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	09/18/2025

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility failed to consider the views of the resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility or to demonstrate their response and rationale for such response for 9 of 9 confidential resident council members reviewed for resident/group response. The facility failed to provide a verbal or written response to the Resident Council addressing the grievances reported from their meetings on February 2025, March 2025, and August 2025 which included issues with nursing services, dietary services, and housekeeping services. These failures could place residents at risk of unresolved grievances, a decreased sense of self-worth, and a decline in quality of life.Findings Included:Record review of the Grievance logs for February 2025 reflected Resident Council made 2 grievances. The first grievance dated 2/28/2025 involving housekeeping services reflected the SW documented that residents were notified of resolution by one-to-one discussion. The second grievance dated 2/28/2025 involving nursing services reflected no documentation that residents were notified of resolution. Record review of the Grievance logs for March 2025 reflected the Resident Council made 3 grievances. The first grievance dated 3/27/2025 involving housekeeping services reflected the SW documented that residents were notified of resolution by one-to-one discussion. The second grievance dated 3/27/2025 involving dietary services reflected the SW documented that residents were notified of resolution by one-to-one discussion. The third grievance dated 3/27/2025 involving nursing services reflected the SW documented that residents were notified of resolution by one-to-one discussion. Record review of the Grievance logs for August 2025 reflected the Resident Council made 10 grievances dated 8/28/2025. There were 3 grievances involving nursing services and seven grievances involving dietary services. On all the grievances the SW documented that residents were notified of resolution by one-to-one discussion. Record review of the Grievance logs reflected an undated grievance by Resident Council involving residents not being assisted outside for smoke breaks by staff at designated time with no facility follow up documented and no documentation that residents were notified of resolution. In a confidential group interview at an undisclosed date at an undisclosed time, 9 of 9 residents stated that no one had gotten back with them about their grievances from August. They stated that rarely anyone had come into the meeting and verified those people were the administrator and the dietary manager. They stated the issues they had filed grievances on all the issues were still ongoing. During an interview on 9/17/2025 at 10:53 a.m., the AD stated she was present during the Resident Council meetings per the residents' request. She stated she would take notes and would fill out grievance forms for the council members. She stated she would hand the completed grievance forms to the SW. The AD stated she believed those forms were then distributed to the various departments. She stated that no staff would come to the Resident Council meetings to go over the resolutions unless the Resident Council members asked for those staff members to attend. She stated the ADMN and DM had come to the meeting before to discuss resolutions. She stated she felt bad that the residents felt they were not notified of grievance notifications. She confirmed that there had never been a nurse or SW invited to the meetings. She stated there had not been any follow up on the grievances that she was aware of. She stated her plan moving forward would be to get the grievance resolutions from the SW prior to the Resident Council meetings to discuss them with the council members. During an interview on 9/17/2025 at 11:17 a.m., the SW stated she was responsible for grievances. She stated she would receive grievance forms and then would hand them to the department head they pertained to. She stated the department heads would then fill out the form with what they had done and hand them back to her. She stated she would ask for the form if she did not get them back. She stated one-to-one meant that she would talk to the resident or family member who made the grievance about how it was resolved. She stated that if the resident council had made the grievance, she believed one-to-one meant that she may have spoken to the Resident Council president but had no documentation of that occurring. She stated that moving forward, the facility decided the AD would announce the resolutions at the next council meeting but that had not been done before. She stated she monitored grievances weekly. She stated the failure occurred due to there was too much for one person to do especially if the grievance was resolved by another department head. She stated the effect of not notifying the Resident Council members of resolution to their grievances could cause them to feel that their concerns were not acknowledged. During an interview on 9/17/2025 at 1:40 p.m., the ADMN stated he expected for grievances to be handled by the SW. He stated after grievances were made, the department heads would investigate the issue and then the person who

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews and record reviews, the facility failed to follow their written policies and procedures that prohibit and prevent abuse, neglect, exploitation of residents and misappropriation of resident property 2 of 15 employees (RN J and DM) reviewed for employability.The facility failed to ensure the record of the initial EMR/NAR check was completed and maintained for DM hired on 7/1/2025 per facility policy. The facility failed to ensure the initial EMR check was completed and maintained for the DM hired on 06/2/2025 per facility policy. These findings placed residents at risk of receiving care by someone that was unemployable. The findings included: Record review of the RN J's employee file revealed a hire date of 07/14/2025 and no evidence of an EMR/NAR check was completed prior to hire. Record review of the DM's employee file revealed a hire date of 06/03/2025 and no evidence of an EMR/NAR check was completed prior to hire. During an interview on 09/18/2025 at 2:30 PM the HR stated she was responsible for running EMR checks upon hire and annually. The HR stated she remembered running RN J's but must have put in the shredder because she could not locate a copy of the EMR. The HR stated the only way to prove she ran the EMR was the copy of the EMR. The HR stated she ran an EMR on 9/16/2025 for RN J, which was after the survey team entered the facility. The HR stated DM was contracted and she assumed the company that was contracted was running checks. The HR stated the facility could not provide a copy of EMR check being completed. During an interview on 9/18/2025 at 4:30 PM the ADMN stated his expectation was EMR checks were to be ran prior to hiring for all staff and should have been maintained. The AMDN stated HR was responsible for running and maintaining EMR checks in resident file. The ADMN stated he was ultimately responsible to ensure employee records were maintained. The ADMN stated residents could have been affected because policy was not followed. The ADMN stated what led to failure was a new HR staff. The ADMN stated that the DM was contracted staff, and he was at the mercy of the contracted company. The ADMN stated they should have had an EMR completed for the DM because their policy required all employees to have an EMR check completed, if they had contact with residents. Record review of facility policy titled, Texas Background Screening Procedures dated 04/27/2021 revealed, All offers of employment are contingent upon the prospective Team Member (Applicant) successfully completing a background screening process conducted according to applicable federal and state laws.Employability Status Check. Regardless of position ALL Team Members are subject to this verification.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not develop a baseline care plan, or comprehensive care plan with necessary information within 48 hours of the resident's admission for 2 (Resident #1 and Resident #54) of 24 residents reviewed for care plan completion.The facility failed to complete a new baseline care plan for Resident #1 upon admission.This failure could place residents who were newly admitted at risk for not receiving necessary care and services or having important care needs identified.Resident #1Review of Resident #1's Face Sheet revealed a [AGE] year-old male initially admitted on [DATE] with a recent admission date of 09/10/2025. Resident #1's medical diagnoses of Pneumonia, acute respiratory failure, depression, cognitive communication deficit and anemia. Review of Resident #1's Baseline Care Plan initiated 08/16/2025 and reviewed/revised upon readmission, 09/10/2025, had used the prior Baseline Care Plan. There was no evidence of updated signatures after readmission. Review of Resident #1's physician orders reviewed on 09/17/2025 revealed: Anticoagulant monitoring, Anticonvulsant medication, antidepressant, CPAP at night. Record review of Resident #54's baseline care plan revealed there was no evidence that the summary of the baseline care plan was given to Resident #54 or her representative. During an interview on 09/17/2025 at 2:54 PM, the ADON stated, the admitting nurse and the RN on duty were responsible for making sure the baseline care plans were updated and completed. She stated it was the DON who monitored signatures and signing off on the baseline care plans. The ADON stated the policy for discharged to home residents with a readmission was based on their referral information and discussed with the IDT team. She stated for Resident #1, they considered his admission a new admission and should start all new admission paperwork and a new baseline care plan. The ADON stated when Resident #1 was readmitted they had not populated a new Baseline Care Plan. She stated in reviewing Resident #1's Baseline Care Plan, it had not been completed based on the facility policy and recommendations. During an interview on 09/17/2025 at 3:10 PM, the SW stated she did all the notifications for Baseline Care and conference meetings. She stated she believed the deadline for care plan conferences was 72 hrs. The SW stated IDT Team were to address each issue. The SW stated it was the nurses who monitored, and it would have been their responsibility