STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455968	A. Building B. Wing	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graham Oaks Care Center	1325 First St Graham, TX 76450

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free from abuse and neglect for one (Resident #1) of 8 residents reviewed for neglect. On 9/2/25 the facility allowed Hospitality Aide A to perform a transfer on Resident #1 and failed to ensure she was trained and permitted per her job description to use Resident #1's personal medical transfer equipment to perform a transfer. No staff in the facility had been trained in the use of Resident #1's personal medical transfer equipment, and the Director of Therapy had asked the former DON to ensure her staff did not use the device. The transfer resulted in a fall during which Resident #1 received a fracture in her left knee. The noncompliance was identified as PNC. The IJ began on 9/2/25 and ended on 9/3/25. The facility had corrected the noncompliance before the survey began. This failure placed residents at risk for serious injuries, a decline in the resident's condition, hospitalization, or death. Findings included: Record review of Resident #1's admission Sheet, not dated, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her active diagnoses included Paraplegia (paralysis that affects the legs and not the arms), muscle weakness, unsteadiness on feet, osteomyelitis of vertebrate, and pain in thoracic spine. Record review of Resident #1's Annual MDS dated [DATE] reflected Resident #1 had a BIMS score of 15 (cognitively intact) and impaired range of motion in both lower extremities and section GG documented Resident #1 required partial to moderate assistance to transfer. Record review of Resident #1's comprehensive care plan, dated 7/14/25, reflected that she had a self-care performance deficit and required 1 staff to reposition and turn in bed, and to transfer from bed to chair. A revision of the care plan on 7/15/24 indicated that she used a sit to stand device, and it was discontinued on 9/3/25 Review of the Provider Investigation report dated 9/3/25 revealed: Resident had a fall during sit to stand transfer to the bathroom, resulting in left knee fracture . The Hospitality Aide that was assisting Resident #1 in the sit to stand transfer to the toilet was not trained or oriented to the sit to stand machine. The resident was sent to the emergency room for evaluation and pain medication was administered as ordered and as needed. There were no other negative findings at this time. Record review of a radiology report for Resident #1 dated 9/3/25 documented: There is a cortical discontinuity (interruption or fracture in the hard, dense, outer layer of bone that makes up most of the skeleton) in the lateral aspect of the left medial femoral condyle (the rounded, smooth end of the thigh bone that forms part of the knee joint), suggesting a fracture. Record review of the video evidence (Clip #1) date 9/2/25 at 6:56 PM provided by Resident #1 from her personal monitoring device located in her room, revealed Resident #1 was transferred by the Hospitality Aide A on 9/2/25 using her personal transfer equipment. The hospitality aide could not be heard in the video stating to Resident #1 that she had never used the sit to stand transfer device to perform a transfer. Resident #1 could be heard stating you have to learn when you're young. The Resident #1 is seen sitting on the transfer device while Hospitality Aide A pushed her into the bathroom after which the resident could not be viewed by the camera. Video clip #2 - Resident #1 is not in view, but Hospitality Aide A is seen standing in the doorway of the bathroom and is heard stating I I can't get in there. I'm sorry. She turned toward the resident's room door which was closed, opened the door and stated: Let me get some help. She then left the room. The resident could be heard groaning and calling out help!. She was not in view of the camera and the clip ended. Record review of the nurses note dated 9/2/2025 11:34 PM reflected the following information: Note Text: BP-146/94. T-97.5. P-101. R-18.Resident had a fall. Location: Resident Bathroom Fall information: Assisted, Legs gave out, .Cognition / Behavior at Time of Event: Oriented / no problem,This nurse was notified by the Hospital Aide that she had assisted residents to the ground via a gait belt from sit to stand device. The Hospitality Aide was assisting the resident to bathroom and during the transfer to toilet, resident could not get bearings on her legs, and they gave out. No injuries noted at the time of assisted fall. The Resident #1 did not hit her head, alert and oriented x4. resident complained of left knee discomfort. Resident assisted to w/c from floor by 3 staff members and placed in bed. Will continue to monitor for delayed injuries. Appears and/or states to be in pain. Describes the pain as: Intermittent, Location of pain: left knee Pain relieving intervention used at this time: routine oxycodone.Initial Treatment/New Orders:Resident Statement: resident stated legs gave out trying to transfer from sit & stand to toiletName of MD/NP notified: Medical Director/Primary Care PhysicianDate/time of notification: 09/02/2025 9:00 PM.Name of RP notified: husband Date/time of notification: 09/02/2025 9:00 PM.Interventions in place prior to fall: Scheduled toileting program, x2 assist when toiletingInterventions initiated in response to fall: Scheduled

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 1 (Resident #1) of 8 residents reviewed for accident hazards were free from accident hazards in their environment. The facility failed to ensure Resident # 1's received adequate supervision and assistive devices to prevent accidents. The lift used by facility staff was not an adequate assistive device since there was no manual for proper staff training and the device was the personal property of Resident #1. This resulted in a fall during a transfer in which Resident #1 received a fracture on her left knee on 9/3/25. The noncompliance was identified as PNC. The IJ began on 9/2/25 and ended on 9/3/25. The facility had corrected the noncompliance before the survey began. This failure placed residents at risk for serious injuries, a decline in the resident's condition, hospitalization, or death. Findings included: Record review of Resident #1's admission Sheet, not dated, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her active diagnoses included Paraplegia (paralysis that affects the legs and not the arms), muscle weakness, unsteadiness on feet, osteomyelitis of vertebrate, and pain in thoracic spine. Record review of Resident #1's Annual MDS dated [DATE] reflected Resident #1 had a BIMS score of 15 (cognitively intact) and impaired range of motion in both lower extremities and section GG documented Resident #1 required partial to moderate assistance to transfer. Record review of Resident #1's comprehensive care plan, dated 7/14/25, reflected that she had a self-care performance deficit and required 1 staff to reposition and turn in bed, and to transfer from bed to chair. 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