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	06/14/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 5 of 7 residents (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #6) reviewed for care plans. The facility failed to ensure the staff developed the comprehensive care plan goals and interventions from the comprehensive assessment for Resident #1, Resident #2, Resident #3, Resident #4, and Resident #6. The facility failed to ensure the comprehensive care plans for Resident #1, Resident #2, and Resident #4 described the resident's preference and potential for future discharge. The facility failed to ensure the comprehensive care plans for Resident #1, Resident #2, and Resident #4 documented a desire to return to the community was assessed. This failure could place the residents at risk of inadequate care and services.Findings included: Record review of Resident #1's face sheet reviewed on 6/14/2026 revealed a [AGE] year-old female, admission date 11/20/2023, Diagnoses: chronic pain syndrome (pain that lasts for over 3 months), muscle weakness, lack of coordination (difficulty making precise physical movements), chronic obstructive pulmonary disease(restricted airflow and breathing difficulties), dysphagia following cerebral infarction(brain damage disrupts the neurological pathways that coordinate swallowing.), cerebral infarction (blood supply to part of the brain is blocked), aphasia following cerebral infarction(brain damage disrupts neurological pathways that coordinate speaking), dysarthria and anarthria(speech difficulty), cognitive communication deficit(underlying disruption in thinking impairs a person's ability to effectively speak, listen, read, write). Resident #1 had a BIMS of 11 (moderate cognitive impairment). Record review of Resident #1's MDS dated [DATE] revealed in the CAA summary indicated ADL function, pressure ulcer, and pain were triggered areas and these areas were to be addressed in the care plan. Record review of Resident #1's comprehensive care plan dated 6/5/2026 revealed no ADL function, pressure ulcers, or pain were addressed in the care plan. Record review of Resident #1's comprehensive care plan dated 6/5/2026 revealed no evidence of documented discharge plan or assessment. In an interview on 6/14/2026 at 12:30 P.M. with Resident #1, she stated she had no plans to leave the facility, and the staff are managing her pain. Resident #1 stated staff take care of her, and she had no wounds or sores. She stated she used to have pressure ulcers, but the facility got her healed up. Resident #1 stated if she needed anything, she could just ask facility staff and they addressed it. Record review of Resident #2's face sheet reviewed on 6/14/2026 revealed an [AGE] year-old male, admission date of 5/04/2026, Diagnoses: dementia (decline in mental ability severe enough to interfere with daily life), major depressive disorder (consistent feeling of sadness lasting and interrupting daily life), epilepsy (recurrent, unprovoked seizures), psychosis (symptoms that indicate a loss of contact with reality). Resident #2 had a BIMS of 4 (severe cognitive impairment). Record review of Resident #2's MDS dated [DATE] revealed in the CAA summary indicated vision, communication, psychotropic drugs, and pain were triggered areas and it further indicated these areas were to be addressed in the care plan. Record review of Resident (continued on next page)

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	#2's comprehensive care plan dated 6/3/2026 revealed no evidence that vision, communication, psychotropic drugs, or pain were addressed in the care plan. Record review of Resident #2's comprehensive care plan dated 6/3/2026 revealed no evidence of documented discharge plan or assessment. In an attempted interview on 6/14/2026 at 12:05 P.M., Resident #2 did not respond any questions. Record review of Resident #3's face sheet reviewed on 6/14/2026 revealed a [AGE] year-old female, admission date of 5/28/2026, with diagnoses: dementia (decline in mental ability severe enough to interfere with daily life), cardiac pacemaker (battery operated device that prevents the heart from beating too slow), depression (persistent sadness affecting daily life), violent behaviors (use of physical force or power to threaten, damage, or harm oneself, others, or property), dorsalgia (back pain), atherosclerotic heart disease of native coronary artery without angina (plague build up in original blood vessels that supply the heart restricting blood flow and oxygen). Resident #3 had a BIMS of 5 (severe cognitive impairment). Record review of Resident #3's MDS dated [DATE] revealed in the CAA summary indicated communication, psychosocial well-being, psychotropic drugs, and pain were triggered areas and it further indicated these areas were to be addressed in the care plan. Record review of Resident #3's comprehensive care plan dated 6/3/2026 revealed no evidence that communication, psychosocial well-being, psychotropic drugs, or pain were addressed in the care plan. In an attempted interview on 6/14/2026 at 11:28 A.M., Resident #3 did not respond to any questions. Record review of Resident #4's face sheet reviewed on 6/14/2026 revealed a [AGE] year-old-female, admission date of 5/13/2026 with diagnoses: rhabdomyolysis (rapid break down of damaged skeletal muscle), acute kidney failure (sudden loss of kidney ability to filter waste), palliative care (specialized medical care for someone living with a serious illness which focuses on pain relief and other symptoms), cerebral infarction (blood flow to brain blocked), myeloma (uncommon blood cancer within bone marrow), type 2 diabetes (resists insulin or doesn't produce enough), idiopathic neuropathy (nerve damage with no clear cause). Resident #4 had a BIMS of 7 (severe cognitive impairment). Record review of Resident #4's MDS dated [DATE] revealed in the CAA summary indicated urinary incontinence, psychosocial well-being, behavior, nutrition, pressure ulcers, psychotropic drugs, and pain were triggered areas and it further indicated these areas were to be addressed in the care plan. Record review of Resident #4's comprehensive care plan dated 5/27/2026 revealed no evidence that urinary incontinence, psychosocial well-being, behavior, nutrition, pressure ulcers, psychotropic drugs, or pain were addressed in the care plan. Record review of Resident #4's comprehensive care plan dated 5/27/2026 revealed Resident #4 was at risk for elopement and resided in the secured unit in the facility. In an observation on 6/14/2026 at 11:45 A.M., Resident #4 walked to LVN C and requested pain medication and LVN C assessed her for pain. LVN C retrieved Resident #4's pain medication and watched her take it. In an interview on 6/14/2026 at 11:50 A.M. with Resident #4, she stated she gets her medications correctly and can bring any concerns she has to staff and they will address them. Resident #4's only concern she had was that staff blow her off when she asked to get out the door. In an observation on 6/14/2026 at 12:15 P.M., LVN C reassessed Resident #4 for pain to ensure the pain medication was effective. Resident #4 revealed it was effective. Record review of Resident #6's face sheet reviewed on 6/14/2026 revealed an [AGE] year-old female, admission date of 5/30/2026 with diagnoses: displaced fracture of surgical neck of left humerus (common shoulder injury where upper arm bone breaks just below the ball of the shoulder joint and the bone fragments shift out of alignment), dementia without behavioral disturbance (decline in mental ability severe enough to interfere with daily life), cerebral infarction (blood flow to brain blocked), acute kidney failure (kidneys do not filter waste like normal). Resident #6 had a BIMS of 13 (cognitive intact). Record review of Resident #6's MDS dated [DATE] revealed in the CAA summary indicated communication, nutrition, and pain were triggered areas and it further indicated these areas were to be addressed in the care plan. Record review of Resident #6's comprehensive care plan dated 6/3/2026 revealed no evidence that communication, nutrition, or pain were addressed in the care plan. In an interview on 6/14/2026 at 12:16 P.M. with Resident #6, she (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she had no concerns with her care and received her pain medication timely and correctly. In an interview on 6/14/2026 at 11:36 A.M., LVN C stated Resident #2, Resident #3, Resident #4, and Resident #6 can make their needs known. LVN C stated Resident #2, Resident #3, Resident #4, and Resident #6 are newer residents that have adjusted well. She stated Resident #2, Resident #3, Resident #4, and Resident #6 needs were met and she had no concerns related to that. In an interview on 6/14/2026 at 12:08 P.M., CNA B stated that Resident #2, Resident #3, Resident #4, and Resident #6's needs are met and she had no concerns. In an interview on 6/14/2026 at 4:56 P.M., ADON A stated that MDS E and DON D were responsible for care plans. ADON A stated that MDS E took care of the initial care plans after the MDS assessment and DON D added changes to the care plan. An attempted was made to contact MDS E by telephone ion 6/14/2026 at 5:45 P.M., there was no answer or return the call recieved. In an interview on 6/14/2026 at 6:25 P.M., DON D stated MDS E was responsible for care plans after the MDS assessment and that she would add any change in condition. DON D stated Resident #2, Resident #3, Resident #4, and Resident #6's needs were being met and addressed. DON D stated a negative effect for CAA trigger areas not in the care plan was that something could be missed from their care DON D stated she tried to contact MDS E, and had not heard back from her. Record review of comprehensive care plan policy undated revealed, The facility will develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights that includes measurable objectives and time frames to meet a residents' medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following-The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the residents' medical, physical, mental and psychosocial needs. Through the planning process, facility staff will work with the resident and his or her representative, if applicable, to understand and meet the residents' preferences, choices and goals during their stay at the facility. The facility will establish common documents and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning drives the type of care and services that a resident receives. The policy further revealed, When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services. If a Care Area Assessment (CAA) is triggered, the facility will further assess the resident to determine whether the resident is at risk of developing or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident. Documentation regarding these assessments and the facility's rationale for deciding whether or not to proceed with care planning for each area triggered will be recorded in the medical record. The comprehensive care plan policy undated further revealed, The comprehensive care plan will address a resident's preference for future discharge, as early as upon admission, to ensure the resident is given every opportunity to attain his/her highest quality of life.