to address dialysis at the care plan and baseline care conference. She stated they (IDT team) review the diagnosis and do not know why the dialysis diagnosis was missed. The SW stated, the failure occurred with the IDT team, that if they knew she had been on dialysis coming in it should have been placed on the Baseline Care Plan. During an interview on 09/18/2025 at 8:16 AM, the DON stated, any RN monitored and/or was responsible to follow up on the responsibilities of making sure that all paperwork was completed and correct. She stated if a resident came back after being discharged , there should have been a new admission paperwork started with a readmission assessment and new orders. The DON stated there should have been a new and updated MDS, all paperwork. She then stated Resident #1 was readmission and his baseline had been established and is in care plan review right now. she stated they have 48 hrs. for the baseline but since he was a readmit, it establishes it, it was dated 9/17/2025. There was no evidence of a readmission policy provided. Record review of facility policy Baseline Care Plans dated 11/08/2016 and revised 2/14/2024 revealed: Policy:Resident person-centered baseline care plans are developed and implemented for new admission residents. Fundamental Information:Resident person-centered baseline care plans communicate fundamental care approaches and goals for resident related clinical diagnosis, identified concerns and as a result of the admission evaluation/assessment of each healthcare discipline.The baseline care plans are inclusive to support effective individualized resident care that meet professional standards of quality care and services. Baseline care plans are developed and implemented within 48 hours of a resident new admission.Process:1. The baseline care plans will be developed and implemented from minimum healthcare information necessary to properly care for a resident including, but not limited to initial goals based on admission orders, admission evaluation/assessments, physician orders, dietary orders, therapy services, social services, and resident choices.4. The baseline care plans are time limited and serves as the basis for the comprehensive care plans.7. The facility provides the residents and representative with a summary of the baseline care plan in a form and manner and resident can understand.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to include in the care plan services that will be provided to the resident for 3 (Resident #9, Resident #54, and Resident #72) of 22 residents reviewed for comprehensive care plans. 1. The facility failed to ensure Resident #9's comprehensive care plan had resident specific care needs for pressure ulcer.2. The facility failed to ensure Resident #54's comprehensive care plan had interventions care needs and interventions for dialysis.3. The facility failed to ensure Resident #72's comprehensive care plan had appropriate interventions for current transfer and sleeping status.4. The facility failed to ensure Resident #72's comprehensive care plan had correct code status and interventions to match her orders and wishes. These failures could affect the residents by placing them at risk for not receiving care and services to meet their wishes and needs.The findings included: Resident #9Record review of Resident #9's electronic face sheet dated [DATE] reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include: Alzheimer's disease, muscle wasting and atrophy (decrease in muscle mass causing weakness), and left knee effusion (fluid buildup in joint of left knee). Record review of Resident #9's admission MDS dated [DATE] reflected: BIMS score of 07 which indicated severe cognitive impairment. Further review of the MDS Section M - Skin Conditions reflected that resident had a stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle) that was present upon admission. Record review of Resident #9's care plan dated [DATE] and revised on [DATE] reflected Resident has a pressure ulcer and is at risk for infection, pain, and a decline in functional abilities. Interventions: Negative pressure wound therapy (a device with a suction pump, tubing, and a dressing that promotes wound healing by placing foam in wound bed which is sealed with a dressing so that there is negative pressure sucking out wound drainage to store in bin attached to the device) date initiated: [DATE]. Record review of Resident #9's electronic physician orders dated [DATE] reflected no order for negative pressure therapy. During an observation and interview on [DATE] at 8:58 a.m., Resident #9 was sitting in a wheelchair in his room beside his bed. There was foam device in his bed that he stated was for his foot. He stated staff changed the dressing on his left foot that was covered with sock during this observation. No evidence of negative pressure therapy (a device with a suction pump, tubing, and a dressing that promotes wound healing by placing foam in wound bed which is sealed with a dressing so that there is negative pressure sucking out wound drainage to store in bin attached to the device) observed. During an interview on [DATE] at 4:00 p.m., LVN F stated Resident #9 did not have a negative pressure therapy that she was aware of. LVN F stated if Resident #9 did