STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455915	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granbury Care Center	301 S Park St Granbury, TX 76048

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 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)

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 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 interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to a meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 6 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #6, Resident #7) of 8 residents reviewed for comprehensive person-centered care plans.1. The facility failed to develop care plans based on assessed needs with measurable objectives in the areas of Hemiplegia/Hemiparesis, Hypertension, GERD, Dementia, and Anxiety for Resident #1.2. The facility failed to develop care plans based on assessed needs with measurable objectives in the areas of Parkinson's Disease, Hypertension, Diabetes Mellitus, diuretic therapy, edema, GERD, and renal failure for Resident #2. 3. The facility failed to develop care plans based on assessed needs with measurable objectives in the areas of Parkinson's Disease, Diabetes Mellitus, and edema for Resident #3.4. The facility failed to develop care plans based on assessed needs with measured objectives in the areas of Anticoagulant Therapy, hypertension, bowel incontinence, GERD, and dementia for Resident #4.5. The facility failed to develop care plans based on assessed needs with measurable objectives in the areas of Diabetes, Atrial Fibrillation, Crohn's Disease, osteoporosis, asthma, and GERD for Resident #6. 6. The facility failed to develop care plans based on assessed needs with measurable objectives in the areas of Hemiplegia, Seizure Disorder, History of Vascular accident with residual right sided Hemiplegia, and COPD for Resident #7.These failures could affect the residents by placing them at risk for not receiving care and services to meet their needs.The findings included:Resident #1Record review of Resident #1's Facesheet, dated 07/03/2025, revealed Resident #1 was a [AGE] year-old female, with an admission date into the facility of 09/08/2023. Diagnoses included Unspecified Dementia (diagnosis given when a person's cognitive impairment was not clearly categorized into a specific type of dementia), Hemiplegia (paralysis on one side of the body) and Hemiparesis (weakness on one side of the body) following cerebral infarction (condition where a part of the brain tissue dies due to lack of blood flow) affecting left non-dominant side, Hypertension (condition where the force of blood against the artery wall was consistently too high), Generalized Anxiety Disorder (mental health condition characterized by excessive, uncontrollable, and often irrational worry about everyday events or activities), and GERD (digestive disorder where stomach acid flows back into the esophagus, causing symptoms like heartburn or regurgitation).Record review of Resident #1's Quarterly MDS, dated [DATE], revealed Resident #1's BIMS score was 05, which indicated severe cognitive impairment. Section I - Active Diagnoses revealed Resident #1 had medically complex conditions, with diagnoses of Dementia, Generalized Anxiety Disorder, GERD, Hypertension, and Hemiplegia/Hemiparesis following cerebral infarction.Record review of Resident #1's Care Plan with recent review of 03/03/2025 revealed objectives lacking ability to be evaluated, quantified, and verified were: The resident will remain free of complications or discomfort related to Hemiplegia/Hemiparesis; the resident will remain free of complications related to hypertension through the review date; the resident will remain free of discomfort, complications, or s/sx related to dx of GERD; the resident will be free from s/sx of complications of cardiac problems; the resident will remain oriented to (person, place, situation, time) though the review date (related to Dementia); and the resident will have no indications of psychosocial well-being problems by/through review date.Resident #2Record review of Resident #2's Facesheet, dated 07/03/2025, revealed Resident #2 was a [AGE] year-old male, with an admission date into the facility of 09/03/2024. Diagnoses included Type II Diabetes Mellitus with foot ulcer (a chronic metabolic disorder characterized by high blood sugar levels due to the body's inability to properly use insulin and/or insufficient insulin production), Essential Hypertension (a condition characterized by persistently high blood pressure without a known secondary cause), Parkinsonism (a term used to describe a group of neurological disorders characterized by motor symptoms such as tremors, rigidity, and slow movement), Acute Kidney Failure (a sudden and rapid decrease in kidney function), localized Edema (condition characterized by swelling caused by fluid retention in body tissues), GERD (digestive disorder where stomach acid flows back into the esophagus, causing symptoms like heartburn or regurgitation), and enlarged and hypertrophic nails (abnormal thickening of the nail plate).Record review of Resident #2's Significant Change in Condition MDS, dated [DATE], revealed Resident #2's BIMS score was

