STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675084	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Nursing & Rehab of Granbury	600 Reunion Court 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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability was performed prior to admission for 1 of 4 (Resident #3) reviewed for PASRR, in that: The facility admitted Resident #3, whose admission was a Pre-admission category and who had a suspicion of mental illness, prior to receiving the required PASRR II evaluation assessment and PASRR determination. This failure could affect all new residents admitted into the facility as a Preadmission with a mental condition at risk for inappropriate admissions and the inability to be evaluated and receive services in the most integrated setting appropriate to their needs.Findings included:Record review of Resident #3's Face Sheet, dated 04/21/2026, revealed a [AGE] year-old male, with an original admission date into the facility of 02/27/2026. Resident #3 was most recent admission date was 04/10/2026. Resident #5 had diagnoses which included Post traumatic seizures (convulsions resulting from traumatic brain injury), Schizoaffective disorder (a chronic mental condition characterized by a combination of schizophrenia symptoms such as hallucinations or delusions and mood disorder symptoms, including mania or depression), Generalized Anxiety, and Schizophrenia (a severe brain disorder characterized by hallucinations, delusions, disorganized speech, and impaired social/occupational functioning). Record review of Resident #3's admission MDS, dated [DATE], revealed Resident #3 had a BIMS score of 99, which indicated the Resident #3 was unable to complete the interview. Section 1 - Active Diagnoses, Section I8000 revealed Resident #3 had the diagnosis of Post traumatic seizures, Unspecified Intellectual Disabilities, and Schizophrenia. Record review of Resident #3's PASRR Level 1 Screening, dated 02/26/2026, revealed Resident #3 was categorized as a Preadmission admission due to Section A0900A marked as #7, which indicated the referring entity was other. Section A0900B indicated the type of entity for Resident #3 was the Texas Department of Criminal Justice. Review of Section C - PASRR Screening, Section C0100 revealed a code of 1, which indicated there was a suspicion Resident #3 had evidence or an indicator of a Mental Illness. Section C0200 was coded 1, which indicated there was suspicion Resident #3 had evidence or an indicator of an Intellectual Disability. During an interview on 04/21/2026 at 2:05 p.m., Resident #3 confirmed he had been in the hospital and said he would not bang his head or be mean to others. During an interview on 04/23/2026 at 10:01 p.m., the Regional Nurse Consultant said the facility was currently going through a CHOW since September or October of 2025 and the facility had received correspondence from the local LMHA/LIDDA that they would be unable to proceed with the PASRR process in TMHP LTC Online Portal due to the CHOW and due to the lack of a provider number. The Regional Nurse Consultant said this meant the LHMA could not entered the PL1s into the state electronic portal to initiate the PASRR process. The Regional Nurse Consultant said the PL1s for residents who were admitted after the initiation of the CHOW were completed on a paper form that the facility had kept hard copies to provide to the LMHA/LIDDA to be entered into the portal once the facility received a provider number and the CHOW was completed. The Regional Nurse Consultant said the LMHA/LIDDA had not completed Level II PASRR Assessments since the CHOW had been initiated in September 2025. The Regional Nurse Consultant said she was aware that the facility could not admitted a Preadmission (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	category PASRR positive individual until after the PASRR Level II assessment was completed and a determination was made. During an interview on 04/23/2026 at 10:19 a.m., the Administrator said he was not aware the LMHA/LIDDA was not completing the PASRR Level II assessments. The Administrator said he was not aware of that the facility had admitted a resident who was a PASRR Preadmission and PL1 positive for Mental Illness. During an interview on 04/23/2026 at 11:16 a.m., the Marketing Director said she was responsible for admitting new residents and ensured the PASRR PL1 was completed prior to admission. She said she would obtain a copy of PL1 for the facility. The Marketing Director said she would gather all the information for the admission packet when she admitted a new resident and send the information to admissions. The Market Director said she was unaware of the process with the LMHA/LIDDA after that point. The Marketing Director said she was not responsible for sending the PL1s to the LMHA/LIDDA. She said the medical team would reach out the LMHA/LIDDA if the PL1 was positive. During an interview on 04/23/2026 at 11:33 a.m., the MDS Coordinator said she was guided by TMHP to keep a list of all PL1 positives that were admitted after the initiation of CHOW until provider number was