not use negative pressure therapy, then it should not be in his care plan. She stated she did not update care plans but the nurse managers and MDS nurse were responsible for updating the care plans. Resident #54Record review of Resident #54's electronic face sheet dated [DATE] reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: unspecified severe protein-calorie malnutrition (significant loss of body weight without trying), muscle wasting and atrophy (decrease in muscle mass causing weakness), dysphagia (difficulty swallowing), and overactive bladder. Record review of Resident #54's admission MDS dated [DATE] revealed: BIMS score of 12 which indicated moderate cognitive impairment. Further review of the MDS Section O - Special Treatments reflected Resident #54 was on hemodialysis (dialysis from blood being taken from the body and ran through a machine to clear out the toxins then put back into the body) on admission and while a resident. Record review of Resident #54's care plan dated [DATE] reflected she required Enhanced Barrier Precautions for implanted vascular access device for dialysis with intervention to wear gown and gloved during high-contact resident care activities. Further review of the care plan reflected no evidence to assess the resident's condition and monitor for complications before and after dialysis treatments received as a certified dialysis facility. There was no evidence of ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. Record review of Resident #54's medical record reflected an admission letter dated [DATE] from dialysis center with dialysis schedule starting on [DATE]. During an observation and interview on [DATE] at 12:00 p.m., Resident #54 was sitting in wheelchair talking to a visitor. Resident #54 appeared to have a central line dressing that was dry and intact, with no drainage noted. The dressing was also labeled with staff initials, date, and time. This resident was alert and oriented providing information of dialysis transport twice a week. Resident #72Record review of Resident #72's electronic face sheet dated [DATE] reflected she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses to

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on interviews and record review, the facility failed to ensure a qualified professional directs the activities program for 1 of 1 activity director (AD) reviewed for qualifications. The facility failed to ensure the AD, hired on July 17, 2024, was a qualified therapeutic recreation specialist or an activities professional that met state licensing requirements.This failure could place residents at risk for reduced quality of life due to lack of activities that were individualized to match the skills, abilities, and interests/preferences of each resident.The findings included:Record review of the AD's employee file revealed the AD was hired, on July 17, 2024, as the activity director. Further review revealed no evidence of certification or training as a qualified therapeutic recreation specialist or an activities professional that met state licensing requirements.During an interview on 09/17/2025 at 2:30 PM the AD stated she was hired July 2024 as the activity director. The AD stated she had difficulty getting signed up for the class due to her finances and time.During an interview on 9/18/2025 at 4:30 PM the ADMN stated his expectation was to have a certified activity director. The ADMN stated he was aware the AD did not have a certification when hired, and that the AD was responsible for completing the required courses. The ADMN stated the AD had difficulty paying for the course. The ADMN stated in September 2025 he was able to get the facility's corporate organization to pay for the course and they were waiting for the AD to receive the course. The ADMN stated he did not feel there was a negative effect on the residents due to the AD not being certified. The ADMN stated the AD was the best AD he had ever worked with, she had residents engaged in activities and residents loved her. The ADMN stated what led to failure was the AD had financial issues which delayed her paying for the program, and then it took time to get the facility's cooperation to pay for the program. Record review of the AD's Job Description signed on July 17, 2024, revealed: Qualifications: Successful completion on a state-approved and certified course of instruction in patient activities.successfully completes the state-approved and Certified Activity Director's course within nine months of beginning employment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure that a medication cart not being used was secured for 1 of 4 medication carts (Cart Hall D). The facility failed to ensure Cart Hall D was not left unlocked and unsecured while unattended. These failures could place all residents at risk of harm or decline in health due to lack of potency of supplies, medications/biologicals or misappropriation of medications, or drug diversions.The findings included: During an observation and interview on 09/15/2025 between 1:30 PM and 1:50 PM the medication cart on Hall D (Cart Hall D) was left unattended and unlocked from 1:30 PM to 1:35PM. There were three CNA's and residents walking up and down hall D, within arm's reach of the medication cart. The nurse