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	03/30/2026

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to complete a comprehensive assessment within 14 days after admission to the facility, for 1 of 7 (Resident #6) residents reviewed for comprehensive assessments.The facility failed to complete Resident #5's comprehensive admission MDS assessment within 14 days after admission.This failure could place residents at risk of not having their care and treatment needs assessed to ensure necessary care and services were provided.Findings included:Record review of Resident #5's electronic face sheet dated 03/30/3036, reflected a [AGE] year-old male admitted on [DATE] with diagnoses including non-pressure chronic ulcer of left heel (left heel chronic wound that was not a pressure ulcer), DM type 2 (a chronic condition characterized by high blood sugar levels due to the body's inability to use insulin effectively), hyperlipidemia (high cholesterol), insomnia (inability to fall or stay asleep during the night), cellulitis of left lower limb (left lower leg skin infection), peripheral vascular disease (decreased blood flow to extremities), acquired absence of right leg below knee (right leg amputation below the knee), and hypothyroidism (low thyroid function).Record review of Resident #5's admission MDS assessment, dated 03/30/2026, reflected no evidence that it was completed and no CAAs were triggered.Record review of Resident #5's admission nurses note, dated 03/13/2026, reflected Resident #5 had a PICC line to his right upper arm, was incontinent to bowel and bladder, his right leg was amputated below the knee, he required two-person assistance with bed mobility and needed a mechanical lift for transfers, he required two-person assistance with toileting, he required one-person assistance with dressing, hygiene, and bathing, he was able to eat and drink with supervision, and he used dentures or both upper and lower to consume his regular diet.Record review of Resident #5's care plan, dated 03/13/2026, reflected Resident #5 had care areas with interventions including EBP, peripheral vascular disease, DM, incontinence, osteomyelitis (bone infection), IV (intravenous) access, ADL self-care deficit, oral / dental health problems, and pressure ulcer care.Record review of facility document titled Resident Matrix, dated 03/27/2026, reflected Resident #5 had pressure ulcer stage 4 and was admitted on [DATE]. There was no evidence that Resident #5 received medication for diabetes, had an infection, or was receiving IV therapy. During an observation and interview on 03/30/2026 at 9:22 a.m., Resident #5 was lying in the bed in his room. There was an IV pole to the left of his bed. He had an IV access site to his right upper arm, and the dressing was clean, dry, and intact. He had a wound vac on his left heel, and the dressing was clean, dry, and intact. He stated he had no concerns with how the facility cared for his IV access or about how they had administered his IV medication for infection. He stated he had an issue with the wound vac on Saturday, but the facility had put another dressing on it and they changed the dressing that morning putting on a new wound vac dressing. During an interview on 03/27/2026 at 3:40 p.m., the DON stated she went to the MDS Coordinator and asked why Resident #5 was not listed on the Matrix as receiving IV therapy. She stated she was told the IV therapy was not listed because the Matrix went off of the MDS assessment that had not triggered him to receive IV therapy. She stated Resident #5 was on IV therapy at that time.During an interview on 03/30/2026 at 2:48 p.m., MDS Coordinator A stated she (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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was responsible for completing Resident #5's admission assessment. She stated it had not been completed because she was behind performing those assessments. She stated not completing the MDS assessment timely could cause residents to not get all care needed because the MDS assessment triggered the CAAs for the care planning process. She stated Resident #5's admission MDS assessment should have been completed on 03/25/2026.During a follow-up interview on 03/30/2026 at 3:30 p.m., the DON stated the MDS Coordinators were responsible for completing comprehensive assessments. She stated the facility had two MDS Coordinators and she expected them to come to her when they were behind on those assessments so she could help complete them. She stated she and the Regional Reimbursement Nurse would sign off on the assessments when the MDS Coordinators had completed them. She stated she did not have a process for monitoring that the comprehensive assessments were completed timely because the ADMN monitored them. She stated her expectation would be for the MDS assessments to be completed per policy. She stated the care plan had been done because the facility used the comprehensive care plan as the baseline care plan and the care areas had already been added onto the care plan. She stated not having the MDS assessment completed could cause a delay in the residents not receiving all of the services needed to care for them. She stated she captured care areas on Resident #5's care plan so she did not feel any delay happened with his care due to the comprehensive assessment not being completed timely.During an interview on 03/30/2026 at 4:32 p.m., the ADMN stated the MDS Coordinator nurses were responsible for completing comprehensive assessments and an RN signed the assessments. She stated the Regional Reimbursement Nurse, and the DON would sign them. The ADMN stated the Regional Reimbursement Nurse would monitor facilities on Fridays if there had been situations that required her to be monitoring the comprehensive MDS assessments and she would now add this facility onto her list to check. The ADMN stated she would now be asking in the morning meeting if those comprehensive assessments had been done and would be looking daily to see that they were. She did not state how she had been monitoring that the assessments were completed prior to that day. She stated the assessments should be completed timely per the RAI manual, and she did not know why Resident #5's admission assessment had not been completed. She stated completing those comprehensive assessments was important for accuracy in providing proper care for the residents. Record review of the facility's undated policy titled Resident Assessment, reflected: A comprehensive assessment will be completed within 14 days of admission.The results of the assessment are used to develop, review, and revise the resident's comprehensive plan of care.Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment.