

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455915	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/12/2025
NAME OF PROVIDER OR SUPPLIER  Granbury Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>(continued on next page)</p>

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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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to ensure that a resident received CPR in accordance with professional standards of practice for one (Resident #1) of six resident's reviewed for CPR. On [DATE] at 12:20 am, LVN A failed to initiate CPR on Resident #1 who was a full code status. Resident #1 expired on [DATE]. An Immediate Jeopardy was identified on [DATE] at 5:00 pm. The noncompliance began on [DATE] and ended on [DATE]. It was determined to be past non-compliance due to the facility having implemented action that corrected the non-compliance prior to the beginning of the investigation. This failure could affect residents who are full code status and could need CPR by placing them at risk of death. Findings included: Record review of Resident #1's admission Record, dated [DATE] revealed an [AGE] year-old female, with an original admission date of [DATE] and the latest readmission date of [DATE]. The resident expired on [DATE]. The resident had a primary diagnoses of unspecified dementia (the specific type of dementia cannot be clearly identified, despite the presence of cognitive decline and memory loss) and congestive heart failure (hearts ability to pump blood is compromised). The resident was under the care of hospice. Resident #1 was a full code. Resident #1 had a BIMS score of 14 indicating she was cognitively intact. Record review of Resident #1's Physician's Orders, dated [DATE], revealed an active order with a start date of [DATE] for full code. Record review of Resident #1's Care Plan, last revised on [DATE] revealed the following: Focus: Full Code/CPR in place. Goal: Resident has an order for CPR to be initiated will be followed. Interventions: Initiate CPR if the resident is without a heartbeat or not breathing. Notify EMS. Record review of Resident #1's progress noted, dated [DATE] at 3:40 am, by LVN A, revealed the following [in part]: [12:05 am] aide at this time has reported that patient is noted breathing abnormally. [12:07 am] This nurse went to assess pt and pt was noted semi-Fowlers (30 to 45 degree angle with the head elevated) in bed with head cocked to left side, pt appears to be taking deep breaths for air constantly at this time with eyes fixed as if she is imminent to passing. palpated for pulse and pulse is faint. skin is still warm to touch. [12:10 am to 12:15 am] Went to verify advance directive and was not found in hospice binder but did verify in PCC full code only. [12:20 am] returned to pt bedside and pt was noted unresponsive. aide prepared body immediately. A record review of Resident #1's vitals revealed there were no vitals documented in the Electronic Health Record on [DATE]. In an interview on [DATE] at 11:00 am, the DON said she did not know why LVN A did not initiate CPR on Resident #1. She said LVN A told her she was distracted by a phone call from her family member. In an interview on [DATE] at 1:40 pm, LVN A she said at the time of the incident on [DATE] at approximately 12:00 am, she had a lot going on, and said I had an emergency with my kids who were home alone and was distracted. In my head, all hospice patients have DNR's. My aide came and told me [Resident #1] took a turn, I went and saw her, and she was already basically gone. I went and looked at the hospice binder and did not see an advance directive. I looked in PCC (Electronic Health Record) and it said full code. I thought it was a mistake. I did not honor her code status. In an interview on [DATE] at 1:50 am, CNA B said on [DATE] at about 12:00 am, I went to check on and change [Resident #1] and she was having trouble breathing, I went and told [LVN A], the nurse went down with me to check her. [LVN A] said she didn't look good, and she went back to the nurses' station to look at computer. I stayed with [Resident #1], she got worse, she stopped breathing and had a blank staring off look. I went and got [LVN A] again. She came and took her vitals, told me she stopped breathing and passed, and told me to perform post-mortem care. [LVN A] did not initiate CPR. In an interview on [DATE] at 2:15 pm, the Medical Director said Resident #1 had an order for full code. He said it was his expectation for staff to follow the physician's orders. He said in this instance, failing to follow physician's orders had the potential that the resident's life could have been saved. In an interview on [DATE] at 3:19 pm, Resident #1's Family Member, he said LVN A called him sometime after midnight on [DATE] telling him that Resident #1 stopped breathing and did not have a DNR in place. He thought LVN A had told him CPR had been attempted but was too distraught to know for sure. In interview and record review on [DATE] at 10:30 am, the Administrator said he was no longer the Administrator of the facility since [DATE]. He said he was the Administrator of the facility during the time of the incident. He said he reported the incident and the LVN should have initiated CPR on Resident #1 who was a full code status. Record review of the facility policy Cardiopulmonary Resuscitation, not dated, revealed the following [in part]: Cardiopulmonary resuscitation (CPR) is a method of providing systemic circulation by manual chest compression and oxygen by mouth-to-mouth breathing or providing air to the lungs via ambu-bag. The</p>		