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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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 0657 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 interviews and record reviews, the facility failed to make sure that the comprehensive care plan was prepared by an interdisciplinary team that included a nurse aide with responsibility for the resident for 8 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, and Resident #8) of 8 residents reviewed for care plans. The facility failed to ensure the nurse aides with responsibility for the residents were invited and attended the resident care plan conferences. These failures could place the residents at risk for not receiving the care and services to meet their needs.The findings included: Resident #1: Record review of Resident #1's Facesheet, dated 07/03/2025, revealed Resident #1 was a [AGE] year-old female, with an admission date into the facility of 09/08/2023. Diagnoses included Unspecified Dementia (diagnosis given when a person's cognitive impairment was not clearly categorized into a specific type of dementia). Record review of Resident #1's Quarterly MDS, dated [DATE], revealed Resident #1's BIMS score was 05, which indicated severe cognitive impairment. Resident #2 Record review of Resident #2's Facesheet, dated 07/03/2025, revealed Resident #2 was a [AGE] year-old male, with an admission date into the facility of 09/03/2024. Diagnoses included Type II Diabetes Mellitus with foot ulcer (a chronic metabolic disorder characterized by high blood sugar levels due to the body's inability to properly use insulin and/or insufficient insulin production). Record review of Resident #2's Significant Change in Condition MDS, dated [DATE], revealed Resident #2's BIMS score was 15, which indicated intact cognition. Resident #3 Record review of Resident #3's Facesheet, dated 07/01/2025, revealed Resident #3 was a [AGE] year-old female, with an admission date into the facility of 11/16/2024. Diagnoses included Neuroleptic induced Parkinsonism (a movement disorder that resembles Parkinson's disease but was caused by certain medications, particularly antipsychotics). Record review of Resident #3's Quarterly MDS, dated [DATE], revealed Resident #3's BIMS score was not calculated. C0100, Should Brief Interview for Mental Status (C0200 - C0500) be Conducted was coded 0 for No - resident was rarely/never understood; therefore, BIMS score was not determined. Resident #4 Record review of Resident #4's Facesheet, dated 07/03/2025, revealed Resident #4 was an [AGE] year-old female, with an admission date into the facility of 01/30/2025. Diagnoses included Other Alzheimer's Disease (most common form, where a person experienced the effects of more than one type of dementia). Record review of Resident #4's Quarterly MDS, dated [DATE], revealed Resident #4's BIMS score was 06, which indicated severe cognitive impairment. Resident #5 Record review of Resident #5's Facesheet, dated 07/03/2025, revealed Resident #5 was a [AGE] year-old female, with an admission date into the facility of 07/16/2018. Diagnoses included Cerebral Palsy, Unspecified (a group of neurological disorders that appear in infancy or early childhood and permanently affect a person's movement and muscle coordination. Record review of Resident #5's MDS, dated [DATE], revealed Resident #5's BIMS score was not calculated. C0100, Should Brief Interview for Mental Status (C0200 - C0500) be Conducted was coded 0 for No - resident was rarely/never understood; therefore, BIMS score was not determined. Resident #6 Record review of Resident #6's Facesheet, dated 07/03/2025, revealed Resident #6 was an [AGE] year-old female, with an admission date into the facility of 12/23/2020. Diagnoses included Legal blindness (a severe level of vision impairment, defined as having a visual acuity of 20/200 or less in the better-seeing eye with corrective lenses, or as restricted visual field of 20 degrees or less). Record review of Resident #6's Annual MDS, dated [DATE], revealed Resident #6's BIMS score was 13, which indicated intact cognition. Resident #7 Record review of Resident #7's Facesheet, dated 07/03/2025, revealed Resident #7 was a [AGE] year-old male, with an admission date into the facility of 06/25/2025 . Diagnoses included Chronic Obstructive Pulmonary Disease (progressive lung disease that makes it hard to breathe), Epilepsy (neurological disorder characterized by seizures due to abnormal electrical activity in the brain). Record review of Resident #7's Annual MDS, dated [DATE], revealed Resident #7's BIMS score was 15, which indicated intact cognition. Resident #8 Record review of Resident #8's Facesheet, dated 07/03/2025, revealed Resident #8 was a [AGE] year-old female, with an admission date into the facility of 03/11/2024. Diagnoses included Hemiplegia (paralysis on one side of the body) and Hemiparesis (weakness on one side of the body) following cerebral infarction (condition where a part of the brain tissue dies due to lack of blood flow) affecting Right dominant side. Record review of Resident #8's Quarterly MDS, dated [DATE], revealed Resident #8's BIMS score was 13, which indicated intact cognition. During an interview on 07/01/2025 at 7:57 a.m., CNA D said he did not attend or participate in the IDT meetings of any of the residents in the