received. The MDS Coordinator said after the CHOW was approved, the facility would be required to submit a new PL1 for all residents who resided in the facility within 90 days after the approval of the CHOW. The MDS Coordinator said she was under the impression that Preadmissions who were PASRR positive and newly admitted would be included in the list and she had not been informed to not admit a resident as Preadmission and PASRR positive. The MDS Coordinator said she knew that a PASRR Preadmission who had a suspicion of mental health or intellectual disabilities could not be admitted until after the PASRR Level II Assessment was completed and the facility determined that they could meet his/her needs. Record Review of the facility's policy, PASRR, dated 01/20/2026, revealed the aim of the PASRR program was to identify residents with Mental Illness (MI), Intellectual Disability (ID), or Developmental Disability (DD), Related Conditions (RC) and to ensure they are properly placed, whether from the community or Nursing Facility an to ensure they receive the services they require for their MI, or ID/DD. The PASRR Level Screen (PL1)In the event the facility is considering an admission from the community (home, homeless shelter, jail, group home, off the street, etc.) and the facility Interdisciplinary Team (IDT) suspects any MI, ID, or DD, the community Admissions Coordinator prior to admission will contact the LIDDA and follow the preadmission process.

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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 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 interview 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 needs that were 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 of 6 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6) residents reviewed for comprehensive person-centered care plans. For Resident #1, the facility failed to develop a comprehensive person-centered care plan based on assessed needs with measurable objectives in the focus areas of decreased functional abilities r/t impaired cognition and impaired mobility, resistive to care at times r/t new to nursing facility and adjustment to nursing facility, impaired daily decisions making and rejecting of necessary care at times r/t Dx Dementia and Encephalopathy, resident wishes to remain in the nursing facility, risk for cardiac complications r/t diagnoses of HLD, ASHD, and HTN, risk of adverse drug effects r/t use of psychotropic medications use for Depression and Psychosis, at risk for adverse reaction r/t Polypharmacy (antidepressant and antipsychotic medications), at risk for weight changes r/t Dx of Depression and new to this NF, at risk for decline in psychosocial well-being r/t new SNF, frequent pain r/t migraines and impaired mobility, decreased visual acuity r/t aging progress, and (risk for respiratory distress r/t Dx of Asthma. For Resident #2, the facility failed to develop a comprehensive person-centered care plan based on assessed needs with measured objectives in the focus areas of resident is at high risk for falls related to quadriplegia, wheelchair dependence, bladder, and impaired mobility, resident has gastroesophageal reflux disease requiring ongoing management, resident is at increased risk for infection related to chronic UTI, incontinence, neuromuscular bladder, COPD, and frequent hospital visits, resident has atrial fibrillation and hypertension requiring ongoing monitoring to prevent cardiac complications, resident is quadriplegic and wheelchair dependent, requiring total assistance with mobility and ADLs, resident requires ongoing long-term care due to complex medical and functional needs, resident has COPD and respiratory failure requiring PRN oxygen therapy and has a history of nicotine dependence, resident has bladder and BPH with a history of chronic UTIs, resident has depression, anxiety, mood disorder and insomnia, affecting overall wellbeing and participation in care, resident has an ADL self-care performance deficit r/t Quadriplegia, resident is verbally aggressive to staff during care due to ineffective copy skills, poor impulse control, resident has a history of false accusations, making unfounded claims due to mistrust of others, resident uses antidepressants medication r/t Depression, resident is on anticoagulant therapy r/t Atrial fibrillation, resident uses anti-anxiety medications r/t Anxiety Disorder, resident is on diuretic therapy r/t hypertension, resident receives anticonvulsant medication r/t anxiety, MDD, Mood Disorder, resident has oxygen therapy r/t COPD, and resident has SOB r/t COPD. For Resident #3, the facility failed to develop a comprehensive person-centered care plan based on assessed needs with measured objectives in the focus areas of: resident has an ADL self-care performance deficit r/t mobility impairment, resident has a behavior problem/self-harm (Schizophrenia) r/t yelling, refuses care, hitting himself on objects, curses, hits hand on wall/door/window, attempts to pull fire extinguisher, resident will be able to make basic needs know on a daily basis through the