STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455915	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granbury Care Center	301 S Park St 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47044 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free from accident hazards as was possible and each resident received adequate supervision and assistive devices to prevent accidents for 2 of 5 residents (Resident #1 & Resident #2) reviewed for accidents and supervision. 1. The facility failed to ensure Resident #1, and Resident #2 were properly supervised during smoke break to prevent agitation and altercations. These failures could place the residents at risk of injury. Findings included: Record review of Resident #1's electronic health record revealed a [AGE] year-old female, admitted [DATE], Diagnoses: hypertension (high blood pressure), unspecified dementia (brain degeneration) chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe), major depressive disorder (persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities). Record review of Resident #1's electronic health record revealed the most recent Care Plan revision dated 03/19/25, date initiated of 12/13/24, revealed, Resident resides in SecureUnit .assist and monitor resident for off unit activities. Record review of Resident #1's progress note dated 3/16/25 at 1:54 pm revealed Experienced a behavior in the hallway. Resident to resident, agitated, cognitive impairment. Resident was yelling and she hit the male resident and he hit her back. Record review of Resident #2's electronic health record revealed a [AGE] year-old male, admitted [DATE], Diagnoses: cerebral infarction (blood flow to the brain interruption causing brain tissue damage), anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), adjustment disorder with mixed anxiety and depressed mood (struggle to cope with a significant stressor, experiencing both anxiety and depressed mood symptoms), personal history of transient ischemic attack and cerebral infarction without residual deficits (occurrence of mini stroke and blood flow to brain interrupted without lasting neurological problems), vascular dementia with agitation (behavioral disturbance featuring exaggerated motor activity and verbal/physical aggression). (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's electronic health record revealed the most recent Care Plan revision dated 3/19/2025, initiated on 7/17/24, revealed, Resident is a smoker .2. Explain/Show where designated smoking areas are and smoking times-repeat PRN. 3. Monitor PRN when smoking to assure resident safety. Record review of Resident #1's Provider Investigation Report, dated 03/21/2025, revealed , Residents were waiting outside smoke porch door for staff member to come supervise smoke break. Resident #1 was yelling and hollering about smoke break being late. Resident #2 told Resident #1 to shup up. Resident #1 slapped at Resident #2's face and Resident #2 slapped back ay Resident #1's mid-section. Record review of Smoke Breaks and Department undated revealed Monday through Friday: 8:30am-activities, 11:00am-Southside CNA, 1:30pm -Dietary, 4:00pm-Activities, 6:00pm-housekeeping, 8:30pm - Northside CNA. Saturday & Sunday: 8:30am - Northside CNA, 11:00am - Southside CNA, 1:30pm - Dietary, 4:00pm - Northside CNA, 6:00pm-Housekeeping, 8:30pm-Southside CNA. Interview on 3/23/25 at 4:48 pm, CNA A stated Resident #1 was on secure unit. Staff got her and took her to smoke and bring her back every time. Interview on 3/23/25 at 5:01 pm, Resident #2 stated the residents yelled when staff were late, and Resident #1 was yelling, and staff were late that day and he told Resident #1 to be quiet and she hit him, and he hit her back. Resident #2 stated there were no injuries. Resident #2 stated staff were usually late on weekends, like 15 to 30 minutes late. Resident #2 stated that no staff were with them during that time, and they were waiting on staff. Observation on 3/23/25 at 5:57 pm at hall inside smoker door revealed a group of 8 residents waiting for smoke break. One female resident stated staff were usually 15 minutes late and today's schedule said housekeeping, but no one from housekeeping was there at 6:00 pm on a Sunday. Male resident stated sometimes they were 30 minutes late. Sign on wall near door stated smoking times and department responsible. Resident #2 came to the group and asked if anyone had come yet and residents told him no. Resident #2 stated he already went to north side of building staff to see if they would smoke the residents, and they said no. Observation on 3/23/25 at 6:10 pm revealed Resident #2 went to south side nurse's station. Resident #2 asked nurse who was going to smoke the residents and the nurse stated she can't because she gets bronchitis. Resident #2 asked if the aide could, and the nurse said she can't either because she just had stints put in. Resident #2 asked CNA B and she stated people are doing things and can Resident #2 give her 5 minutes. CNA B stated to Resident #2 not to get all crazy like yesterday and hit the walls and yell. Resident #2 stated he was just trying to get someone to smoke the residents, and he got frustrated. Residents taken out to smoke at 6:15pm. Interview on 3/23/25 at 6:15 pm with CNA B stated she was allergic to smoke, but someone has to take them. She stated facility has staff, but the schedule is not followed, and it is not logical. CNA B stated no one wants to take them. This happens a lot on weekends. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 3/24/25 at 10:37 am, CNA B stated Saturday 3/22/25, she took the resident's out three times yesterday because no one else would take them out. CNA B stated she could hear staff over the intercom to get someone to take them (residents) out. Saturday Resident #2 got very upset and punched a wall and she understood; he was upset. CNA B stated she has seen residents wait an hour past smoke time. Saturday, they waited about 30 minutes before CNA B took them out one time, another time it was on time, and the last time CNA B took them out, but it was an hour late because she was working two halls all weekend and no one else would do it. She stated it was hard to do that and take all the smokers out. CNA B took the residents out at the 11am smoke break time and that was when Resident #2 punched the wall, because she did not get residents out until after 11:30 am. CNA B stated Resident #2 calmed down because CNA B took him out. She stated Resident #2 was the person that went around to get someone to smoke the residents. Interview on 3/24/25 at 10:56 am, the ADON stated she believed staff were running late for the smoke break when the incident between Resident #1 and Resident #2 occurred, and the smoke breaks were late on weekends. The ADON stated the schedule was created by AD and ADM and she told them to pick someone specific from each department, but she did not think that happened. She stated she had smokers tell her staff were late, and she told the DON and ADM. She stated they were aware of the weekend issue and have the smoking schedule posted everywhere. The ADON state the facility brought the hospitality aide on to make it better, but he did not work weekends. She stated the smoke break times was a failure. Interview on 3/24/25 at 12:25 pm, the AD stated he made the smoking schedule with the ADM, and he had a hospitality aide that did smoke breaks on Monday through Friday at 8:30 am, 11:00 am, and 1:30 pm. He stated there should be a floor tech at facility on 6:00 pm on Sundays that would be a part of housekeeping. The AD stated he heard from residents and staff that there is an issue on weekends and occasional evenings, and he was trying to figure it out. He stated he can only make suggestions and can't hold staff accountable. Staff bosses would be the ones to hold them accountable. The AD stated the facility, including the ADM, knew there was an issue when there was an altercation with Resident #1 and Resident #2. Interview on 3/24/25 at 2:00 pm with the ADM stated the smoke break was late the time of the incident with Resident #1 and Resident #2. The ADM stated the facility had a weekend floor tech, but he had open heart surgery and there was a breakdown in communication. Record review of Resident Rights undated revealed 2. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Under Respect and Dignity: 3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health and safety of the resident or other residents.