was not in sight of the medication cart. ADON was walking down the hall and stated LVN A was responsible for the medication cart. ADON stated the medication cart should not have been left unlocked and unattended. Contents of the medication cart included: Zoloft (anti-depressant), Trazodone (anti-depressant), Eliquis (blood thinner), Pradaxa (anti-coagulant), Metoprolol (high blood pressure), Lisinopril (high blood pressure), Furosemide (diuretic), Bumex (diuretic), Glargine Insulin Pen (anti-diabetic), Lispro Insulin Pen (anti-diabetic), Lidocaine patches (pain relief), Seroquel (anti-psychotic), Buspar (anti-anxiety), Depakote (used for epilepsy). The medication cart also contained creams, syringes, liquid medications, alcohol pads and over the counter medications. LVN A stated she was distracted by a family member who was upset and followed the family member down the hall. LVN A stated she never left her cart unlocked. LVN A stated medication carts being left unlocked could have had negative effects to residents. During an interview on 09/18/2025 at 4:32 PM the DON stated her expectations was that all medication carts be locked when out of direct vision of the nurse. The DON stated that she was responsible to ensure medications carts are locked when not in use. The DON stated she checks to see if medication carts are locked periodically throughout the day. The DON stated this failure occurred due to poor judgement on the nurse's part. The DON stated residents could be affected if they were to get something out of the medication cart that could potentially cause them harm. Record review of the facility policy titled, Storage Medications dated 09/2018 revealed: Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications. Medication rooms, carts and medication supplies are locked when they are not attended by persons with authorized access.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to make sure that its menus are followed and document any substitutions made to the menus on 4 of 4 halls reviewed for food and nutrition services. The facility failed to ensure residents who ate from the kitchen received all food items according to the menu or an approved alternative during lunch meal on 9/15/2025. This failure could place residents that eat out of the kitchen at risk of poor intake, chemical imbalance and/or weight loss.Findings included:Resident #54Record review of Resident #54's electronic face sheet dated 9/16/2025 reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: unspecified severe protein-calorie malnutrition (significant loss of body weight without trying), and dysphagia (difficulty swallowing). Record review of Resident #54's admission MDS dated [DATE] revealed: BIMS score of 12 which indicated moderate cognitive impairment. Further review of the MDS Section K - Swallowing/Nutritional Status reflected Resident #54 was on a mechanically altered diet. Record review of Resident #54's care plan dated 9/15/2025 reflected she had a swallowing problem with intervention Diet to be followed as prescribed Date Initiated: 08/26/2025. Record review of facility document with lunch notes revealed there were 2 residents (Resident #10 & Resident #54) with puree diets 9/15/2025 for the lunch service. Record review of facility's grievance log in 2025 reflected: 2/3/2025 grievance about not getting what was asked for most of the time; 2/12/2025 grievance about resident not getting a tray for breakfast and only had some bacon left so bacon and cold cereal offered to resident; 2/17/2025 grievance about lunch supposed to be pot roast and a baked potato but received a grilled cheese; 3/30/2025 grievance about resident receiving chicken tenders for lunch instead of fried chicken; 4/10/2025 another grievance about resident receiving chicken tenders instead of fried chicken; 8/4/2025 grievance about receiving grilled cheese sandwiches for 2 days in a row because the kitchen ran out of food; 8/28/2025 grievance about not getting all items that belong on delivery tray (i.e. missing drinks, missing food, and missing utensils). During an observation on 9/15/2025 at 12:32 p.m., the dry erase board in the dining room titled Menu had Week 3 written to the left side of it and Monday 9/15/25 Lunch Kielbasa Sausage, Macaroni Salad, [NAME] Peas, Dinner Roll, and Chocolate Brownie. During an observation on 9/15/2025 at 12:30 p.m., the DON was standing at the door from the kitchen leading into the dining room and asked that the food be served without the macaroni salad since the residents were waiting on the food. She stated that she realized that there were regulations, but the residents needed to eat. During an observation on 9/15/2025 at 12:33 p.m., [NAME] B started plating food. She plated food for the hall that Resident #54 resided on. Resident #54 received all items except pureed roll. All other residents residing on that hall did not receive macaroni salad. During an observation on 9/15/2025 at 12:39 p.m., ADON D observed checking trays at the door between the kitchen and the dining room for the hall that Resident #54 resided on. During an observation on 9/15/2025 at 12:41 p.m., trays left the dining room and were served down A hall without macaroni salad for residents with diets other than puree. Dining room was served trays without macaroni salad. During an observation on 9/15/2025 at 1:02 p.m., several residents left the dining room without receiving macaroni salad or a substitute. During an observation on 9/15/2025 at 1:04 p.m., trays left the dining room and were served down B hall without macaroni salad for resident with diets other than puree. During an interview on 9/15/2025 at 1:14 p.m., CNA I stated there had not been any macaroni salad served on the trays due to the kitchen did not have it available. She stated she had not informed the residents that macaroni salad did not get served. She stated not informing the residents could cause residents to have confusion from not receiving all of their food as well as residents not getting their full nutrition for their disease processes and healing. During an observation on 9/15/2025 at 1:16 p.m., trays left the dining room and were served down C hall without macaroni salad for residents with diets other than puree. During an observation on 9/15/2025 at 1:23 p.m., [NAME] B started plating food for the hall that Resident #10 resided on. No pureed roll was added to the plate for Resident #10. During an observation on 9/15/2025 at 1:29 p.m., trays left the dining room and were served down D hall without macaroni salad for residents with diets other than puree. During an observation and interview on 9/15/2025 at 1:30 p.m., Resident #54's tray observed in her room to not have pureed roll. Beside her plate, there was a meal ticket dated 9/15/2025 with items listed that included pureed dinner roll buttered. She stated she had not been given a bread option in the past. She stated she would have added the roll to her broth and drank the broth if the roll were given. During an interview on 9/15/2025 at 1:32 p.m., ADON D stated all residents should get the items on the menu when

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	455929	A. Building B. Wing	09/18/2025

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview, and record review the facility failed to provide food prepared and served on time for 1 of 1 dining room and 4 (A, B, C, and D) of 4 halls. The facility failed to ensure that 1 of 1 lunch observed on 9/15/2025 was served at the posted mealtime 11:45 a.m. This failure could affect all residents who received meals served from the facility's only kitchen by placing residents at risk for unplanned weight loss, side effects from medication given without food, and diminished quality of life. Findings included:During an observation on 09/15/2025 at 12:32 p.m., resident mealtimes posted outside of kitchen: Breakfast 7:00AM, Lunch 11:45AM, and Dinner 5:00PM. During an observation on 9/15/2025 at 12:30 p.m., the DON was standing at the door from the kitchen leading into the dining room and asked that the food be served without the macaroni salad since the residents were waiting on the food. She stated that she realized that there were regulations, but the residents needed to eat. During an observation on 9/15/2025 at 12:41 p.m., trays left the dining room and were served down A hall then dining room started to be served. During an observation on 9/15/2025 at 1:04 p.m., trays left the dining room and were served down B hall. During an observation on 9/15/2025 at 1:16 p.m., trays left the dining room and were served down C hall. During an observation on 9/15/2025 at 1:29 p.m., trays left the dining room and were served down D hall. All trays had been served at 1:32 p.m. During a confidential group interview on an undisclosed date at an undisclosed time, 9 of 9 residents voiced meals are not on time and they would like to have food served by 12:30 p.m. They stated they had filed a grievance in the past about mealtimes, but it continued to be late at times. During an interview on 9/15/2025 at 4:06 p.m., the DM stated she had asked her supervisor if there was a policy on meal service timing and there was not one. She did not know if there was a specific time that meals had to be served. She stated not serving meals on time could upset residents. During an interview on 9/17/2025 at 8:33 a.m., the DOO for [dietary staff contracted] stated there was no policy on meal service timing. He stated that if lunch was to be served at 11:45 a.m. and the last resident to receive a tray was at 1:30 p.m., then the meal service was not timely. During a telephone interview on 9/17/2025 at 9:51 a.m., the dietitian stated her expectation would be for meal trays to all be served within 45 minutes of the posted mealtime. She stated the DM was responsible for monitoring meals were served timely. She stated she monitored meal service sometimes when she was in the facility approximately two to three times a month. She did not know why lunch service was not timely on 9/15/2025. She stated more education was needed for the kitchen staff. Record review of facility's grievance log in 2025 reflected: 1/30/2025 grievance about food delivery service being late and food and/or plates cold; 2/3/2025 grievance about resident not getting food tray until 20 minutes after other residents served and having to go get her tray because she didn't get one at all three to four times; 8/4/2025 grievance about meals ran 30 minutes to an hour late; 8/28/2025 grievance about food delivery service more than an hour late.

