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	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granbury Rehab & Nursing	2124 Paluxy Hwy Granbury, TX 76048

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility must not use any individual working in the facility as a nurse aide for more than four months on a full-time basis unless that individual has completed a training and competency evaluation program for 1 of 4 (NA C) non-certified nurse aides reviewed. The facility failed to ensure full-time NA C was certified within four months of the date of hire.This failure placed residents at risk of receiving inappropriate care from an individual whose skill level was not known. Findings included:Record review of the facility's employee files reflected NA C was hired on 12/03/2025 as a full-time nurse aide in training. Further review reflected NA C filled out employment application for CNA position on 11/19/2025. Pre-Employment Checklist for NA C with Yes circled by CNA Certification Verification and completed by [NA C name] on 12/03/2025. No staff member signed or dated approved to start employment section of NA C's Pre-Employment Checklist form.Record review of NA C's training documents reflected he completed skills check-off form on 12/22/2025 and was satisfactory for direct patient care. Further review reflected a NATCEP certificate dated 12/22/2025 for completing the nurse aide training program at [facility name].Record review of Nurse Staffing schedules from April 23, 2026 - May 1, 2026 reflected NA C worked as only nurse aide on hall with one nurse:-Hall C from 2 p.m. - 10 p.m. on April 23, 2026;-Hall C from 2 p.m. - 10 p.m. on April 24, 2026;-Hall C from 2 p.m. - 10 p.m. on April 27, 2026;-Hall C from 2 p.m. - 10 p.m. on April 28, 2026;-Hall C from 2 p.m. - 10 p.m. on April 29, 2026;-Hall C from 2 p.m. - 10 p.m. on April 30, 2026;-Hall C from 2 p.m. - 10 p.m. on May 1, 2026;-Hall C from 2 p.m. - 10 p.m. on May 4, 2026;-Hall C from 2 p.m. - 10 p.m. on May 5, 2026;-Hall C from 2 p.m. - 10 p.m. on May 6, 2026;-Hall C from 2 p.m. - 10 p.m. on May 7, 2026;-Hall A from 6 a.m. - 2 p.m. on May 9, 2026;-Hall C from 2 p.m. - 10 p.m. on May 11, 2026;-Hall B from 2 p.m. - 10 p.m. on May 12, 2026;-Hall B from 2 p.m. - 10 p.m. on May 13, 2026;-Hall B from 2 p.m. - 10 p.m. on May 14, 2026;-Hall B from 2 p.m. - 10 p.m. on May 15, 2026;-Hall B from 2 p.m. - 10 p.m. on May 18, 2026; -Hall B from 2 p.m. - 10 p.m. on May 19, 2026;-Hall B from 2 p.m. - 10 p.m. on May 20, 2026;-Hall B from 2 p.m. - 10 p.m. on May 21, 2026;-Hall C from 2 p.m. - 10 p.m. on May 22, 2026;-Hall C from 2 p.m. - 10 p.m. on May 25, 2026;-Hall B from 2 p.m. - 10 p.m. on May 26, 2026; -Hall B from 2 p.m. - 10 p.m. on May 27, 2026; -Hall C from 2 p.m. - 10 p.m. on May 28, 2026;-Hall B from 2 p.m. - 10 p.m. on June 1, 2026; -Hall B from 2 p.m. - 10 p.m. on June 2, 2026; -Hall B from 2 p.m. - 10 p.m. on June 4, 2026;-Hall B from 2 p.m. - 10 p.m. on June 5, 2026;-Hall B from 2 p.m. - 10 p.m. on June 8, 2026;-Hall B from 2 p.m. - 10 p.m. on June 9, 2026;-Hall B from 2 p.m. - 10 p.m. on June 10, 2026;-Hall C from 2 p.m. - 10 p.m. on June 15, 2026;-Hall B from 2 p.m. - 10 p.m. on June 16, 2026;-Hall B from 2 p.m. - 10 p.m. on June 17, 2026;-Hall B from 2 p.m. - 10 p.m. on June 18, 2026;-Hall C from 2 p.m. - 10 p.m. on June 19, 2026;-Hall D from 10 p.m. - 6 a.m. on June 23, 2026.Record review of the facility census report, dated 06/23/2026, reflected there were 24 residents who resided on Hall B and 20 residents who resided on Hall C.During a telephone interview on 06/24/2026 at 3:45 p.m., NA C stated he was hired as a nurse aide in training and went through the CNA class at the facility. He stated he passed his written exam for certification but did not pass his clinical exam the first attempt. He stated he was scheduled for the clinical exam again and took it without passing in April 2026. He did not give specific date that second attempt performed. He stated he was let go from the facility today (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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and stated the facility told him he should have been let go in April 2026 when he did not get certification. He stated the facility told him that it was overlooked then because the facility went through a change in ownership. He stated he normally worked on the 2-10 shift in the facility. He stated he worked with RN E and CNA D some and both were present at times when he performed resident care. He stated he was allowed to pass water and perform resident care with other staff present. He denied transferring residents, performing incontinent care, assisting with feeding, and showering residents alone.During an interview on 06/24/2026 at 3:52 p.m., CNA D stated she would assist NA C when he needed her for resident transfers. She stated she worked on a different hall, but the nurses and CNAs would help out other areas when needed. She stated she did not know if another CNA or nurse was with NA C all the time when he performed resident care. She stated she was not aware of any stipulations on what NA C could or could not do when working in the facility. During an interview on 06/24/2026 at 3:57 p.m., RN E stated she had been working at the facility for approximately one month. She stated she was unsure if NA C ever performed resident care without another CNA or nurse present. She stated she was not comfortable answering questions on what NA C could or could not do in the facility.During an interview on 06/25/2026 at 10:45 a.m., ADON B stated she did participate in the scheduling of staff including nurse aides among other duties. She stated NA C had worked as an NA on the floor after he went through the nurse aide course at the facility. She stated NA C was allowed to continue to work at the facility after he had failed his clinical test due to the facility was trying to work with him and help him get certified. She stated NAs were not allowed to transfer someone alone but could do incontinent care and showers alone because NA C had completed the skills check-off at the facility as competent. She stated the DON would know more about NA C's training, skills check-offs, and when he had failed his clinical test for certification. She stated she worked on the halls and monitored the nurses and nurse aides every day that she worked. She stated she had no concerns with NA C's direct resident care when she worked. She stated she had not been told he was not eligible to continue working in the facility after not being certified within four months. She stated she did not feel NA C was unsafe to provide resident care.During an interview on 06/25/2026 at 12:15 p.m., the HR stated she started working for the facility in December of 2025. She stated she did not have any information of NA C's job description with signature in his employee file. She stated she did not have any information of NA C's skills check-off form in his employee file, but ADON B may have that information. She stated she would put the skills check-off forms in the employee's file if she was given those documents but did not have a process of monitoring that she was given those documents. She stated she was able to provide NA C's employment application that stated he was applying for CNA position. The HR stated she did not know why NA C's Pre-Employment Checklist form was not signed or dated by a staff member approving he was approved to start employment. She stated the ADMN was responsible for signing the Pre-Employment Checklist form. She stated NA C was interviewed for job on 11/19/2025 by ADON B but she did not know when he was approved to be hired.During an interview on 06/25/2026 at 1:25 p.m., the DON stated ADON B was responsible for nursing staff scheduling. She stated she had looked for NA C's signed job description and could not find the document. She stated she was able to find and provided the skills check-off form for NA C dated 12/22/2025 along with his NATCEP certificate dated 12/22/2025 for completing the nurse aide training program at [facility name]. She stated she expected nurse aides to be demoted to hospitality aides who could not obtain certification by 120 days after hire. She stated HR was responsible for keeping up with licensures and certifications. She did not give an explanation of why NA C continued to be allowed to work as a nurse aide. She stated she felt confident in his ability to provide resident care since he had passed the skills check off during his nurse aide training at the facility. She stated she did not know why he was unable to pass the clinical test for his certification but stated he may just not be good at taking tests because of nerves. She stated she did not feel any negative impact on residents had occurred due to him continuing to work as a nurse aide but stated there was a potential for infection spread and falls from (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	uncertified staff working after not being able to pass certification tests. She stated she had looked for a policy on sufficient and competent nurse staffing and could not find one. She stated she would continue to look but the company had gone through a change in ownership and the policies had changed.During an interview on 06/25/2026 at 2:23 p.m., the interim ADMN stated he expected HR to monitor that nurse aides were certified. He stated nurse aides should be termed if they were unable to get certified within 4 months per regulation. He stated not being certified could cause residents to be at a greater risk for infections and falls from inappropriate care. He stated NA C should have had a person with him when he provided care at all times. The interim ADMN stated he had NA C termed on 06/24/2026 when he found out that he had been allowed to work full time over 4 months without obtaining his certification. Record review of the facility's document titled, Facility Assessment for [facility name], dated 06/20/2026, reflected Our facility considered the ethnic, cultural, religious, and clinical characteristics of the resident population to determine the skills and competencies required to meet out resident needs. We identified four categories of competencies: knowledge, assessment, pharmacological/treatment/care considerations, and technical/hands-on skills. Refer to the worksheet Facility Education / Staff Competencies Necessary to Care for resident Population. The worksheet identified which staff require certain competencies and skill sets, and the frequency of education. See also Staff Development Training Plan.At the time of exit on 6/25/2026 at 3:30 PM, the requested policy for Sufficient / Competent Nurse Staffing was not provided by by the interim ADMN or the DON.