STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455586	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Terrace Rehabilitation and Healthcare	812 W Houston Ave McAllen, TX 78501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review the facility failed to ensure the residents right to be informed of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers, for 3 of 10 residents (Resident #1, Resident #2, and Resident #5) reviewed for consent for antipsychotic medications in that: 1. The facility failed to obtain prior consent based on information of the benefits and risks and options available before the administration of Zyprexa (an antipsychotic) for Resident #37. 2. The facility failed to obtain prior consent based on information of the benefits and risks and options available before the administration of Haldol (an antipsychotic) for Resident #61. 3. The facility failed to obtain proper consent before the administration of Zyprexa and had accepted a consent signed by Resident #5 who had severely impaired cognitive skills to make decisions for himself. This failure could affect the right to self-determination of all facility residents who receive medication by allowing them to receive medication without their prior knowledge or consent, or that of their responsible party or emergency contacts. The findings included: 1. Record review of Resident #37's admission record dated 02/18/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning) with agitation, hemiplegia and hemiparesis (neurological conditions causing motor impairment on one side of the body due to brain injury) following cerebral infarction (stroke), hypertension (high blood pressure), heart failure, generalized anxiety disorder (a mental health condition characterized by chronic, excessive, and uncontrollable worry about everyday events, activities, or potential disasters), and emotional lability (rapid, exaggerated, and often uncontrollable mood swings, characterized by intense outbursts of crying, laughing, or anger that are disproportionate to the situation). Record review of Resident #37's Quarterly MDS, dated [DATE], revealed a BIMS score of 03, indicating severe cognitive impairment. There were no potential indicators of psychosis and no behavioral symptoms indicated. Active diagnoses included: dementia, hemiplegia and hemiparesis following a cerebral infarction, heart failure, anxiety disorder, depression, and lability. Resident #37 was dependent (Helper did ALL of the effort. Resident did none of the effort to complete the activity. Or, the assistance of 2 or more helpers was required for the resident to complete the activity) for eating, toileting, and personal hygiene. Resident #1 was not receiving an antipsychotic. Record review of Resident #37's Care Plan dated 01/16/26 revealed the focus (Resident #37) is on a Anti psychotic medication r/t psychosis Date Initiated: 01/26/2026. [sic] Record review of Resident #37's Physician's Order dated 01/19/26, revealed Order Summary: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ZyPREXA Oral Tablet 5 MG (Olanzapine). Give 1 tablet by mouth at bedtime for Psychosis. Record review of Resident #37's Order Summary dated 01/19/2026 revealed Zyprexa Oral Tablet 5 mg (Olanzapine) Give 1 tablet by mouth at bedtime for Psychosis. Record review of Resident #37's January 2026 MAR revealed Zyprexa 5 mg tablet was administered nightly from 01/20/26 through 01/31/26. Record review of Resident #37's February 2026 MAR revealed Zyprexa 5 mg tablet was administered nightly from 02/01/26 through 02/17/26. Record review of Resident #37's Progress Note written on 01/20/26 at 03:24 pm by LVN G Resident was seen by (NP G) (pysch), Appetit increased, remains depressed (crying spells), Stop Namenda 5mg, stop Aricept. Start Zyprexa 5mg PO HS Unspec psychosis dementia aggression. Please keep (NP G) posted. [sic] Record review on 02/18/26 of Resident #37's medical record did not reveal a consent signed by the RP for the antipsychotic Zyprexa 5 mg tablet. 2. Record review of Resident #61's admission record dated 02/17/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included hypertension (high blood pressure), hemiplegia and hemiparesis (neurological conditions causing motor impairment on one side of the body due to brain injury) following cerebral infarction (stroke), chronic respiratory failure, heart disease, seizures, alcoholic cirrhosis of liver (a chronic advanced liver disease caused by long-term alcohol misuse, characterized by significant, irreversible scarring of the liver tissue), and depression. Record review of Resident #61's Annual MDS, dated [DATE], revealed a BIMS score of 06, indicating severe cognitive impairment. There were no potential indicators of psychosis and no behavioral symptoms indicated. Active diagnoses included: hemiplegia and hemiparesis following a cerebral infarction, heart disease, depression, and alcoholic cirrhosis of the liver. Resident #61 was dependent (Helper did ALL of the effort. Resident did none of the effort to complete the activity. Or, the assistance of 2 or more helpers was required for the resident to complete the activity) for eating, toileting, and personal hygiene. Resident #61 was not receiving an antipsychotic. Record review of Resident #61's Care Plan dated 12/02/25 revealed the focus (Resident #61) is on Anti psychotic medication use r/t altered mental status Date Initiated: 02/12/2026. Record review of Resident #61's Physician's Order 02/11/26 (Discontinued on 02/14/26) revealed Order Summary: Haloperidol Tablet 5 MG Give 1 tablet by mouth one time a day for alter mental status for 30 Days. [sic] Record review of Resident #61's Physician's Order dated 02/14/26 (Discontinued on 02/16/26) revealed Order Summary: Haloperidol Tablet 5 MG Give 1 tablet by mouth in the evening for alter mental status for 30 Days [sic] Record review of Resident #61's February 2026 MAR revealed Haldol 5 mg tablet was administered 02/12/26 and 02/13/26 in the morning and on 02/15/26 Haldol 5 mg tablet was administered in the evening. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 02/18/26 of Resident #61's medical record did not reveal a consent signed by the RP for the antipsychotic Haldol 5 mg tablet. 3. Record review of Resident #5's face sheet, dated 02/19/26, reflected an [AGE] year-old male who was initially admitted to the facility on [DATE]. Resident #5 had diagnoses which included: paranoid schizophrenia (mental health disorder with intense irrational delusions and vivid auditory hallucinations), cerebral infarction, unspecified (blocked blood supply to the brain causing lack of oxygen and damage to the brain), anoxic brain damage, unspecified (occurs when the brain is completely deprived of oxygen), aphasia following cerebral infarction, (language disorder after a stroke causing difficulty or inability to communicate), and cognitive communication deficit (difficulty with verbal and non-verbal communication caused by underlying cognitive impairment). Record review of Resident #5's care plan, with an initiation date of 04/10/25 reflected a focus of [Resident #5] is on a Anti-psychotic medication use r/t for [sic] schizophrenia with an initiation date of 05/16/25. Record review of Resident #5's MDS assessment, dated 04/29/25, reflected Resident #5 was rarely or never able to be understood and was rarely or never able to understand. Resident #5 was categorized as severely impaired for cognitive skills for daily decision making and did not have a BIMS completed due to being rarely or never understood. Record review of Resident #5's consent for antipsychotic or neuroleptic medication treatment reflected Resident #5 signed the consent form on 05/16/25. Record review of Resident #5's order summary report reflected an order for Zyprexa 5mg via peg tube two times a day related to paranoid schizophrenia was started on 05/16/25 and was discontinued on 01/19/26. During an interview and record review with the DON on 02/19/26 at 9:07am the DON stated they were required to get consent in person by either the residents if they are able to consent or their responsible party for any antipsychotic medication such as Zyprexa. The DON stated Resident #5 was his own responsible party and did not have any other contacts for him. The DON stated when Resident #5 admitted he was able to make his own decisions such as signing consents for Zyprexa but stated he had recently been declining. The DON reviewed Resident #5's admission MDS and stated Resident #5 had a BIMS of 0 and was marked as severely impaired for his cognitive skills for daily decision making. The DON stated based on Resident #5's MDS documentation he would not be able to give consent for Zyprexa. The DON stated Resident #5 was allowed to sign for consent because based upon visual assessment he was able to follow commands. The DON stated the facility's interdisciplinary team was responsible for reviewing consents to ensure they were completed accurately and stated they would discuss the consents and review them upon admission and weekly and would review any new orders. The DON stated Resident #5 was on Zyprexa from 05/16/25 until 01/19/26 for his diagnosis of paranoid schizophrenia. The DON stated it was important to ensure proper consents were granted prior to administration of an antipsychotic such as Zyprexa because of the side effects and stated these were also potential negative impacts if consents were not in place. The DON stated Resident #5 did not experience any adverse effects related to his antipsychotic use. During an interview and record review on 02/19/2026 at 09:25 am, the DON stated either DON, ADON or the nurse on admission was responsible for getting the consent (for an antipsychotic medication). The DON stated Resident #37 did not have the consent for Zyprexa. The DON stated Resident #61 had (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not