Resident #107 had a focus of, The resident has a psychosocial well-being problem (actual or potential) related illness/disease process due to history of trauma from working as a police officer in a large City, has been homeless, had a family member commit suicide when at a young age and resident was age 10. Resident has a diagnosis of bipolar. Review of Care Plan revealed Resident #107 had a focus of, The Resident has depression related to Bipolar maniac state. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #107's Psychiatric Progress Note, dated 10/11/2023, revealed Resident #107 was seen for mania following PCP med adjustments. Formal diagnoses included Bipolar disorder, current episode manic without psychotic features, moderate and Generalized anxiety disorder, active. Psychiatric medications were adjusted. Record review of Resident #107's Psychiatric Progress Note, dated 07/01/2024, revealed Resident #107 was seen due to symptoms of mania and his statement of, I think I need some help with my mood. Review revealed continued diagnoses of Bipolar disorder and Generalized anxiety disorder. Psychiatric medications were adjusted. During an observation on 12/03/2024 at 1:35 p.m., Resident #107 sat in the designated smoking area of the facility and smoked a cigarette. Resident #107 look around the area with a frown on his face. During an interview on 12/03/2024 at 1:39 p.m., Resident #107 said he was doing ok but he felt slightly nervous. Resident #107 said he had taken his medication, but he still felt anxious at times. Resident #107 said he saw the psychiatric doctor who came to the nursing facility and the psychiatric doctor adjusted his medication for anxiety. During an interview on 12/04/2024 at 2:28 p.m., the MDS Coordinator said Resident #107 came into the facility with no psychological diagnoses when he was admitted on [DATE] and had self-diagnosed himself with depression. MDS Coordinator said Resident #107 had been formally diagnosed with Post-traumatic stress disorder after admission on 09/11/2023. MDS Coordinator said she completed the Form 1012 on 12/03/2024 and was waiting for the doctor's signature. MDS Coordinator said she had submitted the PL1 in the portal to request a new PASRR evaluation be completed on Resident #107 on 12/03/2024. MDS Coordinator said the facility had an internal audit recently and recognized the facility had an issue with Resident #107's record and submitted the PL1. MDS Coordinator said she was not familiar with the Form 1012 prior to 12/03/2024 and was not aware that the form was required to be submitted. The MDS Coordinator provided the policy, PASRR Nursing Facility Specialized Services Policy and Procedure, dated as revised 03/06/2024, and stated the policy was the only policy the facility had in the area of PASRR specialized services. During an interview on 12/04/2024 at 3:30 p.m., the Area Director of Operations said the PASRR forms were monitored at a higher level than the facility. The Area Director of Operations said the corporate regional audit nurses inspected and audited, routinely, and provided feedback to the MDS Coordinators. The Area Director of Operations said the Form 1012 should have been completed and processed for Resident #107. During an interview on 12/04/2024 at 3:40 p.m., the Administrator said the MDS Coordinators were monitored by the facility and corporate staff and audited routinely. The Administrator said the Coordinator who did not complete the Form 1012 as required for Resident #107 when a suspicion of mental illness was present was an error and the form should have been completed and processed. Record review of the facility policy's, PASRR Nursing Facility Specialized Services Policy and Procedure, dated as revised 03/06/2024, revealed the policy did not address the process to take if a resident had a negative PL1 and the resident was diagnosed with a psychiatric diagnosis that could trigger a suspicion of eligibility for PASRR Mental Health services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48883 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles and included the appropriate accessory and cautionary instructions for 2 of 6 medication carts (Hall B nurse medication cart & Hall A-D nurse medication cart) reviewed for medication labeling and storage. The facility failed to ensure Schedule II-V medications subject to abuse were stored so that shortage of medication was readily detectable for 1 of 2 medication rooms (Hall G-H medication room) reviewed for medication labeling and storage. 1. The facility failed to dispose of expired medications from Hall A-D nurse medication cart. 2. The facility failed to have pharmacy labels on 2 insulin flex pens from Hall B nurse medication cart. 3. The facility failed to have medication count sheets with controlled substances from Hall G-H medication room. These failures could place residents at risk of misappropriation of medications, receiving the wrong medication doses, and receiving medications with reduced therapeutic effects of medication. Findings Included: Resident #2 Record review of Resident #2's electronic face sheet dated 12/04/2024 revealed he was a [AGE] year-old male admitted to the facility on most recently on 09/11/2023 with diagnoses to include: type 2 diabetes. Record review of Resident #2's electronic physician orders dated 09/11/2023 revealed Lantus SoloStar Subcutaneous Solution Pen-Injector 100 unit/ml (Insulin Glargine) Inject 40 unit subcutaneously two time a day related to type 2 diabetes. Resident #111 Record review of Resident #111's electronic face sheet dated 12/04/2024 revealed she was a [AGE] year-old female admitted to the facility most recently on 01/05/2024 with diagnoses to include: type 2 diabetes. Record review of Resident #111's electronic physician orders dated 01/06/2024 revealed Insulin Lispro (1 unit dial) Subcutaneous Solution Pen-Injector 100 unit/ml (Insulin Lispro) Inject as per sliding scale: if 131-170 = 2 units; 171-210 = 3 units; 211-250 = 5 units; 251-290 = 6 units; 291-330 = 7 units; 331-400 = 8 units, subcutaneously four times a day related to type 2 diabetes. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/03/2024 at 8:33 AM, Hall G-H medication room revealed the medication refrigerator lock box affixed to refrigerator that included: 1. 1-30 ml bottle of lorazepam 2 mg/1 ml with Resident #21's name on pharmacy label. No evidence that medication had count sheet in H Hall binder behind refrigerator tab. 2. 1 medication bottle of buprenorphine/nalox 2-0.5 mg with Resident #93's name on pharmacy label and 23 individual wrapped films inside of bottle. No evidence that medication had count sheet in H Hall binder behind refrigerator tab. 3. 1 unopened medication box quantity of 30 buprenorphine/nalox 2-0.5mg with Resident #93's name on pharmacy label. CIII labeled on medication box. No evidence that medication had count sheet in H Hall binder behind refrigerator tab. During an observation on 12/03/2024 at 9:15 AM, Hall B nurse medication cart included 1 Lantus insulin flex pen for Resident #2 with resident's last name and open date of 11/24 and 1 Lispro insulin flex pen for Resident #111 with resident's last name and open date of 11/30. No evidence of prescribed dose observed on either flex pens. During an observation on 12/03/2024 at 11:43 AM, A-D Hall nurse medication cart included 1 bottle of OTC diphenhydramine 25 mg that had expiration date of 10/2024. During an interview on 12/03/2024 at 8:40 AM, LVN A stated nurses were supposed to count medications stored in locked controlled substance box when coming on shift. She stated she had not counted the medications that morning because she did not normally work Hall H and did not know that Hall H nurses' keys had the key to open controlled substance box in the medication room refrigerator. She stated she had not noticed count sheets for the 3 medications were not present at shift change. She stated the count sheets would be in the Hall H nurses binder for controlled substances behind the tab labeled Fridge. She stated not having count sheets could lead to medication being lost. During an interview on 12/03/2024 at 8:42 AM, LVN B stated medications stored in the locked box in the medication room refrigerator needed to have count sheets. She stated she remembered there being a discussion the night before about Lorazepam needed to be left in refrigerator when nurses were removing medications from the refrigerator for residents that no longer were at the facility or were discontinued. She felt the count sheet for lorazepam may have been misplaced during time when refrigerator medications were being removed the night before but did not know where it would be now. LVN B stated she had no knowledge of why the count sheets for buprenorphine/nalox 2-0.5mg were not present. She stated the count sheets should be kept in Hall H nurses' binder for narcotics as the H Hall nurse had keys to locked box. She stated not having a count sheet could lead to medication being lost. During an interview on 12/03/2024 at 8:57 AM, the DON stated she expected medication stored in locked controlled substance box in medication room refrigerator to have count sheets. She stated that nurses were responsible for making sure controlled medications had count sheets and should count the medications during shift change. She stated she did not have count sheet for Lorazepam or buprenorphine/nalox 2-0.5mg in her office. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/03/2024 at 9:15 AM, ADON C stated she did not know why insulin flex pens in Hall B treatment cart did not have pharmacy label on them. She stated that flex pen medications should have labels on them and that nurses were responsible for making sure medications were labeled. During an interview on 12/03/2024 at 11:43 AM, LVN D stated expired medications should not be left on medication carts. She stated she did not know why expired diphenhydramine was on Hall B medication cart, but it could be because that medication was not given often. She stated leaving expired medication on cart could lead to someone receiving expired medication. During an interview on 12/03/2024 at 4:08 PM, the DON stated that count sheets were required for any opioid medication or controlled medication. She stated scheduled III controlled substances should have count sheets per the facility's policy. She stated that she expected flex pens received from pharmacy to be labeled with resident's name, physician's name, directions for administration, and expiration date. She stated if flex pens were gotten out of emergency