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and record review the facility failed to post nurse staffing information that included the resident census for 70 days of 70 days reviewed for required postings.The facility failed to update the daily nurse staffing required posting in a prominent location of the facility since April 16, 2026.This failure could place all residents, their families, and facility visitors at risk of not having access to information regarding staffing data and the facility census. Findings included:During an observation on 06/24/2026 at 10:52 a.m., the daily nurse staffing was posted in a binder where visitors signed in at desk in front lobby. The date on the most current daily nurse staffing posting was April 16th 2026.During an observation on 06/25/2026 at 8:20 a.m., the daily nurse staffing was posted in a binder where visitors signed in at desk in front lobby. The date on the most current daily nurse staffing posting was April 16th 2026.During an interview on 06/25/2026 at 10:45 a.m., ADON B stated she was responsible for posting the daily nurse staffing. She stated back in April she could no longer pull the report from the computer system as she had been doing. She stated the daily staffing would be posted in the binder in the front lobby for visitors to review. She stated she was not sure if anyone was posting it anymore but would ask the interim ADMN if he was able to pull the report from a computer system. She stated she had not asked prior to today if anyone had access to a system to pull report.During an interview on 06/25/2026 at 11:35 a.m., the interim ADMN stated his expectation would be for the daily nurse staffing posting to be posted daily. She stated ADON B was responsible for posting that report in the binder at the front entrance for visitors, families, or residents to review. He stated no posting could cause people to not be informed about the census or nursing staff hours. He stated he was not aware ADON B was having issues with printing out the posting until today. He stated ADON B was using another system for the posting and with the change in ownership the previous system was no longer available. He stated ADON B should have notified him that she was not able to pull the information. He did not feel any negative impact had occurred from the posting not being updated since April 16th 2026 because he would have provided that information had he been asked.During an interview on 06/25/2026 at 1:25 p.m., the DON stated her expectation would be for the daily nurse staffing posting to be updated daily and placed in the binder at the entrance to the facility per regulation. She stated that if visitors, families, or residents wanted to know about staffing, they could always look in the schedule binder at the nurses' station. She stated the schedule binder did not have the census documented on it. She stated she did not agree with the requirement because anyone could ask any member of management for the information and it would be provided. She stated ADON B was responsible for the daily nurse staff posting but she was ultimately responsible for the posting being updated daily.Review of facility policy titled, Posting Direct Care Daily Staffing Numbers, dated August 2022, reflected Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents.1. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPN, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.2. Directly responsible for resident care means that individuals are responsible for residents' total care or some aspect of the residents' care including but not limited to: assisting with activities of daily living (ADLs), administering medications, supervising care provided by CNAs, and performing nursing assessments. Medication aides, feeding assistants, hospice staff, private duty aides and administrative staff are not calculated in direct care staffing numbers. Shift staffing information is recorded on a form for each shift. The information recorded on the form shall include the following: a. The name of the facility; b. The current date (the date for which the information is posted); c. The resident census at the beginning of the shift for which the information is posted; d. Twenty-four (24)-hour shift schedule operated by the facility; e. The shift for which the information is posted; f. Type (RN, LPN, LVN, or CNA) and category (licensed or (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	non-licensed) of nursing staff working during that shift who are paid by the facility (including contract staff); g. The actual time worked during that shift for each category and type of nursing staff; and h. Total number of licensed and non-licensed nursing staff working for the posted shift.