review date, resident has impaired thought processes r/t Schizophrenia, psychosis, and IDD, resident has hypertension, resident had an actual fall with no injury r/t poor communication/comprehension, resident uses antidepressant medication r/t insomnia, resident receives anticonvulsant medication r/t Schizophrenia and Psychosis, resident has potential nutritional problem r/t cognitive impairment, and resident has potential for psychosocial well-being problem r/t recent admission. For Resident #4, the facility failed to develop a (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comprehensive person-centered care plan based on assessed needs with measured objectives in the areas of : resident has difficulty making self-understood r/t Dx of Dementia, Discharge Plan: resident does not have plans/wishes to discharge from SNF, resident has hx of Major Depression and Anxiety, (resident is at risk for nutritional decline r/t Hx of Depression, Hx of Dysphagia, Diuretic use, and GERD, resident has impaired abilities r/t weakness and impaired cognition, resident is incontinent of bowel and bladder r/t impaired mobility and impaired cognition, resident is at risk for pain r/t to diabetic neuropathy, disease process, and Dx of chronic pain, potential for adverse reaction to drug Sulfa and Tramadol, resident uses medication Lexapro r/t depression, (resident will receive diet as ordered by MD. For Resident #5, the facility failed to develop a comprehensive person-centered care plan based on assessed needs with measured objectives in the areas of resident requires staff supervision when using tobacco products, Hypertension, wound management, documented pressure ulcer, resident has decreased functional abilities r/t lung cancer with tongue and lymph, terminal Dx, resident has congestive heart failure, resident has anemia, resident is at risk for wt. changes and/or potential aspiration r/t terminal condition and Dx Dysphagia, resident has chronic pain r/t cancer, resident has a terminal prognosis r/t lung cancer with tong and lymph cancer, and resident is at risk for bowel and bladder incontinence r/t terminal condition. For Resident #6, the facility failed to develop a comprehensive person-centered care plan based on assessed needs with measured objectives in the areas of wound management. These failures could place residents at risk for not receiving care and services to meet their needs and deficits.The findings include: 1. Record review of Resident #1 Face Sheet, dated 04/21/2026, revealed a [AGE] year-old female, with an admission date of 04/01/2026. Resident #1 had diagnoses which included Hypothyroidism (condition where the thyroid gland is underactive and fails to produce sufficient hormones to meet the body's needs), Unspecified Dementia diagnosis used when symptoms of cognitive decline, such as memory loss, confusion, and impaired thinking, are present, but the underlying cause cannot be definitely determined or does not fit a specific pattern), Unspecified Psychosis (mental health symptom including hallucinations, and delusions), Migraine, unspecified, Metabolic Encephalopathy (serious, often reversible brain dysfunction caused by systemic illness, such as liver failure, kidney failure, or severe infection), Essential (primary) hypertension (high blood pressure), and Unspecified asthma. Record review of Resident #1s admission MDS assessment, dated 04/07/2026, revealed Resident #1 had a BIMS score of 15, which indicated intact cognitive response. Record review of Resident #1 Care Plan, with a recent review date of 04/10/2026, revealed the objectives that were not person-centered and lacked the ability to be evaluated, quantified, and verified were: The resident will maintain current level of function through the review date (decreased functional abilities r/t impaired cognition and impaired mobility), the resident will cooperate with care through next review date (resistive to care at times r/t new to nursing facility and adjustment to nursing facility), the resident will maintain current level of cognitive function through the review date (impaired daily decisions making and rejecting of necessary care at times r/t Dx Dementia and Encephalopathy), Care needs will be met daily and PRN while residing in the nursing facility (resident wishes to remain in the nursing facility), the resident will be free from complications of cardiac problems through the review date (risk for cardiac complications r/t diagnoses of HLD, ASHD, and HTN), the resident will be free of falls through the next review date (risk of adverse drug effects r/t use of psychotropic medications use for Depression and Psychosis), the resident will be free of adverse drug reactions through the review date (at risk for adverse reaction r/t Polypharmacy [antidepressant and antipsychotic medications]), the resident will maintain stable weight through next review period (a risk for weight changes r/t Dx of Depression and new to this NF), the resident will demonstrate adjustment to nursing home placement by/through review date (at risk for decline in psychosocial well-being r/t new SNF), the resident will not have discomfort related to analgesia through the review date (frequent pain r/t migraines and impaired mobility), the resident will show no decline in visual function through review date (decreased visual acuity r/t aging progress), the resident will remain free from complications of asthma (risk for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	respiratory distress r/t Dx of Asthma). 2. Record review of Resident #2's Facesheet, dated 04/21/2026, revealed a [AGE] year-old male, with an admission date of 07/2//2023. Resident #2 had diagnoses which included Chronic Obstructive Pulmonary Disease (progressive, preventable inflammatory lung disease causing restricted airflow and breathing difficulties), Polyneuropathy (widespread damage to multiple peripheral nerves often causing numbness, burning pain, or muscle weakness), unspecified, Urinary Tract Infection, Unspecified Atrial fibrillation (heart rhythm disorder where the heart's upper chambers beat rapidly and irregularly, increasing risks for stroke, blood clots, and heart failure), Nicotine dependence, Major Depressive Disorder, Quadriplegia (paralysis affecting all four limbs and the torso, caused by cervical spinal cord injury), Essential (Primary) Hypertension (high blood pressure), and Generalized anxiety disorder. Record review of Resident #2's Quarterly MDS assessment, dated 03/04/2026, revealed Resident #2 had a BIMS score of 13, which indicated intact cognitive response. Record review of Resident #2's Care Plan, with a recent review of date of 02/03/2026, revealed the objectives that were not person-centered and lacked the ability to be evaluated, quantified, and verified were: Resident will remain free from falls and fall-related injuries (resident is at high risk for falls related to quadriplegia, wheelchair dependence, bladder, and impaired mobility), resident will remain free from GERD-related discomfort or complications (resident has gastroesophageal reflux disease requiring ongoing management), resident will remain free from signs and symptoms of infection (resident is at increased risk for infection related to chronic UTI, incontinence, neuromuscular bladder, COPD, and frequent hospital visits), resident will maintain stable cardiovascular status without acute events (resident has atrial fibrillation and hypertension requiring ongoing monitoring to prevent cardiac complications), resident will maintain skin integrity an highest practicable level of comfort and function (resident is quadriplegic and wheelchair dependent, requiring total assistance with mobility and ADLs), resident will maintain the highest practicable quality of life in LTC setting (resident requires ongoing long-term care due to complex medical and functional needs), resident will maintain adequate oxygenation and remain free from respiratory distress (resident has COPD and respiratory failure requiring PRN oxygen therapy and has a history of nicotine dependence), resident will maintain urinary elimination and remain free from UTI symptoms (resident has bladder and BPH with a history of chronic UTIs), Resident will demonstrate stable mood and improved sleep patterns (resident has depression, anxiety, mood disorder and insomnia, affecting overall wellbeing and participation in care), Resident will maintain current level of function through the review date (resident has an ADL self-care performance deficit r/t Quadriplegia), Resident will demonstrate effective coping skills through the review date (resident is verbally aggressive to staff during care due to ineffective copy skills, poor impulse control), resident will have fewer episodes of false accusations and outburst by the review date (resident has a history of false accusations, making unfounded claims due to mistrust of others), resident will be free from discomfort or adverse reactions related to antidepressants (resident uses antidepressants medication r/t Depression), resident will be free from discomfort or adverse reactions related to anticoagulant use (resident is on anticoagulant therapy r/t Atrial fibrillation), resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date (resident uses anti-anxiety medications r/t Anxiety Disorder), resident will be free from discomfort or adverse reactions related to diuretic therapy through the review date (resident is on diuretic therapy r/t hypertension), resident will be free from discomfort or adverse reactions related to anticonvulsant medications through the review date (resident receives anticonvulsant medication r/t anxiety, MDD, Mood Disorder), resident will have no s/sx of poor oxygen absorption through the review date (resident has oxygen therapy r/t COPD), and resident will have complications relate to SOB through the review date (resident has SOB r/t COPD), 3. Record review of Resident #3's Face Sheet, dated 04/21/2026, revealed a [AGE] year-old male, with an original admission date into the facility of 02/27/2026. Resident #3 was most recent admission date was 04/10/2026. Resident #5 had diagnoses which included Post traumatic seizures (convulsions resulting from traumatic brain injury), Schizoaffective disorder (a chronic (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mental condition characterized by a combination of schizophrenia symptoms such as hallucinations or delusions and mood disorder symptoms, including mania or depression), Generalized Anxiety, and Schizophrenia (a severe brain disorder characterized by hallucinations, delusions, disorganized speech, and impaired social/occupational functioning). Record review of Resident #3's admission MDS, dated [DATE], revealed Resident #3 had a BIMS score of 99, which indicated the Resident #3 was unable to complete the interview. Record review of Resident #3's Care Plan, with recent review of date of 03/09/2026, revealed the objectives that were not person-centered and lacked the ability to be evaluated, quantified, and verified were: Resident will maintain current level of function in ADL's through the next review date (resident has an ADL self-care performance deficit r/t mobility impairment), (Resident) will have fewer episodes of yelling, refuses care, hitting himself on objects daily by review date (resident has a behavior problem/self-harm (Schizophrenia) r/t yelling, refuses care, hitting himself on objects, curses, hits hand on wall/door/window, attempts to pull fire extinguisher), resident will be able to make basic needs know on a daily basis through the review date, (resident will be able to make basic needs know on a daily basis through the review date), Resident will be able to communicate basic needs on a daily basis through the next review date (resident has impaired thought processes r/t Schizophrenia, psychosis, and IDD), resident will remain free of complications related to hypertension through review date (resident has hypertension), resident will resume usual activities without further incident through the review date (resident had an actual fall with no injury r/t poor communication/comprehension), resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date (resident uses antidepressant medication r/t insomnia), resident will be free from side effects of anticonvulsant medication through review date (resident receives anticonvulsant medication r/t Schizophrenia and Psychosis), resident will comply with recommended daily diet through review date (resident has potential nutritional problem r/t cognitive impairment) and resident will have no indications of psychosocial will being problems by/through review date (the resident has potential for psychosocial well-being problem r/t recent admission. 4. Record review for Resident #4's Face Sheet, dated 04/22/2026, revealed an [AGE] year-old female, with an admission date of 07/13/2018. Resident #4 had diagnoses which included Unspecified combined systolic (congestive) and diastolic (congestive) heart failure, Major Depressive Disorder, Acute respiratory failure, Unspecified dementia (progressive syndrome characterized by severe cognitive decline), Generalized anxiety, and GERD (chronic condition where stomach acid flows back into the esophagus causing persisting heartburn, regurgitation, chest pain, and damage to the esophageal lining). Record review of Resident #4's Quarterly MDS assessment, dated 03/20/2026, revealed Resident #4's had a BIMS score of 12, which indicated moderate cognitive impairment Record review of Resident #4's Care Plan, with recent review of date of 12/09/2025, revealed the objectives that were not person-centered and lacked the ability to be evaluated, quantified, and verified were: Resident will maintain ability to make basic needs/wants known daily through next review date (resident has difficulty making self-understood r/t Dx of Dementia), resident's care needs will be met daily and PRN while residing in the SNF (Discharge Plan: resident does not have plans/wishes to discharge from SNF), resident will be free from s/sx of increased depression or anxiety (resident has hx of Major Depression and Anxiety), Resident will be free from nutritional decline and will maintain stable weight (resident is at risk for nutritional decline r/t Hx of Depression, DM, Hx of Dysphagia, Diuretic use, and GERD), resident will maintain or improve current functional abilities without significant functional decline over the next 90-days (resident has impaired abilities r/t weakness and impaired cognition), resident will be clean and dry and will maintain dignity daily (resident is incontinent of bowel and bladder r/t impaired mobility and impaired cognition), resident will function on an acceptable level with minimal interference from pain and medication side effects through the review date (resident is at risk for pain r/t to diabetic neuropathy, disease process, and Dx of chronic pain), resident will have no allergic reactions (potential for adverse reaction to drug Sulfa and Tramadol), resident will be free from (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discomfort or adverse reactions related to antidepressants (resident uses medication Lexapro r/t depression), and resident will comply with recommended diet daily through review date (resident will receive diet as ordered by MD). 