

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Harbor Lakes Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 2nd 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain pharmacy services procedures that ensure accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for 1 of 5 (Resident #114) residents reviewed for medication administration in that: The facility did not accurately reconcile medication orders for Resident #114. This failure could place residents at risk for improper medication administration. The findings were: Record Review of Resident #114 Face Sheet dated 9-4-2025 revealed resident was a [AGE] year-old female admitted on [DATE] for after care following joint replacement surgery of left hip, with diagnosis of: Idiopathic Neuropathy (weakness, numbness, and pain from nerve damage of unknown cause), Osteoporosis (condition in which bones become weak). Record Review Resident #114 medication order for Lyrica 150 mg (pregabalin) dated 9-4-2025 Give 1 capsule by mouth two times a day for neuropathy (weakness, numbness, and pain from nerve damage). Start date 9/5/2025 Discontinue date 9/10/2025 by LVN A. Record Review of Medication Review dated 9-4-2025 for Pregabalin revealed Resident #114 had received 1 tablet of 50 mg Pregabalin twice daily every day from 9-5-2025 to 9-9-2025. Record Review of nursing note dated 9-10-2025 created at 7:45 am by DON revealed Lyrica order was clarified with PMD and NP, Resident #114 was to receive 1- 50 mg capsule twice daily routinely. Observation on 09/10/2025 at 7:15 am revealed CMA B obtained Resident #114's Pregabalin (Lyrica 50mg) from the locked medication box of the medication cart. Upon checking orders, he realized the computer EMR (electronic medication record) milligram dosage did not match the medication label on the card of medication or the logbook sheet in the controlled substance sign out book. CMA B stated the orders did not match so he did not administer the medication. He then went to talk with his nurse to get order verification. CMA B administered the rest of Resident #114's medications and informed them he would get the Pregabalin order verified and would return to administer it. Record Review on 9/10/2025 at 7:18 am of the Controlled Substance Logbook and medication card for the controlled substance Pregabalin revealed the dose (50 mg) had been given twice a day since delivery on 9-5-2025 and Controlled Substance logbook was current and correct on count of the medication. Interview on 9/10/2025 at 8:00 am with LVN A revealed CMA B advised her of the discrepancy and had reported findings to her DON for advising. Interview on 9-10-2025 at 9:15 am with the DON revealed she was made aware of drug order discrepancy by the nurse. DON stated she clarified order with PMD via phone, clarified order with NP, then discontinued the incorrect order in the computer, put in new order with correct dosage, put in a progress note related to the discrepancy on 9/10/25. DON stated orders are transcribed into the computer system by the nurses and an in-service with education on the issue had been initiated on 9-10-2025. The DON stated a negative outcome could have caused harm to the resident by giving a higher dose. Record review of the facility's policy titled Pharmacy Services Overview dated 2001 and revised 2007 revealed [in part] #3 The facility shall contract with a licensed Pharmacist to help obtain and maintain timely and appropriate pharmacy services that supports' residents' needs, are consistent with current standards of practice, and meet state and federal requirements. This includes, but is not limited to, collaborating with the facility and medical director to: Develop, implement, (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 676185	Facility ID: 676185 If continuation sheet Page 1 of 2

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluate, and revise (as necessary) the procedures for the provision of all aspects of pharmacy services including ordering, delivery and acceptance, storage, distribution, preparation, dispensing, administration, disposal, documentation, and reconciliation of all medications and biologicals in the facility.		