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to make sure that all persons in food service meet local, state, and federal requirements for 1 of 1 kitchen reviewed. 1. The facility failed to ensure holding temperatures were taken on food served during lunch service on 9/15/2025.2. The facility failed to ensure pureed kielbasa sausage, pureed greens beans, and pureed macaroni salad were heated to appropriate temperature after mechanically altering the food on 9/15/2025 during lunch service. 3. The facility failed to ensure required temperatures were documented on temperature log for 9/8/2025 breakfast, 9/8/2025 lunch, 9/9/2025 breakfast, 9/9/2025 lunch, 9/9/2025 dinner, 9/10/2025 breakfast, 9/10/2025 lunch, 9/10/2025 dinner, 9/11/2025 breakfast, 9/11/2025 lunch, 9/12/2025 breakfast, 9/12/2025 lunch, 9/13/2025 breakfast, 9/13/2025 lunch, 9/13/2025 dinner, 9/14/2025 dinner, 9/15/2025 breakfast, 9/15/2025 lunch, and 9/15/2025 dinner.These failures could place residents that eat out of the kitchen at risk for food borne illnesses.The findings included:During an observation and interview on 9/15/2025 between 11:18 a.m. and 12:30 p.m., [NAME] B pureed kielbasa sausage using cold milk as the thinning liquid. She then placed pureed kielbasa sausage into metal bin and took a temperature reading 127 F. She then put a lid on the metal bin and placed it into the steam table. [NAME] B pureed green beans using cold milk as the thinning liquid. She then placed pureed green beans into metal bin and took a temperature reading 133 F. She then put a lid on the metal bin and placed it into the steam table. [NAME] B pureed macaroni salad using cold milk as the thinning liquid. She then placed pureed macaroni salad into metal bin and took a temperature reading 127 F. She put a lid on the metal bin and placed it into the steam table. [NAME] B failed to take another temperature of any foods prior to the food being plated and placed on cart ready to leave the kitchen. [NAME] B stated she thought the steam table would bring food to correct temperature so she did not heat or cool the foods after mechanically altering them. She stated foods not being the correct temperatures could cause residents to become sick. During an interview on 9/15/2025 at 12:02 p.m., the DM stated foods should be heated to greater than 165 F for warm food and less than 40 F for cold foods after they had been prepared. She stated foods did not have to have temperatures taken again while on the steam table prior to meal service if they were appropriate temperatures after being prepared. The DM stated she felt [NAME] B being nervous caused her to not heat / cool the food after temperatures were obtained for the pureed foods. She stated food not being the correct temperature could lead to bacteria growth. During a follow-up interview on 9/15/2025 at 4:06 p.m., the DM stated the cook was responsible for obtaining temperatures. She stated that if the recipe stated food temperatures should be taken every 30 minutes then cooks should take temperatures every 30 minutes, but the food usually doesn't sit that long. She stated she monitored that the cooks were taking temperatures. She stated she did not know why temperature log on 9/13/2025 breakfast meal had no evidence that temperatures were taken. During an interview on 9/17/2025 at 8:33 a.m., the DOO for [dietary staff contracted] stated he expected for staff to follow recipes. He stated milk was an appropriate liquid to add to pureed foods, but he expected for the milk to be warmed up prior to adding to pureed warm foods. He stated pureed warm foods should be brought back up to 165 F after being mechanically altered. He stated he expected for cold foods to be kept in the refrigerator until the food was going to be served to keep it from getting warm. He stated the steam table was not appropriate for warming up food. The DOO for [dietary staff contracted] stated food temperatures should be obtained after being prepared and then again prior to food service. He stated temperatures not being done correctly could cause sickness. He stated it was the responsibility of the DM to monitor that food temperatures were being done correctly. During an interview on 9/17/2025 at 9:51 a.m., the dietitian stated she expected for food temperatures to be taken at the end of the cook time and when food was on the steam table prior to service. She