5. Record review of Resident #5's Face Sheet, dated 04/22/2026, revealed a [AGE] year-old male, with an admission date of 03/18/2026. Resident #5's diagnoses included Malignant (cancer) neoplasm of unspecified part of lung, Essential (Primary) Hypertension, Secondary and unspecified malignant neoplasm of lymph node, and Chronic systolic heart failure. Record review of Resident #5's admission MDS assessment, dated 03/25/2026, revealed Resident #5 had a BIMS score of 14, which indicated intact cognitive response. Record review of Resident #5's Care Plan, with recent review of date of 04/01/2026, revealed the objectives that were not person-centered and lacked the ability to be evaluated, quantified, and verified were: Resident will follow tobacco policy of facility without injury to self or others (resident requires staff supervision when using tobacco products), resident blood pressure will be within normal limits (Hypertension), wound will show signs of improvement (wound management), management of pressure ulcer (documented pressure ulcer), resident will maintain current level of function through the review date (resident has decreased functional abilities r/t lung cancer with tongue and lymph, terminal Dx), resident will have clear lung sounds, heart rate, and rhythm within normal limits through the review date (resident has congestive hear failure), resident will remain free of s/sx or complications related to anemia through review date (resident has anemia), resident will maintain stable wt. as able and be free from s/sx of aspiration through next review (resident is at risk for wt. changes and/or potential aspiration r/t terminal condition and Dx Dysphagia), resident will not have discomfort related to side effects of analgesia through the review date (resident has chronic pain r/t cancer), resident's comfort will be maintained through the review date (resident has a terminal prognosis r/t lung cancer with tong and lymph cancer), resident will be continent at all times through the review date (resident is at risk for bowel and bladder incontinence r/t terminal condition) 6. Record review of Resident #6's Face Sheet, dated 04/22/2026, revealed a [AGE] year-old male with an admission date of 04/18/2026. Resident #6's diagnoses included Displaced fracture of lesser Trochanter (long bony prominence on the upper femur that acts as an anchor for hip and thigh muscles, crucial for movement) of right femur. Record review of Resident #6's admission MDS assessment, dated 04/22/2026, revealed Section C - Cognitive Patterns was not completed, and a BIMS score was not determined Record review of Resident #6's Care Plan, with recent review of date of 04/29/2026, revealed the objectives that were not person-centered and lacked the ability to be evaluated, quantified, and verified were: Wound will show signs of improvement (wound management). During an interview on 04/22/2026 at 1:48 p.m., the MDS Coordinator said she was responsible for ensuring the MDS assessments were completed and entered into the electronic platform. The MDS Coordinator said the person who completed the MDS was responsible for the objectives and the IDT would be responsible to ensure the objectives and goals were measurable. The MDS Coordinator said the nursing and therapy department were able to update objectives prior to the IDT's final approval. The MDS Coordinator said she was aware the objectives were not person-centered and measurable. The MDS Coordinator said the positive outcome of measurable objectives would be to ensure the resident was making progress and not declining and objectives were met. During an interview on 04/22/2026 at 3:00 p.m. the Social Worker said the IDT reviewed all care plans and reviewed the objectives and goals. The Social Worker said the MDS nurse was in charge of coordinating the care plan and ensuring the objectives were person-centered and measurable. The Social Worker said in the facility, the MDS Coordinator would be responsible to change the generic objectives that populated the care plan after the MDS assessment was entered into the electronic platform. The Social Worker agreed the majority of the objectives in the care plans were not person-centered or measurable. She said objectives should be measurable to see if the resident was progressing or declining. On 04/23/2026 at 10:19 a.m., the Administrator said he was a member of the IDT and would attend care plan meetings. The Administrator said the MDS Coordinator and nurses were responsible for updating the care plan and ensuring the objectives were (continued on next page)

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Trinity Nursing & Rehab of Granbury	600 Reunion Court 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	person-centered and measurable. The Administrator said objectives should be measurable to gauge the level of improvement including behavioral and track the needs to ensure the resident was receiving appropriate services. Record review of the facility's policy, Care Plans, Comprehensive Person-Centered, dated 03/2022, revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to met the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes;