STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676192	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garnet Hill Rehabilitation and Skilled Care	1420 McCreary Rd Wylie, TX 75098

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for one of five residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 was free from sexual abuse. Resident #1 was cognitively impaired and had diagnoses of Alzheimer's. Resident #1 was sexually assaulted by a visitor whom she did not know, on 11/28/24. An IJ was identified on 12/05/24. The IJ template was provided to the facility on [DATE] at 4:04 PM. While the IJ was removed on 12/06/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimum harm to resident health or safety because all staff had not been trained on the plan of removal. This failure placed residents at risk for abuse, mental anguish, and emotional distress. Findings included: Record review of Resident #1's electronic face sheet, printed 12/05/24, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis that included but not limited to Alzheimer's without behavioral disturbance, psychotic disturbance, or mood disturbance (the most common cause of dementia). Record review of Resident #1's Quarterly MDS Assessment, dated 10/18/24, reflected she had a BIMS score of 03 indicating severe cognitive impairment. Functional abilities section GG revealed Resident#1 needed assistance with eating, oral hygiene, partial moderate assistance with toileting, shower, bathing. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan revised 10/07/24 reflected the following, Cognitive Deficit: Decision-making with interventions that included, monitor for any changes, or decline in cognitive, administer meds as ordered, allow ample time for task completion, assess for unmet need (pain, hunger, thirst, toileting), Decreased stimulation as needed, Encourage simple leisure activities. Wandering/At risk for elopement, Bracelet alarm for alarm door with interventions: Bracelet alarm for alarm doors, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, document all incidents of wandering, keep picture of resident at front desk, make sure all staff are aware of elopement risk, reorientation to person, place, and time prn. Review of Resident #1's clinical record did not reveal an incident report regarding sexual abuse. Interview on 12/05/24 at 11:15 AM with the Administrator stated there was a Male Visitor who did not know Resident #1 and had never visited her. The Male Visitor began coming to the facility about 4 weeks ago to visit Resident #3 once a week. The Administrator stated according to the video provide Resident #1's roommate, Resident #4's responsible party, on Thanksgiving Day (11/28/24) around 12:30pm the Male Visitor entered the facility. He was seen on camera interacting with Resident #1. Resident #1 and the Male Visitor interacted then went to her room to make out. They left her room, and he went to visit Resident #3's , and Resident #1 followed him. He alerted the nursing staff that Resident #1 was following him, and they intervened. He left Resident #3's room and went back to the Resident #1's room looking for her. The Male Visitor found Resident #1 in the hall, and they went back to Resident#1's room and were seen on camera disrobing. The Vale Visitor pulled the curtain and was seen after a few minutes naked and getting dressed and telling the resident to get dressed. The Male Visitor told Resident#1 he would be back on Tuesday((12/03)24, and they could do it again. The Male Visitor left the building. The Social Worker was contacted on Friday ((11/29/24) by Resident #4's responsible party about the incident. Police were called and Resident #1 was taken home by her family. Resident #1 had not returned to the facility Wednesday (12/04/24). The Administrator stated staff were in-serviced on 11/29/24 on identifying the Male Visitor and notifying law enforcement should the Male Visitor be seen on the property. The Administrator stated staff was in-serviced on 11/30/24, 12/01/24 and 12/2/24 regarding identifying sexual abuse. The Administrator initiated safe surveys with residents on 11/30/24 and 12/01/24. The Administrator stated the facility did not have a procedure for tracking visitors in the building. The Administrator stated the door to Resident #1's room was typically closed therefore staff would not have thought it was unusual that the door was closed. The Administrator stated he was informed about the incident on 11/29/24 and a self-report was completed and investigated by a state surveyor on 12/01/24. The Administrator was asked to provide the internal investigation however stated the details of the investigation had not been type up and completed yet because he had not had time. The internal investigation notes were not provided. The Administrator stated the facility did not have a visitor log and did not track visitor upon entry. The code to the front door was posted outside the front door which allowed visitors access to the building at any time. Review of safe surveys with residents initiated on 11/30/24 and 12/1/24. Review of the