STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455929	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granbury Rehab & Nursing	2124 Paluxy Hwy 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews and record reviews, the facility failed to maintain medical records on each resident that were complete and accurately documented for 2 (Resident #2 and Resident #4) of 6 residents reviewed for administration.1. The facility failed to provide care as ordered to Resident #1's left lower leg wound on 06/01/2026.2. The facility failed to document Resident #2's72 hours surveillance, and notifications of the physician and representative in the chart following a fall on 5/27/2026. 3.The facility failed to document Resident #4's fall in nurses notes, 72 hours surveillance, and notifications of the physician and representative in the chart following a fall on 05/26/2026.4. The facility failed to document Resident #4 72 hours surveillance, and notifications of the physician and representative in the chart following a fall on 04/27/2026. These failures could place residents at risk of health and safety due to incomplete medical records. Findings included:Record review of Resident #1's electronic face sheet, dated 06/01/2026, reflected an [AGE] year-old female who was admitted on [DATE] and readmitted on [DATE] with diagnoses including: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (inability to move or weakened left side after a stroke), and muscle wasting and atrophy (decreased muscle and weakness). Record review of Resident #1's quarterly MDS assessment, dated 04/28/2026, reflected Resident #1 had a BIMS score of 14 indicating intact cognition. Further review reflected her range of motion was impaired on both lower extremities, she used a wheelchair for mobility, she was dependent on staff for lower body dressing including putting on and taking off footwear, and she was at risk of developing pressure ulcers. Record review of Resident #1's comprehensive care plan, dated 06/01/2026, reflected Resident #1 needed assistance of one staff for bed mobility and dressing, Resident #1 was at risk for pressure ulcer with new intervention on 6/1/2026 to apply air mattress, and Resident #1 had fragile skin and staff to keep skin clean and dry and use lotion on dry scaly skin as needed. Record review of Resident #1's wound evaluation, dated 05/01/2026, reflected stage 4 pressure wound of the left lateral calf resolved (healed) with recommendations for prevention, continue offloading measures and skin prep daily for 7 days. Review of Resident #1's progress notes reflected: 5/27/2026 nurse practitioner rounded on resident and documented Patient is a high risk of developing pressure sores, indicated by a score of 12 on Braden Scale for Predicting Pressure Sore Risk. 5/31/2026 Re-Opened wound to left posterior calf. 06/01/2026 Plan of care meeting with Resident #1's family member who was concerned about the recurring wound on Resident #1's calf. Air mattress to be placed on resident bed.Record review of Resident #1's physician orders dated 06/02/2026 reflected: Order with start date of 06/01/2026 cleanse 1 x 1 cm opened area to left calf region with NS (normal saline), apply telfa (sterile, non-adherent wound pad) non-adherent pad, then cover with bordered gauze daily until healed in the morning for wound care; Order with start date of 06/02/2026 cleanse area to posterior (toward the back of) left calf with NS or wound cleanser, pat dry, apply mupirocin (prescription antibiotic ointment) ointment to wound bed, then cover with bordered gauze daily and PRN until healed.Record review of Resident #1's June 2026 TAR reflected: No staff documented that care was performed on the 10p - 6a shift on 5/2/2026 for Left posterior calf: Healed wound: Apply skin prep (continued on next page)

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

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	every shift and LOTA for 7 days every shift. There was no rationale why treatment was not performed.Record review of Resident #1's May 2026 MAR reflected: 06/01/2026 LVN B documented she completed the wound care scheduled for 9:00 a.m. cleanse 1 x 1 cm opened area to left calf region with NS (normal saline), apply telfa (sterile, non-adherent wound pad) non-adherent pad, then cover with bordered gauze daily until healed.Record review of facility document titled weekly measurements, dated 6/1/2026, reflected Resident #1 had a wound to the left posterior leg (calf), old pressure reopened with measurements of 3 x 1.5 x 0.1.During an observation and interview on 06/01/2026 at 4:10 p.m., Resident #1 was sitting in a reclining wheelchair in her room and her left leg was propped on a wedge. Her family member was sitting beside her. Resident #1's family member stated the wound on Resident #1's left leg started looking redder last Friday, and RN A assessed the wound and did not feel it needed intervention. Resident #1's family member stated the nurse practitioner was in the building and looked at the leg also with no new intervention. Resident #1 stated, over the weekend, the wound opened