STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675572	A. Building B. Wing	05/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Rose Nursing and Rehab Center	1019 Holden St Glen Rose, TX 76043

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to keep the residents free from abuse, neglect, misappropriation of resident property, and exploitation for 2 (Resident #1, Resident #2) of 7 residents reviewed. The facility failed to prevent Resident #2 from being slapped by her spouse which led to redness to the cheek. The facility failed to prevent verbal abuse to Resident #1 by a hospitality aide (HA). The noncompliance was identified as PNC. The noncompliance began 3/2/25 and ended on 4/24/25. The facility had corrected the noncompliance before the investigation began. This failure could place the residents at risk of physical harm, pain, or mental anguish. Findings included: Record review of Resident #1's electronic health record revealed a [AGE] year-old male, admission date 9/16/24, Diagnoses: delusional disorder (persistent false beliefs that are not based on reality), impulse disorder (difficult to resist urges), cerebral infarction (blood flow to brain is blocked), senile degeneration of brain (progressive decline in memory, behavior, and cognitive skills), dementia with other behavioral disturbances (impairment of at least two brain functions such as memory and judgement), Generalized anxiety disorder (severe ongoing anxiety that interferes with daily activities), vascular dementia with agitation (impaired blood flow and can lead to agitation), repeated falls, muscle wasting and atrophy (shrinking and weakening of muscle tissue). Record review of Resident #1's Progress note dated 3/2/2025 revealed 'Resident noted to keep standing up from his wheelchair HA C kept yelling rudely at resident to sit down. Resident yelled back and stated, I'm wet bitch. HA C then said, you don't talk to me like that you fucking dick head she then told him when you can wipe your own ass you can let me know she then said to this RN that she wasn't going to provide care for him and stated you or [HA B] can do it but I refuse to do it.' (continued on next page)

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 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/10/25 at 12:10pm with RN, she stated she was seated at the nurse's station and heard the HA C telling Resident #1 she wasn't going to change him and called him a fucking dickhead. RN removed HA C and had an aide take the resident to his room and change him. When RN removed HA C, she told RN that Resident #1 called her a bitch and she didn't feel good, and RN told her it did not matter, and she could not act like that to a resident. RN stated she told the HA C that it was abuse. RN stated the other aide cleaned Resident #1 up and when the RN assessed him, he had no recall of the event with no adverse effects. RN reported to abuse coordinator. RN stated that HA C was fired . In an interview on 5/11/25 at 9:28am with CNA, she stated that Resident #1 was sitting against the wall in his wheelchair across from the nurse's station and the HA C was sitting at the end of the nurse's station and CNA and RN were there. CNA stated Resident #1 stood up and CNA told him to sit down before he falls, and Resident #1 stated he could not sit down, and HA C asked him why not. Resident #1 stated he was wet, and HA C asked him why and Resident #1 called her bitch and HA C blew up and yelled at him cursing and stated, when you start wiping your own ass, let me know. CNA stated the RN contacted the DON and the HA C told the RN she would not care for Resident #1. Another aide came and took care of Resident #1. HA C was taken off the schedule. CNA stated that this was verbal abuse and felt the HA C had intent to be disrespectful to Resident #1. She stated that Resident #1 did not remember the incident. In an interview on 5/11/25 at 11:06am with HA C, she stated she probably said something to Resident #1 and should not say things like that. HA C stated she yelled at the nurse, and she was a battered woman and was triggered. HA C stated she did not really remember what she said to the resident but probably said something. HA C stated she remembers Resident #1 kept calling her a bitch, and another girl came and took him. Facility had her leave. HA C stated she thinks she said something like, well, I've got your fucking bitch but she did not punch him or anything. HA C stated she did tell the nurse she needed to care for Resident #1 because she was not. HA C stated she did not believe it to be abuse but she just got triggered. In an interview on 5/11/25 at 1:15pm with the DON, she stated the incident with Resident #1 and the HA C was abuse and Resident #1 yelled at HA C and her at him , but staff did immediately intervene and kept him safe. DON stated they suspended and terminated the HA C. DON stated the HA C had been trained on abuse and neglect and dementia care at hire and they do regular in-services. In an interview on 5/11/25 at 2:11pm with the ADM, she stated the HA C had verbally abused Resident #1 and it was witnessed, and she was suspended and terminated. The ADM stated Resident #1 had no emotional distress or any recollection of the event. All staff were retrained, and they did what they were supposed to [removed the resident to safety and reported to the abuse coordinator]. Record review of the HA C employee file revealed Abuse and Neglect training on 1/26/24 and 