stated cold foods should be stored in the refrigerator right up until service so that the temperature would be less than 41 F. She stated holding temperatures for hot foods needed to be greater than 135 and foods that were below needed to be brought up to greater than 165 F to kill any bacteria. She stated the cooks were responsible for storing prepared foods at the correct temperature and the DM monitored the cooks. She stated she monitored food temperatures at times when she was in the building approximately two to three times a month. The dietitian stated adding cold milk to hot foods could have caused the foods to become below appropriate temperature. She stated foods not being the correct temperature could cause residents to get food borne illnesses. Record review of facility document titled Food Temperature and Evaluation Log; dated 9/8/2025 - 9/15/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to establish and maintain an infection control program 2 of 2 (CNA-E and CNA-I) staff observed during incontinent care. The facility failed to ensure CNA E, and CNA I performed proper peri-care (incontinent care) and proper hand hygiene during peri-care for Resident #91. These failures placed residents of the facility at risk of infections from improper incontinent care and hand hygiene while performing incontinent care.Findings included: Resident #91Record Review of the Resident #91's Face Sheet dated 09/18/2025, revealed she was a [AGE] year-old female. Her original admission to the facility was on 3/06/2025 with the most recent admission on [DATE]. Resident #91 had diagnoses of metabolic encephalopathy (brain lesions), cystitis (inflammation of the bladder). Record review of Resident #91's MDS assessment Section C, Cognitive Patterns dated 06/02/2025, revealed a BIMS score of 13 (cognitively intact). Record review of Resident #91's Comprehensive Care Plan initiated 09/11/2025 revealed the following focused areas:Incontinence: Resident is incontinent of bowel/bladder related to age related deficits. Goal: The resident will be clean and odor free through next review date . Interventions for the focus on incontinent care included checking frequently for wetness and being soiled, change as needed. During an observation on 09/16/2025 at 09:45 AM, CNA-E and CNA-I both performed peri-care for Resident #91. Neither CNA-E nor CNA-I washed their hands nor used hand sanitizer throughout peri-care. CNA-E was also observed folding a wipe 2 times and wiped resident before being discarded. It was observed that Resident #1 had a BM. During an Interview on 09/16/2025 at 9:55 AM, CNA E stated she knew she had failed the skills of peri-care. She stated she had double wiped as well as not using hand hygiene between the changing of dirty gloves and after incontinent care. CNA E stated she had not used hand hygiene between the changing of gloves because they had not brought hand gel into the room with them. CNA E stated she had done Infection Control/peri-care training about 3 months ago. She stated the negative impact to resident could possibly have been cross contamination, and transferring of bacteria between residents. During an interview on 09/16/2025 at 10:00 AM, the DON stated what staff should had typically followed the facility policy. She stated the facility monitored the staff on a regular basis. The DON stated she felt if the surveyor had not been watching, the CNA E would not have been nervous and would have performed it correctly. The DON stated, It would be hard to tell what the negative impact for the resident would have been on residents for not performing proper peri care. The DON stated, you should observe another incontinent care because we are always monitoring our staff. She stated the potential harm could have possibly been infection and/or cross contamination. The DON stated the facility failure was that the survey team was in the facility watching, which made the staff member nervous. Record review of facility policy Incontinent care dated 4/10/17 and revised 2/14/20 revealed: Purpose: To outline a procedure for cleansing the perineum and buttocks after an incontinence episode. Procedure.8. If feces present, remove with.disposable wipe by wiping from front or perineum toward rectum. Discard soiled materials and gloves. Wash hands. 9. Put on non-sterile, latex free gloves.15. Remove and discard gloves. 16. Wash hands.