in-service regarding identifying the male visitor and contact law enforcement and the administrator dated 12/29/24. Review of in-service regarding identifying sexual abuse dated 11/30/24, 12/01/24 and 12/2/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the video provided by Resident #1's room mate, Resident #4's responsible party, to facility on 12/01/24 was undated which and was 15 minutes an 44 seconds long revealed while in Resident #1's room the Male Visitor asked Resident #1 if she ever pulled the curtains for privacy and proceeded to kiss her and rub his hands over her body as they stood body to body near Resident #4's side of the room. The Male Visitor pointed at Resident #4's bed and asked how old she was, and Resident #1 stated I do not even know who she is. The Male Visitor stated he was going to see Resident #3, who was his mother, but before leaving told Resident #1 she was so beautiful. The Male Visitor proceeded to kiss and rub his hands over Resident #1's body and then told her he would come back in a little bit. The Male Visitor was seen closing the door of Resident #1's room and kissing and rubbing Resident #1 while body to body again. The Male Visitor told Resident #1 You're so sexy. You did well. and continued kissing and rubbing Resident #1's body while standing body to body. Resident #1 and the visitor were no longer in the room and another male appearing to be a resident entered the view of the camera and walked out of the room. The Male Visitor and Resident #1 returned to the room however the camera view does not show the room of the door being closed. The Male Visitor directed Resident #1 to close the blinds. The Male Visitor closed the curtains at 9 minutes and 38 seconds on the video and was seen coming back from behind the curtain fully naked at 10 minutes and 12 seconds on the video. The Male Visitor dressed and stated to Resident #1 I will see you on Tuesday and we can do a repeat. You can have me again. The Male Visitor reiterated to Resident #1 multiple times I will see you on Tuesday. I will see you in five days. The Male Visitor asked Resident#1 to repeat when she was going to see him again and when she stated 5 days he stated You got it. Good job. Give me a high five. The Male Visitor asked Resident #1 How many days would it be before you see me? Resident #1 responded 10 and the Male Visitor stated 5 and Resident #1 repeated 5. The Male Visitor reminded Resident #1 to get dressed and left the room. Resident #1 was seen fully naked and began getting dressed at 14 minutes and 8 seconds into the video. Review of the 2nd video titled angle 2 provided by Resident #4's responsible party was undated and was 6 minutes and 30 seconds long. At 2 minutes and 33 seconds the Male visitor was seen undressing and Resident#1 was seen fully nude. The curtains were closed, and the Male visitor was seen naked at 3 minutes and 34 seconds and Resident #1 was seen laying in bed. At 6 minutes and 01 second Resident #1 was seen naked and began getting dressed. Record review of the summary provided by the police department, undated, revealed: Sexual Assault Investigations at Assisted living Facility (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[City and state], December 4,2023- On November 28,2024 at approximately 2:44pm, [City/state] Police department responded to [facility name] at [facility address] in reference to a visitor possibly having sexual contact with a resident. Responding officers learned a family member of a resident installed a security camera inside that resident's room. The family member reported that while reviewing video from the camera, they observed an unknown male engaging in some type of sexual act with the family member's roommate. The family was aware of the lack of mental capacity of the roommate and contacted staff. [Facility name] staff contacted law enforcement and were able to identify the male wo was a visitor at the facility as [Male Visitor], age and of state/ city]. [name of police department] criminal investigation division began investigating the allegation immediately. The resident was moved from the facility by family. The Facility was asked to contact the policed department if [Male Visitor] returned. Detectives received information that [Male Visitor] would be back at the facility on December 4, 24, and set up surveillance. [Male Visitor] was taken into custody at 11:04 PM on December 4, 24 for a warrant obtained for indecent assault. After speaking with [Male Visitor], charges were also filed for aggravated sexual assault. [Facility name] has been cooperative throughout the investigation. They will be conducting an internal investigation, but at this time it is not believed that there are other victims. Interview on 12/06/24 at 5:25 AM with CNA A revealed she was made aware that there was an incident of sexual abuse in the facility however she was not informed of the details. She stated on 11/30/24 she was provided information regarding the Male Visitor and informed that if she saw him to contact law enforcement and the Administrator. CNA A stated she also completed a in- service regarding identifying sexual abuse. CNA A revealed visitors did not have sign in to visit residents. CNA A stated she did not received training on changes to how visitors accessed the building. Interview on 12/06/24 at 5:28 AM with RN B revealed she was informed on11/30/24 to alert the Administrator and law enforcement if she saw the Male Visitor. RN B stated she completed an in-service regarding recognizing sexual abuse however she had not completed any training regarding how visitors accessed the building. RN B stated staff were not currently tracking visitors in the building and visitors did not have to sign in to visit. Interview on 12/06/24 at 5:32 AM with RN C revealed she worked with Resident #3 and was informed that the family member was involved in the sexual assault however she did not know the details. RN C stated she had never seen the Male Visitor in the building and stated he only recently began visiting and calling the facility for Resident #3. RN C stated she was informed that if she saw the Male Visitor to contact law enforcement and she completed a training on sexual abuse. She stated she had not completed training regarding any changes to how visitors accessed the building however she did know that there was a person sitting near the front door who was screening visitors as they entered due to the sexual assault. RN C stated Resident #3 was verbal however due to cognitive ability would not likely be able to complete an interview. Interview on 12/06/24 at 5:36 AM with CNA J revealed she was informed about the sexual abuse in the facility and showed a picture of the Male Visitor and was told to contact law and the Administrator if she saw him. She stated she received training on sexual abuse and was informed that visitors would begin using a sign in sheet moving forward. Attempted interview on 12/06/24 at 9:35 AM with Resident #4 revealed she was unable to answer questions due to cognitive ability. A family member spoke through the camera and provided her contact information. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview via phone on 12/06/24 with Resident #4's family member revealed she informed the facility about the sexual abuse. She stated she was not sure why staff kept asking Resident #4 about the incident because she did not know anything. She stated she was concerned that a random resident kept walking in the room and making Resident #4 uncomfortable. The family member stated she would like for the staff to be more aware of who was going into the rooms. Review of the facility policy ABUSE, NEGLECT AND EXPLOITATION AND MISAPPROPRIATION OF RESIDENT PROPERTY revised February 12, 2020 revealed: The purpose of this policy is to ensure that all healthcare facilities comply with federal and state regulations regarding (i) protecting facility patients and residents from abuse, neglect, exploitation and misappropriation of resident property, and (ii) timely investigation of and reporting to state and local agencies all allegations of abuse, neglect, exploitation and misappropriation of resident property. All managed healthcare facilities and all management company staff members or third parties providing services to such facilities and/or their residents. 1.Resident Rights. Each resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident's property, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse, neglect, exploitation, misappropriation of resident's property by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, resident representative, friends, or other individuals. 2.Facility Duty to Protect Resident Rights. The facility must prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. An Immediate Jeopardy was identified on 12/05/24. The Administrator and DON were notified of the Immediate Jeopardy on 12/05/24 at 4:04 PM. The IJ template was provided to the facility on [DATE] at 4:04 PM. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The Plan of removal was accepted on 12/05/24 at 9:54 AM and revealed the following: [Facility name}] 3rd Draft Plan of Removal for F600 submitted on 12/05/24. What corrective action will be taken for those residents found to have been affected by the deficient practice; o The facility immediately notified the police of the allegation. o The resident was taken to an acute care hospital for sane exam by the resident's family member per police request. o After the resident's sane exam was completed at the acute care hospital, she went home with her family member and remains there today. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o The perpetrator was immediately identified by the Administrator and Licensed Social Worker after viewing video that was provided by a family. The video was in place per the AEM programs. o The location of the perpetrator was unknown and all staff were trained on how to identify him and what actions needed to take place if he appeared on the property again. o A door monitor was initiated to monitor all visitors entering the facility to identify him if he enters the facility. The monitor was in place 24 hours a day. o The facility cooperated with the [City name] Police Detective and contacted the perpetrator to arrange a care plan meeting. This was an attempt to identify when he would return to the facility as he resides in [State name]. The care plan meeting was scheduled for 10:00 am on 12/04/24. The perpetrator arrived and the [City name] Police Department immediately arrested him, and he is currently in the [City name] City Jail after being charged with Aggravated Sexual Assault. o All staff were trained multiple time on sexual abuse, their responsibilities, and how to identify sexual assault. How other residents with the potential to be affected by the same deficient practice will be identified; o All residents have the potential to be affected by this practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; o On 12.06.24, the Administrator will implement a visitor log at the entrance to the facility for visitors to sign in and out. o On 12.06.24, the Administrator will place signage at the entrance of the facility that describes the requirement for the visitor to sign in and out. o Beginning on 12.06.24 all staff will be trained on this new visitation requirement. This training will be provided by their respective supervisors. o In the event that [Resident #1] request to be return to the facility the facility will take the following actions: o Resident #1's care plan will be updated to include: ? Increase visual checks of [Resident #1] to every hour by a designated staff member. ? If [Resident #1's] door to her room is found to be closed, staff will check resident status to ensure safety. ? If [Resident #1] is observed to be exhibiting overly friendly behavior with another resident or visitor, staff will redirect, as able. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	? [Resident #1] will be assessed upon admission any additional care plan updates will be completed to ensure we meet the psychosocial needs of [Resident #1]. o [Resident #1's] representative will be informed of the right to have video surveillance in her room per Authorized Electronic Monitoring. How the corrective action(s) will be monitored to ensure the deficient practice is being corrected and will not recur; i.e., what program will be put into place to monitor the continued effectiveness of the system changes; o A designated staff member will make hourly rounds in the facility round and identify visitors in the facility. o This designated staff member will then review the visitor log to ensure the visitor has completed the log. If it is found the visitor has not, then they will be provided education on the requirement and complete the log. Monitoring is as follows: Observation on 12/06/24 at 10:20 AM and review of the visitor log dated 12/06/24 revealed visitors were signing the visitor log as they entered the building. Observation on 12/06/24 10:21 AM at of the signage outside the facility front door revealed it informed visitors of the requirements to be allowed in the building by staff and to complete the sign in sheet. Review of staff in- service completed 12/06/24 regarding visitor requirements. The In- service revealed all visitor would complete a sign in log. Staff were to report anything suspicion and a designated staff would make hourly rounds to ensure all visitor completed the sign in sheet. In the instance that a visitor is found not have completed the sign in sheet the visitor would be educated on the requirement and directed to complete the sign in sheet. Interviews on 12/06/24 between 10:20 AM- 11:15 AM with LVN D, MA E, CNA F, CNA G, and CNA H, revealed staff were trained on visitor requirements. Staff revealed visitors would be allowed access to the building by staff and would need to complete a sign in sheet. Staff revealed a designated staff member would complete hourly rounds to ensure all visitors signed in and would be educated on the new policy if they were not signed in. Interview on 12/06/24 at 11:25 AM with the Administrator In Training revealed he had been tasked to complete the hourly checks to ensure all visitors were accounted for and would educate and direct anyone who had not completed the sign in sheet to do so. The AIT stated he was designated to check the sign in sheet and verify that each visitor was with their family member and had completed the sign in sheet. The AIT stated if a visitor is found that had not completed the sign in sheet the visitor would be educated on the requirement and directed to complete the sign in sheet. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An IJ was identified on 12/05/24. The IJ template was provided to the facility on [DATE] at 4:04 PM. While the IJ was removed on 12/06/24 at 12:00 PM the facility remained out of compliance at a scope of isolated and a potential for more than minimal harm to residents' health or safety because all staff had not been trained on the Plan of Removal.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based observation, interview and record review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infection for one of one resident (Resident #1) reviewed for Incontinent Care. The facility failed to ensure CNA G did not use the same wipes used to clean Resident #5's lower abdomen to clean the resident's perineal area on 12/03/2024. This failure could place residents at risk of cross-contamination and development of urinary tract infections. Findings include: Record review of Resident #5's Face Sheet, dated 12/03/2024, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 was diagnosed with chronic kidney disease (loss of kidney function) and overactive bladder (frequent feeling of needing to urinate). Record review of Resident #5's Comprehensive MDS Assessment, dated 10/08/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 11. The Comprehensive MDS Assessment reflected Resident #5 was frequently incontinent for both bowel and bladder. Record review of Resident #5's Comprehensive Care Plan, dated 10/09/2024, reflected the resident was at risk for problems with bladder and bowel elimination and one of the interventions was to provide assistance as needed. Observation on 12/03/2024 at 9:17 AM revealed CNA G was about to do incontinent care for Resident #1. CNA G put on a pair of gloves and prepared the things needed for incontinent care. CNA G raised the bed and removed the resident's blanket and pillows and put them on the resident's recliner. She pulled the resident's dress up, unfastened the brief, and pushed it between the resident's legs. CNA G pulled some wipes and cleaned the resident's lower abdomen. After cleaning the resident's lower abdomen, she used the same wipes to clean the resident's front part. She did not get new wipes to clean the front part. In an interview with CNA G on 12/03/2024 at 9:33 AM, CNA G stated she used the front to back technique when she cleaned Resident #1's front part. CNA G said she pulled some wipes to clean the resident's belly and front part. She said she folded the same wipes used to clean the belly before using them to clean the resident's front part. She said she should have thrown the wipe away after each use to prevent the microorganisms from the belly to go to the front part. She said what she did could cause a urinary tract infection. She said she should be attentive of how she did incontinent care because the resident would be at risk for infection. She said they had in-services for incontinent care but she was not able to apply it. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with ADON A on 12/03/2024 at 1:27 PM, ADON A stated the wipes should be discarded after every stroke and not be reused because it could cause cross contamination and probable infection. She said the expectation was for the staff to do incontinent care the right way which was using one wipe per stroke and then discard it. She said she would initiate an in-service as soon as the interview was over. In an interview with the DON on 12/03/2024 at 3:18 PM, the DON stated the wipes should not be folded for reuse during incontinent care. The wipes should be discarded with every stroke to prevent urinary tract infection. She said the expectation was for the staff to remember and practice the proper way of incontinent care. She said she would do an in-service for staff doing direct care and would do a one-on-one in-service with CNA G. In an interview with the Administrator on 12/03/2024 at 4:06 PM, the Administrator stated improper cleaning of the resident could cause infection. He said the expectation was for the staff to do the right procedure for incontinent care. He said he was not clinical and would let the DON handle the issue about improper incontinent care. Record review of the facility's policy, Perineal (area between the thighs) Care/Incontinent Care Restorative Policy revised 04/2012 reflected Policy Statement: Staff will perform perineal/incontinent care with each bath and after each incontinent episode . Provisions . 5. Start at waistband and clean upper abdomen, middle abdomen (lift folds), lower abdomen using side to side motion. (ONLY USE ONE WIPE PER SWIPE.) . 8. For female patient/resident . a. Separate the labia and wash downward (down the center of labia), then downward on each side of the labia using a different peri wipe with each stroke.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure the medications for two of two residents (Resident #2 and Resident #3) were stored in locked compartments and permit only authorized personnel to have access to the keys. 1. The facility failed to ensure Resident #6's bottle of Nature Made Fish Oil was not left on resident's recliner on 12/03/2024. 2. The facility failed to ensure Resident #7's Equate Lubricant eye drops was not left on top of the resident's overbed table on 12/03/2024. 3. The facility failed to ensure Resident #7's bottle of Allegra tablets was not left on top of the resident's overbed table on 12/03/2024. These failures could place the residents at risk of not receiving medications, accidental overdose, or misuse of medications. Findings include: 1. Record review of Resident #6's Face Sheet, dated 12/03/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #6 was diagnosed with dementia (term used to describe a group of symptoms affecting memory and thinking) and depressive disorder. Record review of Resident #6's Comprehensive MDS Assessment, dated 10/29/2024, reflected the resident had moderate impairment in cognition with a BIMS score of 11. The Comprehensive MDS Assessment reflected the resident had medically complex conditions. Record review of Resident #6's Comprehensive Care Plan, dated 10/29/2024, reflected the resident was taking antidepressants and one of the interventions was to monitor closely for worsening of depression. The care plan also reflected the resident had a cognitive deficit in decision-making and one of the interventions was to monitor for any decline in cognitive status. The resident did not have a care plan for self-medication. Record review of Resident #6's Physician Orders on 12/03/2024 reflected no order for fish oil. Record review of Resident #6's List of Assessments on 12/03/2024 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment that the resident was competent to manage his own medications. Observation and interview with Resident #6 on 12/03/2024 at 8:59 AM revealed the resident was in his wheelchair inside his room. It was noted that there was a bottle of fish oil in the resident's recliner. The resident said it was his supplement and he did take it once in a while. He said he always put the fish oil in his recliner for easy access. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Garnet Hill Rehabilitation and Skilled Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1420 McCreary Rd Wylie, TX 75098	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #7's Face Sheet, dated 12/03/2024, reflected the resident was an [AGE] year-old female admitted on [DATE]. Resident #7 was diagnosed with anxiety disorder. Review of Resident #7's Comprehensive MDS Assessment, dated 10/07/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 08. Resident #7's Comprehensive MDS Assessment reflected the resident had anxiety. Review of Resident #7's Comprehensive Care Plan on 10/09/2024 reflected the resident was taking an anti-anxiety medication and one of the interventions was to monitor behaviors every shift. The resident did not have a care plan for self-medication. Review of Resident #7's Physician Orders on 10/22/2024 reflected the resident did not have an order for eyedrops. Review of Resident #7's Physician Orders, dated 11/26/2024, reflected ALLERGY RELIEF 180 MG TAB (Fexofenadine Hydrochloride) 1 Tablet by mouth One time daily. Review of Resident #7's List of Assessments on 12/03/2024 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment that the resident was competent to manage her own medications. Observation and interview with Resident #7 on 12/03/2024 at 9:46 AM revealed Resident #7 was in her bed, awake. It was observed that there was an eye drop container and a bottle of Allegra tablets on the resident's overbed table. She said she used her eye drops because her eyes were getting dry. She said Allegra was for allergy. Observation and interview with LVN B on 12/03/2024 at 12:16 PM, LVN B stated the residents were not supposed to self-medicate if there was no assessment and care plan that the resident could self-medicate. She said there should not be any medications inside the room to avoid overdose and choking. She said she did not notice that Resident #3 had eye drops and Allegra on her overbed table. She said she would talk to the resident, that she would take the eye drops and Allegra for now and would check if she had orders for the said medication. She said if there were no orders, she would call the doctor to get orders for the medications. She said if she remembered it right, the resident had an order for antihistamine. She said she did not know why Resident #3 had over the counter medications inside the room. She said she would also talk to the family, that for safety reasons, medication should be administered by the medication aide or the nurses. LVN B went inside Resident #3's room and talked to the resident and said that she had to take her eye drops and Allegra and would check if the doctor had orders for them. The resident refused at first and then complied. LVN B then went inside Resident #2's room and saw the fish oil sitting on the resident's recliner. She talked to the resident and said that she would take the fish oil for now and would call the doctor for an order for the fish oil. The resident complied. Resident #2 said he was taking the fish oil as a supplement. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN D on 12/03/2024 at 12:39 PM, LVN D stated she was the charge nurse on Resident #2's hall and did not notice that there was a bottle of fish oil on the resident's recliner. She said there should be no medications inside the resident's room to prevent overdose and accidental choking. She said it could be accidently ingested by confused residents or children could mistake it for candies. She said she would look at the rooms of other residents and make sure there were no medications inside the rooms. She said, also confused residents might overdose if they cannot remember if they had already taken the medication or not. In an interview with ADON A on 12/03/2024 at 1:27 PM, ADON A stated there should be no medications inside the room because it was not safe. She said it could result in overdose and overmedication. She said fish oil is a supplement but could still have adverse reactions when taking more than required. She said the resident could accidentally poke her eyes if she was doing her eye drops by herself. She said they would check if the residents had orders for the medication, would request an order if there was none, and would let the residents know that the medication aide or the nurses would administer the medication. She said the expectation was no medication would be inside the room and for the staff to be mindful if they saw medications inside the room. She said she would do an in-service about medication storage and would also check the room if there were medications with the residents. In an interview with the DON on 12/03/2024 at 3:18 PM, the DON stated all the medications should be inside the medication carts and administered by qualified staff. She said they should check the residents' rooms during their rounds to see if there were medications inside the rooms of which they were not aware. She said if a family member was the one bringing the medications, the family member should be educated of the harm if the medications were taken by the resident without supervision. She said the resident might overdose, another resident or a visitor might accidentally ingest the medication and there could be adverse reactions especially if somebody who accidentally ingested the medications was allergic to the medications. A child who accidentally swallowed the medication could choke from it. She said the expectation was no medications would be inside the room. She said another expectation was for the staff to be mindful and observant that if they see any medication, they should take appropriate actions to prevent adverse outcomes such as choking and overdose. She said they would collaborate with the physician if the medications were really needed, make orders for them, and place them in the cart for the nurses or aides to administer. She said she would do an in-service about medication administration and making sure no medications were inside the room. In an interview with the Administrator on 12/03/2024 at 4:06 PM, the Administrator stated all medications should be in the cart and not inside the residents' room. He said if there were medications inside the residents' rooms, it could result in accidental ingestion and overdose, especially if nobody was monitoring it. He said the residents could also choke if they were self-medicating and nobody would know. He said the expectation was for the staff to make sure no medications were inside the room or where easily accessible to other residents and visitors. Record review of facility policy, Medication Storage Nursing Care Center Pharmacy Policy & Procedure Manual revised 01/24 revealed POLICY: Medications and biologicals are stored properly . The medication supply shall be accessible only to licensed nursing personnel . or staff members lawfully authorized to administer medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of one resident (Resident #1) reviewed for Infection Control. 1. The facility failed to ensure CNA G changed her gloves and performed hand hygiene while providing incontinent care to Resident #5 on 12/03/2024. 2. The facility failed to ensure CNA G did not hang Resident #1's new brief on the wooden frame of the bed on 12/03/2024. These failures could place residents at risk of cross-contamination and development of infections. Findings include: Record review of Resident #5's Face Sheet, dated 12/03/2024, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 was diagnosed with chronic kidney disease (loss of kidney function) and overactive bladder (frequent feeling of needing to urinate). Record review of Resident #5's Comprehensive MDS Assessment, dated 10/08/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 11. The Comprehensive MDS Assessment reflected Resident #1 was frequently incontinent for both bowel and bladder. Record review of Resident #5's Comprehensive Care Plan, dated 10/09/2024, reflected the resident was at risk for problems with bladder and bowel elimination and one of the interventions was to provide assistance as needed. Observation on 12/03/2024 at 9:17 AM revealed CNA G was about to do incontinent care for Resident #1. CNA G entered the resident's room, put on a pair of gloves, and prepared the things needed for incontinent care. She placed the folded brief beside the resident's left leg. She did not wash her hands before putting on the gloves. CNA G raised the bed and removed the resident's blanket and pillows and put them on the resident's recliner. After putting the blanket and pillows on the recliner, she hung the brief on the wooded frame of the bed's foot side. The inside of the brief was in contact with the wooden frame. She pulled the resident's dress up, unfastened the brief, and pushed it between the resident's legs. CNA G pulled some wipes and cleaned the resident's perineal area (female external reproductive organs). After cleaning the resident's vulva, CNA G changed her gloves and assisted the resident to roll to her side. She did not sanitize her hands before putting on a new pair of gloves. CNA G cleaned the resident's bottom. After cleaning the resident's bottom, she took the brief hanging on the wooden frame and placed it under the resident. She rolled back the resident, fixed the brief, and fastened it on both sides. She did not change her gloves after cleaning the resident's bottom and before touching the new brief. She rolled the resident back and cleaned the resident's vulva some more. After cleaning the vulva of the resident some more, CNA G fixed the brief and then taped it on both sides. She washed her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with CNA G on 12/03/2024 at 9:33 AM, CNA G stated hands should be washed before and after doing incontinent care. She said gloves should be changed after cleaning the resident's bottom and before touching the new brief. She said hands should be sanitized in between changing of gloves. She said she forgot to wash her hands before performing incontinent care, sanitize her hands when she changed her gloves, and change her gloves after cleaning the resident's bottom. She said her actions could result in cross contamination and infection. She said she knew the reasons why the staff needed to do hand hygiene but forgot to do so. She said she had in-services about incontinent care and hand hygiene but failed to practice it. She also said hanging the brief on the wooden frame could also cause cross contamination. In an interview with ADON A on 12/03/2024 at 1:27 PM, ADON A stated hand hygiene was included in all the procedures of any care. She said the staff should do hand hygiene before and after incontinent care. She said gloves should be changed after cleaning the residents' bottom and hands should be sanitized before putting on a new pair of gloves. She said not performing hand hygiene and not changing the gloves could result in cross contamination and probable infections. She also said the brief should not be hung on the wooden frame because the wooden frame was presumed dirty. So in theory, whatever germs were on the wooden frame would transfer to the brief. She said the expectation was for the staff to do hand hygiene before and after every care, after changing their gloves, and would change their gloves when transitioning from a dirty site to a clean site. She said another expectation was not to put the brief on anything presumed dirty. She said the expectation was for the staff to be mindful when they performed incontinent care to prevent infection. ADON A said she would do in-services about infection control and hand hygiene as soon as the interview was done In an interview with the DON on 12/03/2024 at 3:18 PM, the DON stated hand hygiene was the most effective way to prevent cross contamination and infection. She said hands should be washed before and after incontinent care. She said gloves should be changed after cleaning the resident's bottom and hands should be sanitized before putting on a new pair of gloves. She said the brief should not be hung anywhere to prevent transfer of anything dirty. She said the expectation was for the staff to wash their hands before and after incontinent care, change their gloves when going from dirty to clean, and ensure the brief was clean before putting it on the resident. She said she would do an in-service and skills check-off for infection control and hand hygiene. In an interview with the Administrator on 12/03/2024 at 4:06 PM, the Administrator stated staff should wash their hands, change their gloves after touching anything soiled and sanitize their hands before putting on new gloves. He said not washing the hands, not changing the gloves after touching soiled items, and not sanitizing the hands, could contribute to cross contamination and infection. He said the expectation was for the staff to follow the policy and procedures pertaining to infection control. He said he was not clinical and would let the DON handle the issue about infection control. Record review of the facility's policy, Perineal Care/Incontinent Care Restorative Policy revised 04/2012 reflected Policy Statement: Staff will perform perineal/incontinent care with each bath and after each incontinent episode . Provisions . 2. Set up clean field . 10. Remove gloves and wash hands or alcohol gel and re-glove hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, Hand Hygiene for Staff and Residents Infection Control revised August 2018 reflected Purpose: To reduce the spread of infection with proper hand hygiene . Policy: Proper hand hygiene technique is completed whenever hand hygiene is indicated . NOTE: Hand Hygiene is the most important component for preventing the spread of infection . Procedures . 1. Hand hygiene is done . Before . A. resident contact . After . A. contact with soiled article . B. resident contact . H. removal of medical/surgical or utility gloves.