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	11/21/2025

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 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 interview and record review, the facility failed to describe in the care plan the services provided due to the resident's exercise of rights and failed to describe in the care plan the resident's preference and potential for future discharge for 5 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5) of 7 residents reviewed for care plans.The facility failed to include the residents' preference for discharge and if their desire to return to the community had been assessed in Resident #1, Resident #2, Resident #3, Resident #4, Resident #5 care plans.The facility failed to update the care plan of an advanced medical directive ordered for Resident #1. This failure could put the residents at risk of their person-centered care plan not being implemented to meet their preferences and goals which could affect their medical, physical, mental and psychosocial needs. Findings included: 1.Record review of Resident #1's electronic health record revealed a [AGE] year-old female, admission date [DATE], Diagnoses: anxiety disorder (anxiety that interferes with daily activities), senile degeneration of brain (progressive decline in memory, behavior, and cognitive skills), major depressive disorder, recurrent, severe with psychotic symptoms (persistent and overwhelming sadness with delusions or false beliefs), bipolar II disorder (alternating periods of elevated mood and major depressive episodes), generalized anxiety disorder (severe ongoing anxiety that interferes with daily activities). BIMS of 04, severely impaired cognition. Record review of Resident #1's Care Plan dated [DATE] revealed no mention of discharge planning.Record review of Resident #1's Out-Of Hospital-Do-Not-Resuscitate Order dated [DATE] revealed Resident #1's MPOA directs that none of the following resuscitation measures be initiated or continued for the person: CPR, cardiac pacing, defibrillation, advanced airway management, artificial ventilation.Record review of Resident #1's Order in her electronic health record dated [DATE] revealed DNR as current and verified.Record review of Resident #1's Care Plan dated [DATE] revealed Full Code CPR order in place along with a POA. Interventions included to review the medical record to ensure the proper documents are signed. In an interview on [DATE] at 9:52am with RN A, she stated Resident #1 was a DNR. She stated she would look for if a resident was DNR or CPR status in the chart, on the computer, and not on the care plan. RN A stated the DON and SW do care plan meetings with families and residents, and she does not attend those or update any care plans. RN A stated she does not know who updates the care plans.In an interview on [DATE] at 10:03am with the DON, she revealed the SW updates the DNR in care plans or possibly the MDS Coordinator. The DON stated she did not know the DNR status had not been updated in the care plan for Resident #1, but she knew it was to be done.In an interview on [DATE] at 11:33am with the MDS Coordinator, she stated the SW was the one that should put the DNR in the care plan. The MDS coordinator stated that when she did a quarterly MDS, she would check the care plans to check that the DNR status, diagnosis, and diet are up to date because those are things that change. She stated that she was not aware that Resident #1's care plan was not updated.In an interview on [DATE] at 11:45am with the ADM, she stated the SW would receive the DNR and put in the Order and update it in the electronic medical records. The ADM stated she was not sure when the SW would put it in the care plan but assumed it was when she completed the review. The ADM stated care plans are multi-disciplinary on who was responsible, but the SW was who did it. When an interview was attempted, the ADM stated the SW was on PTO and not available to be interviewed but the ADM stated the SW did not know about the DNR status not being updated in this record, or it would have been done. 2.Record review of Resident #2's electronic health record revealed a [AGE] year-old male, admission date [DATE], Diagnoses: atrial fibrillation (rhythm disorder where the upper chambers beat irregularly and rapidly), cerebral infarction (blood flow to the brain is interrupted causing brain cells to die), hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (paralysis & weakness), generalized anxiety disorder (severe ongoing anxiety that interferes with daily activities), vascular dementia, moderate, with other behavioral disturbance (cognitive decline caused by damage to blood vessels in the brain), major depressive disorder, recurrent, severe with psychotic symptoms (persistent and overwhelming sadness with delusions or false beliefs). BIMS of 03, severely impaired cognition.Record review of Resident #2's Care Plan dated [DATE] revealed no mention of discharge planning. 3.Record review of Resident #3's electronic health record revealed a [AGE] year-old female, admission date [DATE], Diagnoses: senile degeneration of brain (progressive decline in memory, behavior, and cognitive skills), atherosclerotic heart disease of native coronary artery without angina pectoris (plaque buildup that restricts blood flow but not yet severe enough to cause chest pain)