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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** Based on observation, interview and record review the facility failed to ensure that residents were free of a med error rate of 5% or greater for 2 (Resident #7) of 25 medication pass opportunities reviewed for medication administration. The facility failed to ensure the medication error rate (8%) was less than 5% for Resident #7. This failure placed residents at risk of incorrect doses of medications and optimal therapeutic response. Findings included: Record review Resident #7's electronic face sheet, dated 06/25/2026, reflected an [AGE] year-old female admitted on [DATE]. She had an active diagnoses of GERD (indigestion caused by gastric fluids refluxing back into the esophagus after consumption), chronic kidney disease (inability for the kidneys to filter out toxins from the blood and get rid of excess fluids through urination) and CHF (chronic heart disease causing heart to not pump as much blood through the body with every beat). Record review of Resident #7's electronic physician orders, dated 06/25/2026, reflected an order for: Pantoprazole sodium 20mg tablet delayed release give 20mg by mouth one time a day for GERD ordered on 04/02/2026; Furosemide 20mg tablet give 0.5 tablet (10mg) by mouth one time a day every other day for CHF ordered on 04/01/2026. During an observation on 06/25/2026 at 8:31a.m., LVN F gave pantoprazole sodium 40mg tablet and furosemide 20mg full tablet to Resident #7. During an interview on 06/25/2026 at 8:45 a.m., LVN F stated she gave Resident #7 40mg of pantoprazole sodium and 20mg of furosemide. She stated the facility received medications from Resident #7's hospice provider and she did not know why the pharmacy delivered a different dose of medications that did not match the physician orders. She stated she should have noticed that the medication doses did not match the physician orders and get clarification about the physician order prior to administering the medications. She stated she did not notice because she was used to giving the dose on the pharmacy medication label. She stated she would call and get clarification about the medication dosage.During an interview on 06/25/2026 at 1:25 p.m., the DON stated her expectation would be for nurses to check that the dose of medication being administered matched the physician orders. She stated that if there was a discrepancy with the dosage and order, she expected for the nurse to stop and get clarification about the physician order prior to administering the medication. She stated administering a dose of medication that did not match the physician order would be considered a medication error because one of the rights of medication administration was right dose. She stated not receiving enough pantoprazole sodium could cause exacerbated epigastric symptoms (heart burn). She stated not receiving enough furosemide could cause too much fluid in the body and receiving too much furosemide could cause too little fluid in the body. She stated the nurses had been trained on the rights of medication administration and she did not know why LVN F did not check the dosage to the physician order prior to medications being given. She stated ADON A monitored nurses administering medication but she was ultimately responsible for monitoring nursing staff including medication administration.During an interview on 06/25/2026 at 2:20 p.m., ADON A stated she monitored nurses were passing medications appropriately. She stated LVN F had always done good when she monitored her administering medications in the past. She stated LVN F may have been nervous from medication pass being observed that could have caused her to not administer the correct dosage. She stated staff should follow the medication rights including right dose before administering medications to residents. During an interview on 06/25/2026 at 2:23 p.m., the interim ADMN stated he expected for nurses to pass the right medication dosage when administering medications. He stated ADON A was responsible for monitoring that nursing staff administered medications appropriately. Record review of facility policy titled Administering Medications, dated April 2019, reflected 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.