had a consent for the Haldol that he received. He stated an antipsychotic should not be given before consent was signed. He stated that if the consent was not given for an antipsychotic, the family had not agreed to the resident getting the antipsychotic and the family had the right to either accept or refuse medication. During an interview on 02/19/2025 at 03:11 pm, LVN A stated the nurse who received the order for an antipsychotic was the one who would get the consent signed. She said an antipsychotic was not given until the consent was signed. LVN A stated if the antipsychotic was given without consent, the family may get very upset because their loved one would be getting an antipsychotic they did not want them to get. Record review of the facility's, undated, policy titled, Psychotropic Drug Use reflected a section titled, procedures stated, 7. Upon change of condition or initiation of a new order for psychoactive medications, the License Nurses shall complete the verification of Informed Consent form prior to the initiation of the new medication.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the residents were free from chemical restraints not required to treat the resident's medical symptoms for 2 (Resident #1 and Resident #2) of 8 residents reviewed for unnecessary medications. 1.The facility failed to have an adequate indication for the use of the medication Zyprexa (an antipsychotic) for Resident #37 before administering the medication with a black box warning. 2.The facility failed to have an adequate indication for the use of the medication Haldol (an antipsychotic) for Resident #61 before administering the medication with a black box warning. This failure could put residents at risk of harm from adverse reactions or harmful side effects. The findings included: 1. Record review of Resident #37's admission record dated 02/18/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning) with agitation, hemiplegia and hemiparesis (neurological conditions causing motor impairment on one side of the body due to brain injury) following cerebral infarction (stroke), hypertension (high blood pressure), heart failure, generalized anxiety disorder (a mental health condition characterized by chronic, excessive, and uncontrollable worry about everyday events, activities, or potential disasters), and emotional lability (rapid, exaggerated, and often uncontrollable mood swings, characterized by intense outbursts of crying, laughing, or anger that are disproportionate to the situation). Record review of Resident #37's Quarterly MDS, dated [DATE], revealed a BIMS score of 03, indicating severe cognitive impairment. There were no potential indicators of psychosis and no behavioral symptoms indicated. Active diagnoses included: dementia, hemiplegia and hemiparesis following a cerebral infarction, heart failure, anxiety disorder, depression, and lability. Resident #37 was dependent (Helper did ALL of the effort. Resident did none of the effort to complete the activity. Or, the assistance of 2 or more helpers was required for the resident to complete the activity) for eating, toileting, and personal hygiene. Resident #37 was not receiving an antipsychotic. Record review of Resident #37's Care Plan dated 01/16/26 revealed the focus (Resident #37) is on a Anti psychotic medication r/t psychosis Date Initiated: 01/26/2026. Record review of Resident #37's Physician's Order dated 01/19/26, revealed Order Summary: ZyPREXA Oral Tablet 5 MG (Olanzapine). Give 1 tablet by mouth at bedtime for Psychosis. Record review of Resident #37's Order Summary dated 01/19/2026 revealed Zyprexa Oral Tablet 5 mg (Olanzapine) Give 1 tablet by mouth at bedtime for Psychosis. Record review of Resident #37's January 2026 MAR revealed Zyprexa 5 mg tablet was administered nightly from 01/20/26 through 01/31/26. Record review of Resident #37's February 2026 MAR revealed Zyprexa 5 mg tablet was administered nightly from 02/01/26 through 02/17/26. Record review of Resident #37's Progress Note written on 01/20/26 at 03:24 pm by LVN G Resident (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was seen by (NP G) (pysch), Appetit increased, remains depressed (crying spells), Stop Namenda 5mg, stop Aricept. Start Zyprexa 5mg PO HS Unspec psychosis dementia aggression. Please keep (NP G) posted. 2. Record review of Resident #61's admission record dated 02/17/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included hypertension (high blood pressure), hemiplegia and hemiparesis (neurological conditions causing motor impairment on one side of the body due to brain injury) following cerebral infarction (stroke), chronic respiratory failure, heart disease, seizures, alcoholic cirrhosis of liver (a chronic advanced liver disease caused by long-term alcohol misuse, characterized by significant, irreversible scarring of the liver tissue), and depression. Record review of Resident #61's Annual MDS, dated [DATE], revealed a BIMS score of 06, indicating severe cognitive impairment. There were no potential indicators of psychosis and no behavioral symptoms indicated. Active diagnoses included: hemiplegia and hemiparesis following a cerebral infarction, heart disease, depression, and alcoholic cirrhosis of the liver. Resident #61 was dependent (Helper did ALL of the effort. Resident did none of the effort to complete the activity. Or, the assistance of 2 or more helpers was required for the resident to complete the activity) for eating, toileting, and personal hygiene. Resident #61 was not receiving an antipsychotic. Record review of Resident #61's Care Plan dated 12/02/25 revealed the focus (Resident #61) is on Anti psychotic medication use r/t altered mental status Date Initiated: 02/12/2026. Record review of Resident #61's Physician's Order 02/11/26 (Discontinued on 02/14/26) revealed Order Summary: Haloperidol Tablet 5 MG Give 1 tablet by mouth one time a day for alter mental status for 30 Days. Record review of Resident #61's Physician's Order dated 02/14/26 (Discontinued on 02/16/26) revealed Order Summary: Haloperidol Tablet 5 MG Give 1 tablet by mouth in the evening for alter mental status for 30 Days. Record review of Resident #61's February 2026 MAR revealed Haldol 5 mg tablet was administered 02/12/26 and 02/13/26 in the morning and on 02/15/26 Haldol 5 mg tablet was administered in the evening. During an interview and record review on 02/19/26 at 09:00 am, the DON stated altered mental status should not be an indication for an antipsychotic order for a resident. He said antipsychotics could not be prescribed with a diagnosis of dementia. He said psychosis should not be an indication for an antipsychotic order for a resident who has dementia. The DON stated when an incorrect diagnosis was written for an antipsychotic, they would call the doctor or NP and clarify, but most times, the NP will not change the diagnosis. During an interview on 02/19/25 03:11 pm LVN A stated antipsychotics needed a correct diagnosis for the residents to get them. She said she sometimes had to call and confirm/clarify the order with the doctor or NP. She said orders for an antipsychotic without a proper diagnosis or especially with the diagnosis for Alzheimer's or dementia are not proper orders. She said an antipsychotic cannot have a diagnosis of Alzheimer's or dementia. During an interview on 02/19/26 at 03:29 pm, RN B stated an antipsychotic order cannot have an (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indication as Alzheimer's or dementia. RN B stated they needed a proper diagnosis and consent signed before administering an antipsychotic. Record review of the facility's, undated, policy titled, Psychotropic Drug Use reflected a section titled, procedures stated: Policy: It is the policy of this facility to ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. 6a. Psychotropic medication was prescribed to treat a specific diagnosed condition, as documented in the clinical record. 6c. Behavior is not related to delirium or other reversible conditions.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial need that were identified in the comprehensive assessment for 2 of 6 residents (Resident #18 and Resident #46) reviewed for comprehensive person-centered care plans.1.The facility failed to ensure Resident #46's care plan included his code status of full code.2.The facility failed to ensure Resident #18's care plan included she was a 2 person assist for ADLs.These deficient practices could place residents at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs.The findings included:1.Record review of Resident #46's admission record dated [DATE], reflected a [AGE] year-old male with an admit date of [DATE]. His relevant diagnoses included myasthenia gravis with (acute) exacerbation (chronic autoimmune disorder causing fluctuating weakness of voluntary muscles), acute respiratory failure (a life-threatening emergency occurring when the lungs cannot properly oxygenate the blood or remove carbon dioxide), tracheostomy (a surgical procedure creating an opening (stoma) in the neck into the trachea), and dependence on respirator (a serious, chronic, or acute state where a person cannot sustain spontaneous breathing on their own).Record review of Resident #46's Medicare 5-day MDS assessment dated [DATE], reflected a BIMS score of 14, which indicated his cognition was intact. Record review of Resident #46's comprehensive care plan dated [DATE], did not reflect his code status of full code.Record review of Resident #46's order summary reflected an active order of full code: use AED (automated external defibrillator) with CPR during sudden cardiac arrest effective [DATE].In an observation and interview on [DATE] at 3:42 p.m., RN E said Resident #46 had been admitted on [DATE] and had a code status of full code. He was observed as he reviewed Resident #46's electronic medical record and said