and the nurse put a dressing last on Sunday. Resident #1stated no wound care had been done today. Resident #1's family member pulled up her pant leg and 4 x 4 island dressing observed covering the skin on Resident #1's left calf with the date of 5/31 written on the dressing. Resident #1 stated there was no consistency with wound care in the past. Resident #1's family member stated the facility was going to try an air mattress. Resident #1's family member stated she felt the wound developed because her mother may be putting her right foot / ankle under the left calf when she was in bed and thought that staff should be putting a pillow in between her legs to help prevent the sore from getting worse. She stated the staff should know how to take care of Resident #1 without her having to tell them.During an observation and interview on 06/02/2026 at 8:30 a.m., Resident #1 was lying in her bed and leg was offloaded with a wedge. RN A performed wound care to Resident #1's left calf. RN A stated she had performed the wound care for Resident #1 yesterday late afternoon. She showed the old dressing with the date of 06/01/2026 proving that the wound care had been performed. She stated she did not know why LVN B charted that she had performed the dressing change on 06/01/2026 morning because the dressing she took off later in the day on 06/01/2026 was dated 5/31 from Sunday. Resident #1's wound bed was pink with small amount clear drainage, no unhealthy tissue present, no odors, and no concerns were observed with the wound care RN A provided. Resident #1 did not voice any pain during the treatment. RN A stated that Resident #1 did have a pressure ulcer that was healed in the same area. She stated Resident #1 had been seen by the wound care physician that rounded until it was healed. She stated she obtained measurements of Resident #1's wound yesterday when she performed the treatment and would provide the document where those measurements were documented. She stated she had to update the order in the medical record that morning so that the treatment would show up on the TAR because it was showing up on the LVN MAR before which may have led to the confusion. She stated nurses should not document a treatment that they did not perform.During an interview on 06/02/2026 at 8:55 a.m., LVN B stated she did not perform wound care on Resident #1's left calf yesterday. She stated she was not aware that she had documented that she completed the wound care. She pulled up Resident #1's MAR and saw that she did chart completed at 10:45 a.m. on 06/01/2026. She stated she must have documented the treatment done in error. She stated she was not told about the wound during shift change, and that may have led to her missing the wound care on the MAR. She stated nurses could let each other know about changes in resident condition by putting in a communication note and she did not remember seeing the communication note on Resident #1. She stated she knew not to document treatments that she did not perform and did it in error. She stated documenting a treatment that wasn't done could cause the resident to miss that treatment and could make the wound worsen.During an interview on 06/02/2026 at 9:05 a.m., the DON stated she expected nurses to document only the treatment that they administered. She stated it was not appropriate for a nurse to document a treatment was performed even when another nurse performed that treatment because it could lead to the treatment being missed. She stated there was a communication note in Resident (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#1's chart and that was how the nurses could communicate changes in condition. She stated LVN B should have known about the wound from the communication note and it should have been communicated verbally at shift change. She stated RN A knew about the wound because of the communication note and that was how she knew to perform the wound care on 06/01/2026. She stated not performing wound care could cause the wound to become worse but stated the wound care was performed. She stated she had a conversation with Resident #1's family member yesterday during a care plan meeting and the facility did get an air mattress to help offload skin but she was unsure if Resident #1's wound met the definition of a pressure ulcer since it was not over a bony prominence. She did not believe the treatment being performed in the afternoon by the treatment nurse would have caused any wound deterioration but stated that it did not make it appropriate for LVN B to document it was done when she did not perform the wound care. She stated she monitored that nurses were performing treatments and documenting during morning meetings. She stated she was not aware that LVN B had documented the treatment when she did not perform it. During an interview on 06/02/2026 at 2:55 p.m., the interim ADMN stated nurses were responsible for documenting what happened on their shift. He stated he expected nurses to follow policy for documenting treatments. He stated the DON monitored the nursing staff documented and performed patient treatments. He stated not documenting correctly could cause confusion on what occurred and could interfere with the next shift not being aware of wound care needs. Record review of the facility's in-services, titled False Documentation, dated 02/18/2026, reflected Charting something that is not true means documenting information in the medical record that did not actually occur, was not observed, or is knowingly inaccurate. In healthcare, this is considered falsification of medical records. What this includes.Charting care of treatments that were not provided.If you didn't see it, do it, hear it, or verify it - don't chart it. LVN B's signature was on the in-service along with other nursing staff members.Review of the facility's policy, titled Clinical Document Guideline, dated 02/14/2020, reflected Clinical document entries should be objective, factual information and communication that pertain to the care of the patient i.e. patient centered.Each healthcare team member must document his or her own clinical record entries.Review of the facility's policy, titled Skin Prevention and Management Guidelines, dated 02/14/2022, reflected Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present.Interventions will be documented in the care plan and communicated to all relevant staff. Compliance with interventions will be documented in the monthly wound note summary charting.Record review of Resident #2's electronic face sheet, dated 06/01/2026, reflected an [AGE] year-old female admitted on [DATE] with diagnoses including dementia (a condition where the brain gradually loses its ability to think, remember, and make decisions, affecting daily life), repeated falls, muscle wasting and atrophy (a wasting or thinning of muscle mass). Record review of Resident #2's annual MDS assessment, dated 05/01/2026, reflected a BIMS score of 6 indicating severe cognitive impairment. Further review reflected she used a wheelchair for mobility and had range of motion impairment to one of her lower extremities. She needed supervision for transfers and had no falls since last assessment. Record review of Resident #2's comprehensive care plan, dated 06/01/2026, reflected Resident #2 needed limited assist with toileting and had fall due to debility and poor safety awareness with interventions to anticipate and meet needs, ensure that she wore appropriate footwear when mobilizing in wheelchair, keep bed in the lowest position when not providing care, and make sure call light was in reach. Record review of Resident #2's progress notes, dated 05/27/2026, reflected Resident #2 was found in bed with wet wipes cleaning left posterior forearm. Resident stated that she got up in the middle of the night to use the bathroom and when she was getting off of the toilet her shoe slipped off and she slid down to the floor. Physical exam completed and vital signs taken. ADON notified. There was no documentation of resident representative or physician notifications. There was no documentation of after-fall surveillance every shift for 72 hours. Record review of Resident #2's medical chart assessments reflected neuros were started and documented at (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	least every shift for 72 hours following her un-witnessed fall on 05/27/2026.Record review of facility's incident report , dated 05/27/2026, reflected Resident #2 had an un-witnessed fall, was alert and oriented to person, place, and situation, had skin tears to left forearm and left knee, no physical environment factors, had gait imbalance, and was ambulating without assistance. The DON, physician, family member, and ADON were notified. 2/3.Record review of Resident #4's electronic face sheet, dated 06/01/2026, reflected a [AGE] year-old female admitted on [DATE] and discharged on 05/29/2026 to acute care hospital with diagnoses including dementia (a condition where the brain gradually loses its ability to think, remember, and make decisions, affecting daily life), multiple myeloma (type of blood cancer that affects plasma cells in your bone marrow, causing problems with your bones, blood, and immune system), and malignant neoplasm of liver and intrahepatic bile duct (cancer that has spread to the liver and small tubes inside the liver that carry bile). Record review of Resident #4's admission MDS assessment, dated 04/28/2026, reflected a BIMS score of 4 indicating severe cognitive impairment. Further review reflected she used a wheelchair for mobility, needed substantial assistance for bed mobility and transfers, and had a life expectancy of less than 6 months.Record review of Resident #4's progress note, dated 04/27/2026, reflected resident had a witnessed fall on 4/27/2026 in the dining room where she fell out of wheelchair and sustained abrasion to left wrist. There was no documented notification of fall to representative or physician observed. There was no documentation of after fall surveillance every shift for 72 hours . Record review of Resident #4's progress notes, dated 05/26/2026 - 05/28/2026, reflected no evidence of fall, representative, or physician notification of fall. There was no documentation of after fall surveillance every shift for 72 hours. Record review of Resident #4's medical chart assessments reflected neuros were started and documented at least every shift for 72 hours following an un-witnessed fall on 05/26/2026. Record review of Resident #4's post fall evaluation, dated 05/26/2026, reflected Resident #4 rolled out of bed onto a fall mat.During an interview on 06/02/2026 at 8:40 a.m., RN A stated she did not see Resident #2 fall but was told by Resident #2 that she fell in the bathroom. She stated she assessed Resident #2, did an incident report, and performed wound care on resident #2. She stated she put in a progress note on Resident #2 and neuro assessments were started and documented under the assessments tab which lasted for 72 hours. She stated she did not know the incident report did not flow into the medical record with physician or representative notification but she documented those notifications on the incident report. She was unaware of any further documentation that would be needed after a fall. She stated neuro assessments were performed whenever there was an unwitnessed fall.During an interview on 06/02/2026 at 8:55 a.m., LVN B stated when a resident fell, the nurse would assess the resident, start neuro assessments if the fall was unwitnessed that would last for 72 hours which were documented under the assessments tab in the medical record. She stated the nurse called the physician and representative and triggered an incident report in the medical record. She stated the incident report would populate a nurses note. She did not voice any further documentation that would be needed after a fall. During an interview on 06/02/2026 at 1:21 p.m., the DON stated there should be a nurses note entered into the medical record by the nurse on duty when the fall occurred. She stated they did not know why there was no nurses note documenting Resident #4's fall on 5/26/2026. She stated the nurses documented notification of management, physician, and resident representative in the incident reports. She stated the nurses may be thinking that incident report was going into the medical record and needed to be taught again that it was an internal QA document and not part of the medical record. She stated the nurses had access to the incident reports so she did not feel, not having a progress note, would interfere with direct care staff being notified of a fall. She stated families and other individuals would not be able to see the incident report such as state agency unless the incident reports were requested so could be confusing on whether there was a fall or not. She stated she monitored that falls were documented appropriately when she completed the second section of post fall evaluation note. She stated she had not noticed that there wasn't a progress note about Resident #4's fall on (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/26/2026. She stated she was unsure what the policy stated about documenting falls in the medical record.During a follow-up interview on 06/02/2026 at 2:50 p.m., the DON stated the fall policy stated for staff to document every shift post fall in the medical record of residents who had a fall for 72 hours. She stated the nurses should document the post fall by initiating a 72 hour occurrence assessment which had not been initiated after the falls for Resident #2 and Resident #4. She stated the nurses were assessing the residents post fall every shift but were not documenting those assessments and for Resident #2 and Resident #4 neuro assessments were documented after 2 of the 3 falls. She stated the nurses needed more education on documentation post falls. During an interview on 06/02/2026 at 2:55 p.m., the interim ADMN stated he expected for nurses to document what happened on their shift. He stated he expected for the nurses to follow policy when performing nursing assessments and documentation. He stated the DON monitored the nurses were documenting appropriately and he monitored the documentation some including the post fall neuro assessments during the morning meetings. He stated not documenting correctly could cause confusion on what occurred and could interfere with the next shift not being aware of incidents. Record review of the facility's policy titled Fall Management System, dated 02/19/2021, reflected A licensed nurse will complete an Incident/Accident Report after each fall. The Incident/Accident report is not part of the medical record and documentation is not to reflect that an incident report was completed. The licensed nurse will document the fall on the nurses notes of the medical record. The documentation will reflect notifications to legal representatives and attending physician or their agent of the fall. The licensed nurse will assess and document the condition of the resident at least once per shift for at least 72 hours post fall. Documentation in the nurses' notes and/or care plan will reflect interventions attempted.An Administrative nurse will ensure that the fall is logged on the Resident Fall Tracking Log and is entered on the Incident Report QA/CQI form.