4/2/24. Record review of the facility's Abuse/Neglect policy dated 10/4/2022 revealed The resident has the right to be free from abuse, neglect, misappropriation of property, and exploitation as defined in this subpart .3. Verbal Abuse: Any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident Rights policy dated February 2021 revealed Employees shall treat all residents with kindness, respect, and dignity .b. be treated with respect, kindness, and dignity; c. be free from abuse, neglect, misappropriation of property, and exploitation;. The facility took the following actions to correct the noncompliance: HA C immediately removed from resident care. Resident assessed and no injury or recall of the incident. Monitored for distress by staff. Continued psych services. Record review of Employee Disciplinary Report dated 3/3/25 for HA C revealed discharge due to verbal abuse towards a resident. SW interview of resident dated 3/3/25 for emotional distress and found no recall or concern. Life safety rounds for 10 residents dated 3/3/25 with no concerns regarding this HA C or abuse noted. Inservice on Abuse and Neglect dated 3/4/25 for 43 employee staff. HR attempted to refer HA C to EMR through email on 3/10/25. This writer interviewed on 5/9/25 at 5:10pm -5/11/25 at 11:25am 1 MA/CNA, 1 CNA, 1 RN Charge nurse, 2 LVN charge nurses, 1 ADON, and 2 Hospitality Aides and they have been trained on abuse and neglect and knew what to do in the event of an incident of abuse. This writer observed Resident #1 on 5/9/25 at 5:03pm, and he smiled and waved but did not answer questions about the incident. No noted distress or fear of staff. This writer interviewed 2 alert residents on 5/10/25 at 10:14am and 11:02am and they stated they had not experienced abuse and felt safe in the facility. Record review of Resident #2's electronic health record revealed an [AGE] year-old female, admission date 04/9/25. Diagnoses: senile degeneration of brain (progressive decline in memory, behavior, and cognitive skills), major depressive disorder, single episode (period of at least two weeks of persistent low mood and loss of interest in activities with a history of previous depressive episodes), mild cognitive impairment of unknown etiology (memory or other cognitive difficulties are noticeable but not severe enough to interfere with basic living), dementia (impairment of two brain functions such as memory loss and judgement), psychotic disturbance, mood disturbance, and anxiety (loss of touch with reality, delusions, effect emotional state, excessive worry and panic), pseudobulbar affect (inappropriate and involuntary laughing and crying due to nervous system disorder). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #2's progress report dated 4/22/25 by DON revealed received phone call from staff and reported that resident spouse slapped her and to please come to unit. Upon arrival to unit, spouse was leaving unit and was upset stating that he had never slapped her before. He stated that she spit the water on him and then he in turn, slapped her. In an observation on 5/9/25 at 5:03pm, the spouse of Resident #2 was sitting next to Resident #2 on the couch in the common area in the secured unit. Two aides and one nurse were within sight of spouse and Resident #2. Resident #2 leaning on spouse hugging him. No distress of fear noted. In an interview on 5/9/25 at 5:27pm with the spouse of Resident #2, he spoke about how difficult it has been to watch his wife (Resident #2) decline. Spouse did not answer questions regarding the incident and appeared shocked and spoke about Resident #2's care. In an interview on 5/10/25 at 11:56am with HA B, she stated that she was standing at the nurse's station prepping trays and the spouse and Resident #2 were behind her at the table, and she heard a slap and turned around and saw the spouse of Resident #2 slap her and say, Don't you do that again to me. HA B stated she was not sure if Resident #2 slapped him, and he slapped her back or if he slapped her twice. HA B immediately took Resident #2 to her room and told the spouse to go to the front. HA B stated the facility staff now had them in sight at all times and there had been no issues since. HA B believed the spouse was hurt over it and a little embarrassed. In an interview on 5/10/25 at 6:04pm with the ADON , she stated she was not sure if Resident #2 slapped the spouse first, but he said she spit on him. The ADON did not feel it was intentional but a reaction. ADON stated Hospice talked to the spouse and his family had to be at the facility with him at all times for the last couple of weeks and now facility staff have to be in line of sight. ADON stated the spouse was torn up about it and thought it was instinct, like a reflex. ADON stated the spouse of Resident #2 comes every day and spends time with her. In an interview on 5/11/25 at 9:28am with CNA, she stated she was standing at the nurse's desk and discussing another resident with staff and Resident #2 was sitting on the couch and the spouse was giving her water or something and she spit it out and CNA heard a slap, slap (twice) and witnessed the spouse slap Resident #2 and ran over and removed Resident #2. CNA stated Resident #2 had redness on her cheek but okay other than that and not out of baseline. CNA stated the spouse could come with supervised visitation and the past week has had to be in line of sight with staff. No incidents before or since. In an interview on 5/11/25 at 11:46am with Family Member, son of Resident #2, he stated he was not aware of any domestic violence or physical aggression from his dad in the past. Family Member did not believe the spouse of Resident #2 understands she is dying and not going to get better. Family Member stated he or his sister had to be with their dad when he came to visit Resident #2 for about two weeks and now, they allow him there under their supervision and could not take her out of the facility. Family Member believed the facility did do counseling for the spouse and that was the plan. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/11/25 at 1:15pm with DON, she stated she caught the spouse of Resident #2 coming out of the secure unit right after the incident and he stated he could not believe he did that and had never done that before. Resident #2 had a slight red mark, and it did not bruise and was barely red. No change in behavior. Facility referred Resident #2 to psych services and the counselor has been seeing him. Family had to be here to supervise and now staff monitor him, and he knows he could not be alone with her. DON stated she did not feel there was intent, and psych picked them up for family counseling. Record review of Diagnostic Assessment for Resident #2 dated 4/25/25 revealed female unable to answer questions in a linear fashion. Her husband has been providing care for her the last two years with help from hospice the past 6 months. He notes a general slow decline over several years. Severe cognitive impairment suggests she will not benefit from individual psychotherapy. We are offering family services to assist her husband in appropriate care taking including demonstrating of safe space, demonstration of safe interactions, and monitoring behaviors while keeping the patient safe. This will include medication management and safe eating. Record review of Abuse/Neglect policy dated 10/4/22 revealed The resident has the right to be free from abuse, neglect, misappropriation of property, and exploitation as defined in this subpart .4. Physical Abuse: Includes, hitting, slapping, pinching, and kicking. The facility took the following actions to correct the noncompliance: Resident immediately removed from spouse and spouse removed from facility. Resident assessed and had slight red mark that disappeared with no bruise or further injury. No emotional distress or recall out of baseline. Facility referred Resident #2 to psych services on 4/24/25. Psych assessment on 4/25/25. Facility and spouse following psych recommendations of supervision and counseling for spouse. Family supervision in facility for two weeks and now on facility staff supervision. Inservice of facility staff on abuse and neglect dated 4/22/25. This writer observed 3 staff in line of sight providing supervision with Resident #2 and spouse on 5/9/25, 5/10/25 and 5/11/25 with no distress or fear noted from Resident #2.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure resident was free from misappropriation of all controlled drugs is maintained and periodically reconciled for 1 (Resident #3) of 7 residents reviewed for controlled substances. The facility failed to ensure LVN B conducted proper counting of the medications at shift change. The facility failed to ensure LVN B reported an identified drug discrepancy for Resident #3. This failure may put the residents at risk of drug diversion and their pharmaceutical needs not being met. Findings included: Record review of Resident #3's electronic health record revealed an [AGE] year-old female, admission date 07/03/24. Diagnoses: congestive heart failure (heart doesn't pump blood as well as it should), type 2 diabetes (adult-onset diabetes), presence of cardiac pacemaker (device provides electronic pulse to heart as needed to regulate heart rate), senile degeneration of brain (progressive decline in memory, behavior, and cognitive skills), muscle wasting and atrophy (loss of muscle mass and strength). Record review of Provider Investigation Report 573259 dated 3/25/25 revealed blister packet on medication room counter at 6:16am on 3/25/25 by LVN C. LVN C inquired with off going night nurse (LVN B) to inform her the count was off. LVN B stated that she noted it during the night but did not want to wake the previous nurse (LVN A). LVN A stated she was not aware and did not administer the med. LVN C reported to DON and ADM . Search initiated and all other narcotics accounted for. Police notified and began drug screening. LVN B did not show up for drug screen and others tested negative. Self-termination for failure to report timely for drug screening. Reviewed Narc count sheet and revealed the count at 21. Staff re-educated. Statement from LVN A revealed LVN B would not count with her upon shift change the evening of 3/24/25 but LVN A counted on her own and it was correct. Record review of written statement dated 3/24/25 by LVN B revealed Resident #3's Tramadol was 1 tablet short. Resident #3 had passed away at 8:45pm that evening and her hospice nurse showed up at shift change so they never counted. Record review of written statement dated 3/26/25 by DON revealed medication count for Resident #3 Tramadol was off by one tablet. Count sheet said 21 but actual count was 20. Medication card located in locked cabinet but not in basket. LVN B verbalized to LVN C she knew the count was off and she thought LVN A had given it and forgot to write it down. LVN A stated she did not. LVN B stated she counted at 2am and realized the difference in count. DON received text from LVN B stating she had counted cabinet with LVN A but not lock box because hospice was there, and she didn't get to. Did not want to call LVN A in the night. DON contacted LVN B at 1:20pm and told her she needed her to come write a statement and do urine screen and she said she would be right in. At 3:05pm, DON text LVN B again asking when she would be coming and to come as soon as possible. As of 6:38pm, ADM nor DON have had conversation with LVN B. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of written statement dated 3/26/25 by LVN C revealed she went into med room to count meds at 6:15am on 3/25/25. Resident #3 tramadol was sitting with the count sheet folded over it next to the basket of narcotics. I pulled it first and noticed the count was off by 1. LVN C asked LVN B why it was short, and she stated she noticed last night about 2am and thought LVN A who worked forgot to sign it out and didn't want to text her in the middle of the night. LVN C told her she would get with LVN A to ask her. LVN C asked LVN A, and she stated no. LVN C then took it to DON. Record review of statement dated 3/26/26 from MA B stated on 3/23/25 she gave Resident #3 her morning meds of tramadol and her meds were discontinued shortly after, so she didn't give her anymore. MA B counted after 6am-2pm and 2pm-10pm shift and count was correct. Record review of written statement dated 3/26/25 by LVN A revealed on 3/23/25 she was notified that Resident #3 would be on hospice care. At this time during 6am-2pm shift maintenance meds had not been discharged . At that time, MA B and LVN A gave Resident #3's morning meds crushed in pudding. LVN A stated she was present, and Resident #3 took her medications without incident. After that scheduled dose of meds a new order from hospice came and it was to discontinue all maintenance meds, only comfort meds were to be given. The 23rd was the last time scheduled Tramadol was given. On 3/25/25 LVN A was notified by LVN B that Tramadol was off by 1 pill and had I administered another dose and I stated no. On the morning of 24th my count was correct. Evening of 23rd I counted with the other nurse and correct. Evening of 24th LVN B did not count with me. I counted for my own accountability. On the night of 3/24/25 Resident #3 passed away and LVN B came in after 8pm. We did not count together hospice nurse was there and we were answering her questions, but LVN A had counted. On, 3/25/25 - LVN B contacted me and asked had I used it for another patient. Record review of 5 Panel Test Result Records for LVN A dated 3/26/25 was negative. Record review of Resident #3's electronic record revealed Tramadol discontinued 3/23/25 and hospice care and comfort measures put in place. Record review of eMAR dated March 2025 for Resident #3 revealed last Tramadol given was 3/23/25 at 8am. Record review of Resident #3's electronic health record revealed she passed away 3/24/25 at 8:45pm. Family at bedside. In an interview on 5/10/25 at 11:25am with MA A, she stated she is not aware of any missing medications. Staff count the cart at change of shift with oncoming nurses. MA A stated they always count and have always had to count. They are no longer to keep the keys when going to another unit and must count and turn in the keys when going to another unit and again when coming back to the other unit, so the keys are always with the nurses. MA A stated that the key thing started a couple of months ago. MA A stated if the count is off, you immediately report to DON and ADM. In an interview on 5/10/25 at 12:10pm with RN, she stated staff count the carts and med rooms at change of shift. If there are any missing meds, they call the DON. It has always been the policy. RN stated when the missing medication happened, they tested everyone, and one nurse did not show, and she got terminated. No one tested positive. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/10/25 at 6:04pm with the ADON , she stated LVN B was notorious for being late, like an hour late, and staff never knew when she would get there so staff counted themselves because they have to be back for another shift. ADON stated she tried hard to get LVN B to come on time, but she always had excuses and they tried to get her to come do a drug test and she was too busy. ADON stated that LVN B never wanted to count meds. ADON stated LVN B was trained and counseled on the issues of being late and not counting meds several times, sometimes by ADON herself. In an interview on 5/11/25 at 11:25am with LVN A, she stated on 3/24/25 Resident #3 passed away and she remembers LVN B coming in and LVN A stated she stayed to help, and hospice had come in and LVN B was very late, and she did not count with LVN A. LVN A stated she herself did count anyway but LVN B said, No, we're good and so LVN A counted on her own and that was norm for LVN B. LVN A stated the count was accurate and she left. LVN A stated she was called in to do the urine test. LVN A stated she had been trained on counting at change of shift and that was the expectation. In an interview on 5/11/25 at 1:15pm with the DON, she stated staff count the med carts, the med rooms, and the discontinued meds which is in the med rooms at every change of shift. DON stated she was informed there was a missing tramadol and looked and ADM and DON couldn't find anything and started calling staff in to do drug testing and one of the staff, LVN B, was notified and she said she'd be in and never came in and notified her again several times and always had an excuse and it was 5-6 in the evening and the next message she got the next day she could come in and then still didn't come and had to go to the doctor to be drug tested but she just couldn't get her in and policy states they have 3 hours after the request to come in when made and she tried every opportunity to get her to come in and so she self-termed. DON stated she felt LVN B very well could have taken the pill because she wouldn't come in. DON stated Resident #3 passed away and that same night was when the pill went missing. DON stated they have monitored closely and in-serviced staff regarding counts and try to pull the discontinued medications off the units and staff have to count with her and they have to sign off on it. DON stated she went weekly to remove discontinued meds but did try to do it more frequently like 2-3 times a week. The tramadol for Resident #3 had just been discontinued the day before on 3/23/25 and Resident #3 passed away 3/24/25 and they noticed it was gone the morning of 3/25/25. DON stated she did random audits now and went behind staff now to make sure counts were done. DON stated she had been informed that LVN B would come late and refuse to do counts. DON stated she counseled LVN B and LVN B assured DON she was doing it. In a record review of Controlled Substances policy dated November 2022 revealed .Dispensing and Reconciling Controlled Substances .3. Nursing staff count controlled medications inventory at the end of each shift, using these records to reconcile inventory count. 4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report the results of an investigation to the State Survey Agency within 5 working days of the incident for 1 (Resident #4) of 5 Residents reviewed. The Administrator failed to report the findings of an investigation concerning Resident #4 to the State Survey Agency within 5 working days of the incident. This failure could put the residents at risk of compromised protection and oversight of the state agency. Findings included: Record review of Resident #4's electronic health record revealed a [AGE] year-old female, admission date 02/01/25. Diagnoses: unspecified dementia (decline in cognitive function), senile degeneration of brain (progressive decline in cognitive abilities that occurs with aging), anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), major depressive disorder (persistent feelings of sadness, loss of interest, and other symptoms that interfere with daily life), muscle weakness. Record review of the Provider Investigation Report dated 3/21/25 revealed Resident #4 was noted pounding on the secure unit door and was agitated but redirected. Staff looked in resident room during next round, within 30 minutes, and found the air conditioning unit on the floor and the window open. Staff began search of resident and located her in the secure unit courtyard area potentially hiding from staff within 30 minutes. No injury noted but agitated and resisting to come inside for breakfast. discharged to behavioral health hospital and staff in-serviced on missing residents. No investigatory findings noted in file. In an interview on 5/10/25 at 6:50pm with the ADM , she stated she did not submit a 5-day for the incident because she determined it was not an elopement. ADM stated she only reported because she was iffy (unsure) if she needed to and then came to the realization that elopement didn't happen. ADM stated that in her mind it didn't even need to be reported and the resident was never out of a safe environment, so she did not do the 5-day. The ADM stated the weather was mild and secure unit residents have access to that area, and it was safe. In an interview on 5/11/25 at 9:28am with CNA, she stated that a little after 6:00am she heard Resident #4 kicking the secure unit door and redirected her. CNA stated she was rounding getting residents up for breakfast and around 615am-620am, CNA went into Resident #4's room and saw the air conditioner on the floor and the window open and ran and told the nurse and started searching. CNA stated she walked all around outside and come to find out Resident #4 was in the garden area, and no one thought to look there for maybe 30 minutes. CNA stated Resident #4 never eloped and was safe. Record review of progress notes dated 3/21/25 at 7:10am revealed resident was found in secure unit courtyard, no injuries upon assessment. Resident is on one-on-one monitoring. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675572	A. Building B. Wing	05/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Rose Nursing and Rehab Center	1019 Holden St Glen Rose, TX 76043

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of progress note dated 3/21/25 at 11:00am revealed resident transported to behavioral health hospital. In an interview on 5/11/25 at 1:15pm with the DON, she stated that the ADM is responsible for completing the 5-day report. In an interview on 5/11/25 at 2:11pm with the ADM, she stated she reported the 5-day today. Record review of the facility's Abuse/Neglect policy dated 10/4/22 revealed Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist .1. The administrator in consultation with the Risk Management Department will be responsible for investigating and reporting cases to the HHSC .f. The written report must be sent to HHSC no later than the fifth working day after the initial report.