his profile reflected he was a full code. RN E said he also had an order (effective [DATE]) which reflected he was a full code. RN E said his code status was not reflected on his care plan. He said there would be no negative outcomes to Resident #46 for not having his code status reflected on his care plan because nursing staff checked a resident's profile and order in case of an emergency. In an interview on [DATE] at 3:38 p.m., MDS D said Resident #46 had been admitted on [DATE]. She said his profile reflected a code status of full code and had an active order effective [DATE]. MDS D said Resident's code status had not been included in his care plan. MDS D said there was no negative outcomes to Resident #46 because if case of an emergency, nursing staff would check his profile and order. She said even though nursing staff would not check a resident's care plan in case of an emergency, a resident's code status needed to be reflected on their care plan. In an interview on [DATE] at 3:02 p.m., the DON said a resident's code status needed to be reflected on their profile, have an order, and an Out-of-hospital DNR form if they opted to have a code status of DNR. He said there were no negative outcomes to Resident #46 if his code status had not been included on his care plan because in case of an emergency, nursing staff would check his profile and order(s). The DON said, even though nursing staff would not check a resident's care plan in case of an emergency, code status needed to be reflected on their care plan. 2. Record review of Resident #18's admission record dated [DATE], reflected a 73- year-old female with an admit date of [DATE]. Her relevant diagnoses included schizophrenia (a severe, chronic brain disorder that distorts reality through hallucinations, delusions, and disordered thinking), cognitive communication deficit (an impairment in communication due to underlying issues with cognitive processes like memory, attention, and executive function), need for assistance with personal care, and lack of coordination. Record review of Resident #18's quarterly MDS assessment dated [DATE], reflected a BIMS score of 5, which indicated her cognition was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	severely impaired. Resident #18 had been coded as dependent for her functional abilities which included oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. A code of dependent indicated helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.Record review of Resident #18's quarterly care plan dated [DATE], reflected a focus of [Resident #18] has ADL self-care performance deficit r/t limited mobility and generalized weakness. Date initiated [DATE] Interventions for toilet use, transfer (chair/bed to chair transfer, toilet transfer), bed mobility (roll left/right, sit to lying, lying to sitting on side of bed), dressing (lower/upper body dressing, putting on taking off footwear), and transfer (chair/bed to chair transfer, toiler transfer) required a 1 person assist.In an interview on [DATE] at 8:03 a.m., CNA F said CNA F said she had provided care to Resident #18 while she was in the memory unit. She said Resident #18 required a 1 person assist with her ADLs; however, during episodes of aggression, she required a 2 person assist. She said if she needed to check or verify what a Resident #18's level of assistance, she would check her electronic medical record or ask the charge nurse. In an observation and interview on [DATE] at 9:45 a.m., MDS D said Resident #18's most recent MDS assessment (dated [DATE]) reflected she was dependent on all ADLs except for eating. She was observed as she reviewed Resident #18's electronic medical record/care plan and said her care plan indicated she was a 1 person assist for all ADLs with the exception of eating. MDS D said if Resident #18's MDS had her coded as dependent on ADLs then her care plan should have reflected a 2 person assist for ADLs also. MDS D said a negative outcome to Resident #18 not having her care plan match the level of care her MDS assessment reflected would be she would not receive the appropriate level of care for her ADLs. In an interview on [DATE] at 3:02 p.m., the DON said a resident's care plan should reflect the same level of care their MDS assessment reflected. He said a negative outcome to Resident #18 not having the correct level of care on her care plan would be she would not receive the appropriate level of care for her ADLs. Record review of the facility's Comprehensive Person-Centered Care Planning policy revised on 04/2025 reflected:Policy It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.Procedure:4. the facility IDT will develop and implement a comprehensive person-centered, culturally competent, and trauma-informed care plan for each resident within 7 day of completion of the MDS and will include resident's needs identified in the comprehensive assessment.the resident's goals and desired outcomes.