kit, then it would be appropriate to write the resident's name and date the medication was opened on pen and no label would be needed. She stated nurses would look at the order in the medication administration record prior to administering medication and did not feel any negative outcome would occur from flex pen not having direction for administration on them. She stated she expected medication to be removed from medication carts when it expired. She stated that medication aides and nurses were responsible for making sure expired medications were not left on medication carts. She denied any negative outcome had occurred from expired medication being left on cart but that it could lose effectiveness. She stated all nurses were responsible for making sure medications were labeled and stored correctly and that corporate and pharmacy monitored the nurses. During an interview on 12/04/2024 at 8:49 AM, LVN E stated she was familiar with H Hall and was working on that hall today. She stated the medication buprenorphine/nalox 2-0.5mg was not in the refrigerator the last day she had worked. She stated she had been off for several days. She stated she had reached out to Resident #93's family and asked them to please come and pick up medication since the facility had gotten buprenorphine filled from their pharmacy. LVN E stated in the past his family member would use outside pharmacies to get medication for the residents while they were waiting on Medicaid, but now used the facility's pharmacy. She did not know who had excepted the medication from family, but stated it should have had a count sheet if kept in facility's medication room refrigerator. She stated she had been counting Lorazepam prior to her being off work and did not know why count sheet was unable to be found on 12/03/2024 morning but that it was found and had been placed back in H Hall binder behind the Fridge tab so she was able to count it this morning. She stated that controlled medications should be counted during shift change. During an interview on 12/04/2024 at 9:11 AM, LVN F stated she had knowledge about G Hall and was working on G Hall today. She stated she did not count controlled medications that were stored in the refrigerator since the key to lock box was stored with H Hall keys. She stated she would only look at those count sheets if she were administering medication for her residents. She stated she had never administered the lorazepam or buprenorphine/nalox 2-0.5mg and did not ever look for those count sheets. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/04/2024 at 11:15 AM, the DON stated she had confirmed with Resident #93's family member that buprenorphine/nalox 2-0.5mg had been picked up from an outside pharmacy. The family member verified that the medication had been dropped off at the facility on 12/01/2024 when Resident #93 came back from being out on pass. The family member stated 7 doses had been given at home prior to being dropped off at the facility and that lined up with how many of the medication had been dispensed and how many the facility had on hand. She stated she had asked Resident #93's family member to pick up medication from the facility, but the family member wanted Resident #93 to go to outside physician and that was what caused the medication to be filled from outside pharmacy in the first place. During a telephone interview on 12/04/2024 at 9:30 AM, the pharmacy Regional VP stated he expected expired medication to be discarded. He stated diphenhydramine should not be administered past its expiration date. He stated medication would start losing effectiveness in general when it expired. He stated that Resident #2 had no record in the pharmacy's system that insulin Lantus had been pulled from emergency kit and on 11/18/2024 the pharmacy had filled 5 insulin Lantus flex pens. He stated Resident #111 had no record in the pharmacy's system that insulin Lispro had been pulled from emergency kit and on 11/29/2024 the pharmacy had filled 2 insulin Lispro flex pens. He stated directions were typically in the plastic bag or box insulin was dispensed in because there was only so much room on the pens. He stated no negative outcome would occur from label being missing since the most current orders would be in the medication administration record and the resident's last name and expiration date were written on pen. He stated pharmacies were required to label controlled medications on original boxes. He stated the medication box would have a Bold C with [NAME] numerals for the schedule of medication on the box for all controlled medications. During a telephone interview on 12/04/2024 at 12:15 PM, the pharmacy VP of clinical services stated he expected for controlled substances to have count sheets. He stated he felt the failure occurred due to the medications being filled by outside pharmacies that did not always know to send count sheet with medication. He stated he did expect facility staff to make a count sheet if none had been provided and that pharmacy consultants do monitor those count sheets were done. He stated not having count sheets for controlled substances could lead to misappropriation of medication but did not feel any negative outcome had occurred to the residents. The pharmacy VP of clinical services stated he expected medications to be discarded when they were expired and not be kept on medication cart. He stated nurses and medication aides were responsible for disposal of expired medications. He stated he did expect for insulin flex pens should be labeled but did state that labels could come off due to adhesive weakened from refrigeration. He stated, at a minimum, the label should have the residents name and date of expiration / opened on the flex pen if facilities pharmacy label had fallen off or medication obtained from an outside pharmacy. He stated that nurses have been trained to go off the medication administration record and physician orders for directions and did not feel any negative outcome would occur from flex pens not having directions present on them. He stated that pharmacy consultants monitored medications were stored and labeled correctly. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy titled, Medication Labeling, dated 2003 read in part: Medications dispensed by a pharmacy: All legend patient medication regardless of source shall be properly labeled as required in State regulations for Long Term Care Facilities .The nurse receiving the drugs assumes the responsibility for assuring that all items entering the facility are properly labeled. Any item improperly labeled shall be rejected and returned to the originating pharmacy or originating provider .All unit dose medication is labeled with the drug name, strength, lot number and date of expiration .When the multiple dose medication label cannot be attached directly to the multiple dose medication container because of size or shape, the Pharmacy will attach the medication label to the companion box or on a baggie and insert in the medication container. The medication container will have a small auxiliary label attached to it which will contain the prescription number, date, and resident name. After the medication is used it must always be returned immediately to the labeled box or baggie. Strip labels are not required on single dose containers .Directions for administration shall be as specific as possible. Review of the policy titled Storage of Controlled Substance revised on date 07/2012 read in part: The Controlled Substances Act of 1970 replaces existing laws regarding labeling, handling and accountability of narcotics, sedatives, stimulants and other drugs with abuse potential .Drugs listed in schedule II, III, and IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 shall not be accessible to other than licensed nursing, pharmacy and medical personnel designated by the HOME. The Director of Nursing is designated by the facility to be responsible for the control of such drugs.

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	455915	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granbury Care Center	301 S Park St Granbury, TX 76048

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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** 44766 45458 Based on observation, interview, and record review, the facility failed to provide food and drink that was palatable, attractive, and at a safe and appetizing temperature for 4 of 26 Residents (Residents #8, #9, #120, and #376) and one (1) of one (1) kitchen. 1. Residents #8, #9, #120, and #376 voiced concerns of cold food, flavor, and/or texture. 2. One (1) of the three (3) foods sampled on the meal tray was cold. These failures could affect the residents by placing them at risk for malnutrition due to residents' decline in consumption in food, dissatisfaction of meals served, and residents to have unwanted weight loss. Findings include: Record review of Resident #120's Facesheet, dated 12/04/2024, revealed Resident #120 was a [AGE] year-old male, with an admitted into the facility of 09/12/2024. Diagnoses included Parkinson's disease (a progressive neurological condition that affects the brain and causes movement and non-movement issues) with dyskinesia (a range of movement disorders that involve involuntary muscle movements, such as tics, tremors, or spasms), with fluctuations (changes in the ability to move) and Depression (a serious mood disorder that can affect a person's thoughts, feelings, behavior, and sense of well-being). Record review of Resident #120's Admission MDS assessment, dated 09/16/2024, revealed Resident #120 had a BIMS score of 10 which indicated a moderate cognitive impairment. During an interview on 12/02/24 at 2:45 p.m., Resident #120 said the food was the only thing that he would consider that needed to be worked on. Resident #120 said breakfast was usually cold, and the food overall was not very good. Resident #120 said the lunch served on the day of the on-site visit was actually pretty good for once, but it was cold when he ate it. Record review of Resident #376's Facesheet, dated 12/03/2024, revealed Resident #376 was an [AGE] year-old male, with an admitted into the facility of 11/18/2024. Diagnoses included Type II Diabetes Mellitus without complications and Iron deficiency secondary to blood loss (chronic). Record review of Resident #376's Admission MDS, dated [DATE], revealed Resident #376's had a BIMS score of 15 which indicated an intact cognitive response. During an interview on 12/03/24 at 12:27 p.m., Resident #376 said the food was inconsistent and he thought the kitchen should be overhauled. Resident #376 said the food was often cold. Resident #376 said he never received condiments and the food tasted terrible. Resident #376 said he attended the monthly council meeting and residents talked about cold food every meeting. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's Facesheet, dated 12/04/2024, revealed Resident #9 was a [AGE] year-old female, with an admitted into the facility of 05/06/2004. Diagnoses included Other cerebrovascular disease (temporary blockage of an artery in the brain that causes stroke-like symptoms) and Gastro-esophageal reflux disease (a chronic condition that occurs when stomach contents leak into the esophagus). Record review of Resident #8's Annual MDS, dated [DATE], revealed Resident #9 had a BIMS score of 15 which indicated an intact cognitive response. During an interview on 12/03/2024 at 4:34 p.m., Resident #8 said the food being cold was brought up at every resident council meeting that was held on a monthly basis. Resident #8 said the was sent out of kitchen and by the time the aids passed the trays out, the food was not hot. During an observation on 12/02/2024 at 12:25 p.m., a test tray was requested. At 12:40 p.m., preparation of the test tray began, and the tray was placed on the serving cart for Hall G. Plate was picked up with suction cup. Meat placed on plate with mashed potatoes and spinach. Observed a slice of cheese to be placed on top of meatloaf and tray place on the bottom slot of the cart for Hall G. Staff placed a roll, cake, tea, silver ware, and a cover on the tray. At 12:48 p.m., Hall G serving cart left the kitchen and was placed outside the kitchen into the hallway. At 12:55 p.m., the test tray left the area and CNA J took possession of the cart, which she took to Hall G. During an interview on 12/02/2024 at 12:27 p.m., CNA J said the residents on Hall G often complained of tea being watered down and no condiments on the trays. CNA J said she observed no butter on the trays for the current meal. During an observation on 12/02/2024 at 1:10 p.m., the sample tray arrived at the conference room. At 1:11 p. m., the Dietary Manager took the temperature of the spinach, which was 117.5 degrees Fahrenheit, hamburger steak with cheese was 100.2 degrees Fahrenheit, and the mashed potatoes were 117.1 degrees Fahrenheit. The food was sampled by the Dietary Manager and surveyors. During an interview on 12/02/2024 at 1:10 p.m., the Dietary Manager said the food was cold and could be warmer. The Dietary Manager said the meatloaf hamburger could be warmer and would taster better. The Dietary Supervisor said the food temperature did not meet her expectations. The Dietary Supervisor said the residents would not eat the food at the present temperature. During record review of the facility's policy, Daily Food Temperature Control, dated 2012, revealed the facility would assure that food was served within acceptable ranges. 48883

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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. 45458 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 in 1 of 1 kitchen reviewed for service safety, in that: 1. The facility failed to ensure staff wore effective hair restraints. 2. The facility failed to ensure staff practiced appropriate hand hygiene during meal prep. These failures could place residents at risk of food borne illness and cross contamination. During an observation on 12/02/2024 at 10:45 a.m., [NAME] G cut a large sheet cake with no gloves on. [NAME] G had white tipped acrylic nails on her fingertips approximately 1/4 inch in length. [NAME] G touched the cake with her left thumb on the left bottom of the pan as she held the pan to steady to cut. [NAME] G then wiped her left hand on the front of her left pant and pick up a knife and spread cool whip frosting over half of the sheet cake. [NAME] G picked up a permanent marker from a rolling cart that contained a bag of frozen bananas and wrote on a empty zip lock bag. [NAME] G the pushed then cart across the kitchen and pick up small plates with her exposed hands. [NAME] G placed her first three fingers over the top of the plates touching the eating surface with her thumb on the bottom of the plates. [NAME] G then pushed the cart back to the counter where the cake was located and put on gloves and place a piece of cake on each plate without washing her hands. [NAME] G's hair hung out of her net approximately three (3) inches in the back and left side of her head. During an observation on 12/02/2024 at 11:05 a.m., [NAME] G picked up a small plate that contained a piece of cake, with no gloves on, and her finger on her right hand touched the top and side of the plate with the acrylic nail touching the bottom of the cake. During an observation on 12/02/2024 at 11:11 a.m., Dietary Aide H poured tea in glasses wearing rubber gloves and she placed plastic lids on the cups. Dietary Aide H walked to a large 30-gallon gray plastic trash can and picked up the lid while she threw a piece of paper in the container and walked back to the cart with the glasses and proceeded to pour tea and place lids on the glasses without changing gloves or washing her hands. Dietary Aide H's hair hung out of her hair net to the left side and back in small pieces approximately one (1) inch in length. During an observation on 12/02/2024 at 11:15 a.m., Dietary Aide I put silver ware on individual trays located on the serving cart. Dietary Aide I picked up a spoon and a knife by the cutting end of the knife and the round eating end of the spoon. Dietary Aide I then placed a large crate of silver ware from the dishwasher on the counter and used both hands to shuffle the silverware until she found a knife and picked the knife up with the cutting end. Dietary Aide I picked up a spoon and fork with the eating end of the utensil, wiped her left hand across her nose and picked up another fork with the end of the eating side of the utensil. Dietary Aide I's hair hung out of her hair net in the back with several strings of hair approximately four (4) inches in length. (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 12/02/2024 at 12:29 p.m., [NAME] G said she had been at the facility for approximately 3 1/2 years. [NAME] G said she had acrylic nails put on the day prior because she was going on vacation but had to work her final shift prior to her time off. [NAME] G said she had never been told that she could or could not wear fake nails because she had never worn them to work before. [NAME] G said she was only wearing the acrylic nails because she was going on vacation and had to work her shift. [NAME] G said she had been in-serviced on not touching the surface of a plate, but she, had slept since then. [NAME] G said, she could see someone getting mad if she touched the surface of their plate but state people had never eaten out and went into the kitchen of the restaurant. [NAME] G said, if they did, then they would never eat in the restaurant again. [NAME] G said she was aware her hair was not inside her hair net and the hairnet did not fit well but she had a hard time keeping her hair in the net due to the quality of the restraint. During an interview on 12/02/2024 at 1:25 p.m., Dietary Aide H said she had been at the facility for three (3) weeks. Dietary Aide H said she had a hard time keeping her hair under her hairnet. Dietary Aide H said she should have taken her gloves off and washed her hands when she stopped putting lids on the glasses and started brewing tea and completing other tasks. Dietary Aide H said the failure to do so could spread germs and could cause the residents who ate from the kitchen to become sick. During an interview on 12/02/2024 at 1:40 p.m., Dietary Aide I said she had been at the facility for approximately two (2) years. Dietary Aide I said she knew she was supposed to pick up silverware from the handle and not the eating end. Dietary Aide I said she should wear gloves if needed. Dietary Aide I said touching the silverware on the wrong end could contaminate it and the residents could get sick. During an interview on 12/04/2024 at 9:46 a.m., the Dietary Manager said she had been at the facility for approximately one (1) month. The Dietary Manager said wearing acrylic nails while working in the kitchen was not in the facility's policy. The Dietary Manager said wearing gloves and performing several tasks without changing gloves did not meet her expectation and was cross contaminations that could cause food borne illness. The Dietary Manager said the staff were trained on handwashing and knew better but were caught off guard. During an interview on 12/04/2024 at 10:17 a.m., the Dietary Supervisor said she had been in the kitchen approximately one (1) month. The Dietary Supervisor said wearing gloves and completing different task without changing or washing hands did not meet her expectations. She said it was cross contamination and could spread to the residents, workers, and everyone in the facility including family. The Dietary Supervisor said the employee that wore the acrylic nails should not have worn them while working in the kitchen due to cross contamination. The Dietary Supervisor said picking up the silverware from the wrong end did not meet her expectations. She did not agree with the hair sticking out but had not asked if the staff in kitchen could have better quality hair nets. On 12/04/2024 at 10:35 a.m., an attempt was made to contact the Registered Dietician by phone. There was no answer. A message was left to return call. Record review of the facility's policy, Infection Control, dated 2012, revealed clean hair was required to be totally covered with an effective hair restraint. Careful hand washing by personnel will be done in the following situations: - Between handling of dirty dishes, boxes, equipment and handling clean food or utensils. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Between handling cook and uncooked foods. - After each instance of coughing, sneezing, touching face and/or hair. - Sanitation of food preparation surfaces: - All kitchenware and food contact surfaces would be cleaned and sanitized after each use. Record review of the Food Code U.S. Food and Drug Administration 2022 Food Code, dated 01/18/2023, revealed: - Food employees shall wear hair restraints such as hats, hair coverings or nets, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, and utensils. - Food employees shall clean their hands and exposed portions of their arms for at least 20 seconds, using a cleaning compound in a handwashing sink.