STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676071	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Groesbeck Ltc Partners	607 Parkside Dr Groesbeck, TX 76642

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45957 Based on observation, interview, and record review the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodations of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 3 of 7 residents (Residents #1, #2 and #3) reviewed for resident rights. The facility failed to ensure Resident #1, Resident #2, and Resident's #3 call lights were within reach on 04/29/2025. This failure could place residents at risk of their needs not being met. Findings include: 1.Record review of Resident #1's admission record, dated 04/29/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: nontraumatic intracerebral hemorrhage in hemisphere cortical (bleeding within the brain tissue, not caused by injury, specifically in the outer layer of one half of the brain.), cachexia (waste disorder characterized by significant weight loss muscle wasting, and fat loss), muscle weakness (reduce ability of the body to contract muscle properly, resulting in a lower strength in one or more muscle), lack of coordination (having difficulty controlling your movements and making them work together smoothly) and need for assistance with personal care (needing help with basic, everyday activities that are necessary for maintaining hygiene, health, and overall well-being). Record review of Resident #1's Admission MDS assessment, dated 04/11/2025, reflected the resident had a BIMS score of 00, which indicated severe cognitive impairment. Resident #1 was dependent in the areas: toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, and putting on/taking off footwear. Resident #1 required substantial/maximal assistance in the areas: eating, oral hygiene, and personal hygiene. Record review of Resident #1's care plan, dated 04/29/2025, reflected Resident #1 was care planned for falls and had an intervention be sure his call light is within reach. During an observation on 04/29/2025 at 9:24 am., Resident #1 was observed in his chair while his call light was observed hanging over his nightstand approximately 3 feet away from Resident #1's chair. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attempted to interview Resident #1 on 04/29/2025 at 9:24 am. but it was not successful due to his severe cognitive impairment. 2.Record review of Resident #2's admission record, dated 04/29/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included: paranoid schizophrenia (when someone experiences strong paranoia/they are intensely suspicious and fearful of others), type 2 diabetes mellitus without complications (condition were your body doesn't use insulin properly causing high blood sugar levels), muscle weakness (reduce ability of the body to contract muscle properly, resulting in a lower strength in one or more muscle), and anxiety disorder (mental health condition characterized by excessive and persistent worry and fear). Record review of Resident #2's Annual MDS assessment, dated 02/14/2025, reflected the resident had a BIMS score of 15, which indicated cognitively intact. Resident #2 required supervision or touching assistance in the area of shower/bathe self. Record review of Resident #2's care plan, dated 04/29/2025, reflected Resident #2 was care planned for risk of falls r/t psychotropic med use, and had an intervention for Resident #2's be sure Resident #2 call light is within reach us for assistance as needed. During an observation and interview on 04/29/2025 at 9:24 am., Resident #2's call light was observed hanging between the wall and his bed. Resident #2 stated that he could not reach his call light if he tried to. Resident #2 stated he would have to move his bed to get to his call light. Resident #2 stated he did not know how long his call light was behind his bed. During an observation on 04/29/2025 at 1:40 pm., Resident #2's call light was observed hanging between the wall and his bed. Resident #2 was sleep at the time of this observation. 3.Record review of Resident #3's admission record, dated 04/29/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included: systolic heart failure (happens when the heart's main pumping chamber, the left ventricle, doesn't pump blood effectively), cognitive communication deficit (someone had trouble communicating because they're struggling with thinking and problem-solving skills), lack of coordination (having difficulty controlling your movements and making them work together smoothly), and anxiety disorder (mental health condition characterized by excessive and persistent worry and fear). Record review of Resident #3's Quarterly MDS assessment, dated 03/03/2025, reflected the resident had a BIMS score of 12, which indicated moderate cognitive impairment. Resident #3 required partial/moderate assistance in the area of shower/bathe self, lower body dressing, and putting on/taking footwear. Record review of Resident #3's care plan, dated 04/29/2025, reflected Resident #2 was care planned for risk of falls r/t gait/balance problems, psychoactive drug use, and had an intervention of be sure Resident #3's call light is within reach and encourage her to use it for assistance as needed. During an observation and interview on 04/29/2025 at 10:15 am., Resident #3's call light was observed hanging towards the ground on the left side of her bed. Resident #3 stated that she could not reach her call light if she tried to. Resident #3 was not aware of how long her call light had been out of reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the CNA A on 04/29/2025 at 1:30 pm., CNA A stated she and CNA B both were working the 100 hall where Residents #1, #2, and #3 resided. CNA A stated CNAs made rounds every two hours or as needed. CNA A stated it was everyone's responsibility for ensure residents' call lights were within reach. CNA A stated, when making rounds, CNAs checked to see if residents needed assistance and ensured the residents were safe. CNA A stated the purpose of a call light was a resident to call for assistance. CNA A stated she was not aware Residents #1, #2 or #3's call lights were not within reach. CNA A stated if a resident could not reach the call light, the resident would not be able to call for help if they need something. During an interview with CNA B on 04/29/2025 at 1:50 pm., CNA B stated she and CNA A both worked the 100 hall where Residents #1, #2, and #3 resided. CNA B stated CNAs made rounds at least every two hours unless there was a resident who may require more frequent checks. CNA B stated that it was the CNAs and anyone who entered the resident's room to ensure the call lights was in reach. CNA B stated during rounds, CNAs were taught to ensure the resident call lights were in reach. CNA B stated she was not aware Resident #1, #2, or #3's call light was not within reach. CNA B stated if a resident's call light was not in reach the resident would not be able to call for assistance. During an interview with the DON on 04/29/2025 at 2:55 pm., the DON stated all residents' call lights should be always within reach. The DON confirmed that CNA A and CNA B were working the 100 halls where Residents #1, #2, and #3 resided. The DON stated it was everyone's responsibility to ensure residents' call lights were always within reach. The DON stated if a resident's call light was not within reach the resident would not be able to receive assistance if they needed it. During an interview with the ADM on 04/29/2025 at 3:55pm., the ADM stated call lights should always be within reach. The ADM stated it was everyone's responsibility to ensure the call light were within reach. The ADM stated if a resident call light was not within reach, then the resident may not be able to call for assistance. The ADM stated her expectation was for all resident's call lights to always be within reach. A record review of the facility's Answering the Call Light policy, undated, reflected The purpose of this procedure is to ensure timely response to the resident's requests and needs. General Guidelines .5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident