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	07/16/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 4 residents (Resident #1) reviewed for ADL care provided to dependent residents. Based on interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 4 residents (Resident #1) reviewed for ADL care provided to dependent residents. The facility failed to ensure Resident #1 received showers consistently for June and July 2025. This failure could place residents at risk of not receiving necessary services to maintain good personal hygiene, skin integrity, or decreased self- esteem. Findings Include: Record review of Resident #1's face sheet, dated 07/16/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident had a diagnosis which included muscle weakness. Record review of Resident #1's Comprehensive MDS Assessment, dated 07/01/25, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment reflected the resident required extensive assistance with ADL care. Record review of Resident #1's Comprehensive Care Plan, dated 07/16/25, reflected the resident was incontinent of urine and bowel. One of the approaches was for hygiene as needed after every incontinent episode to maintain dignity. Record review of Resident #1's Bath/Shower Sheets for the month of June and July 2025, reflected the resident received a shower on 06/14/25, 06/21/25, and 06/25/25. The resident was scheduled to received three showers a week on Monday. Wednesday and Friday. In an interview on 07/16/25 at 10:35 AM, Resident #1 stated she had only received bed baths since last year September 2024 and she and her RP [TF1] had been requesting for her to receive showers, with the most recent request being made during a Care plan meeting on 07/07/25. In a record review and interview on 07/16/25 at 10:40 AM, LVN S reviewed the shower sheets for July 2025 and none of them reflected the resident received a shower. She stated the resident was scheduled to receive her showers from the evening shift CNAs. She stated the CNA was not available at this time. She stated she thought the resident may have just requested bed baths but was not sure. She stated the nurses were responsible for checking to ensure residents received their showers. She stated if the resident was not receiving her scheduled showers on Monday, Wednesday, and Friday, they could have a skin breakdown. She stated various CNAs provided the resident her showers and was not really assigned to any specific person. She stated the CNAs were required to complete shower sheets whether the resident had received a shower, bed bath, or refused. In an interview on 07/16/25 at 10:49 AM, the RP for Resident #1 stated she attended the resident's care plan meeting on 07/07/25 and one of the concerns discussed was the resident not receiving showers since 2024 and the resident's desire to receive them as opposed to the bed baths. She stated the ADON K and DON stated they would ensure this would happen. She stated she was not aware of the resident ever refusing any showers and thought staff were avoiding using the Hoyer lift because they never had two people available to operate it. In an interview and record review on 07/16/25 at 11:15 AM, ADON K stated Resident #1 had been receiving showers and she had been requesting bed baths. She was advised the resident stated she had not received a shower since September 2024, and she stated she had been requesting a shower. She stated the shower sheets provided indicated the resident received showers and she followed up with staff to ensure they were providing showers to the residents when scheduled. She stated if the resident did not receive her showers, she could have skin problems. ADON K provided shower sheets which indicated the Resident received showers on 06/14/25, 06/21/25, and 06/25/25. She was advised this would be verified with Resident #1. In an interview on 07/16/25 at 11:50 AM, Resident #1 was asked if she received showers on 06/14/25, 06/21/25, and 06/26/25. She denied receiving any showers and repeated she had not received a shower since she arrived in September 2024 and only received bed baths. She stated she never refused a shower and would love to take showers. In an interview on 07/16/25 at 2:17 PM, the DON stated Resident #1 had an injury and initially wanted bed baths at the time, but this was some time ago. She stated the CNAs had gotten comfortable just giving her bed baths, had not asked her if she wanted a shower, and just assumed she wanted a bed bath. She stated she was told the resident refused showers, but it was never documented. She stated she was not aware the resident wanted showers until the care plan meeting. She stated the resident not getting a shower could be a dignity issue. Record review of the facility's policy, BATHING (NOT PARTIAL OR COMPLETED

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 of 4 residents (Resident #1) reviewed for accident hazards. Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 of 4 residents (Resident #1) reviewed for accident hazards. The facility failed to ensure CNA D did not transfer Resident #1 using a Hoyer lift (a mechanical lift used to transfer an individual with limited mobility) by herself on 07/16/2025. This failure could place residents at risk of injury. Findings include: Record review of Resident #1's face sheet, dated 07/16/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident had a diagnosis which included muscle weakness. Record review of Resident #1's Comprehensive MDS Assessment, dated 07/01/25, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment reflected the resident required extensive assistance with ADL care. Record review of Resident #1's Comprehensive Care Plan, dated 07/16/25, reflected the resident was incontinent of urine and bowel one of the approaches was for hygiene as needed after every incontinent episode to maintain dignity. In an observation and interview on 07/16/25 at 11:20 AM, Resident #1 was observed lying in bed and the Hoyer lift still positioned over her bed. There was only 1 CNA observed in the room. CNA D stated she and CNA S had assisted her in using the Hoyer lift to move the resident from her wheelchair to her bed. CNA D stated CNA S had just left the room. In an interview on 07/16/25 at 11:25 AM, Resident #1 stated it was only CNA D who was in the room using the Hoyer lift. She stated a lot of the time there was only 1 staff member using the Hoyer lift to get her out of and into her bed. In an interview on 07/16/25 at 12:20 PM, CNA she stated she did not assist CNA D with the transfer of Resident #1 from her wheelchair to the bed. She stated two people were required to operate the Hoyer lift to prevent the resident from falling. In an interview on 07/16/25 at 12:15 PM, ADON K was advised CNA D was observed in Resident #1's room with a Hoyer lift, the resident was apparently moved from her wheelchair to her bed, and she was the only staff member in the room. She was advised the resident stated CNA D was the only staff member who operated the Hoyer lift to move her into the bed. She stated they had just completed an in-service on Hoyer lifts, and the requirement was for two staff members to always use it. She stated the risk of not having two people, could result in the resident falling and getting injured. In an interview on 07/16/25 at 12:50 PM, CNA D was advised that CNA S was interviewed, and she denied assisting her with the Hoyer lift for Resident #1. CNA D stated she was trying to find someone else to assist her but could not. She stated they were supposed to use two people to operate the Hoyer lift for safety and to avoid the resident falling. In an interview on 07/16/25 at 2:17 PM, the DON stated two staff members were always required to use the Hoyer lift when lifting the resident. She stated it was for safety purposes. She stated they reviewed Hoyer lift procedures every year for the annual training and as needed but she could not recall the last time this was done. Record review of the facility's policy, Mechanical Lifts (Hoyer/Sit-To-Stand) reviewed 05/12/23, reflected Residents will be assisted with their Activities of Daily Living, utilizing lifts according to manufacturer's guidelines. Gather necessary equipment and second person to assist.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two of 4 residents (Resident #1 and Resident #2) reviewed for respiratory care. Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two of 4 residents (Resident #1 and Resident #2) reviewed for respiratory care. The facility failed to ensure Resident #1 and Resident #2's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) and breathing mask (used to receive medications by breathing in mist through nose and mouth), were properly stored when not in use on 04/16/25. This failure could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Record review of Resident #1's face sheet, dated 07/16/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident had a diagnosis which included Chronic Obstructive Pulmonary Disease (lung disease). Record review of Resident #1's Comprehensive MDS Assessment, dated 07/01/25, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment reflected the resident had Chronic Obstructive Pulmonary Disease. Record review of Resident #1's Comprehensive Care Plan, dated 07/16/25, reflected the resident had a respiratory diagnosis and one of the approaches was to administer oxygen as ordered. Record review of Resident #1's Physician's Order, dated 07/16/25, reflected D/C @ 1 LPM via NC Every Shift. In an observation and interview on 07/16/25 at 10:35 AM, Resident #1 was observed with an Oxygen device in her room. The device was not in use and her nasal canula was observed hanging on the bedrail, unbagged. She stated she only used the oxygen device at night and had not used it since 6:30 AM. In an observation and interview on 07/16/25 at 10:40 AM, LVN [TF1] S stated she had been at the facility for 2 years. She stated Resident #1 used the oxygen device on an as needed basis. She stated they had to bag the resident's nasal canula when it was not in use. She was shown the nasal canula hanging from the resident's bedrail and she stated the bag was in the nightstand for storage and the nasal canula should have been stored in it for infection control. 2. Record review of Resident #2's face sheet, dated 07/16/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident had a diagnosis which included Chronic Obstructive Pulmonary Disease (lung disease). Record review of Resident #2's Comprehensive MDS Assessment, dated 01/30/25, reflected the resident was cognitively moderately impaired with a BIMS score of 11. The Comprehensive MDS Assessment reflected the resident had Chronic Obstructive Pulmonary Disease. Record review of Resident #2's Comprehensive Care Plan, dated 02/06/25, did not reflect an intervention for oxygen use. Record review of Resident #2's Physician's Order, dated 07/16/25, reflected D/C O2 at 2LPM by NC Every Shift [Time: Shift 2, Shift 1] Chronic obstructive pulmonarydisease, unspecified. In an observation on 07/16/25 at 11:20 AM, revealed Resident #2 was not in her room and her nasal canula was observed sitting on top of the resident's bed, unbagged. In an interview and observation on 07/16/25 at 11:25 AM, ADON K stated Resident #2 used an Oxygen device and when it was not in use, the nasal canula should be bagged to avoid an infection. She observed Resident #2's nasal canula sitting on top of the resident's bed, unbagged and the resident was not in the room. She stated the resident may have just left the room. She stated the nursing staff was responsible for checking to ensure oxygen masks and nasal cannulas were bagged when not in use. In an interview on 07/16/25 at 2:17 PM, the DON stated there was not a policy but it was common practice for staff to check to ensure the nasal cannulas were placed in a bag to avoid infection. Record review of the facility's policy, Oxygen Therapy - Discontinuation revised 01/12/20, reflecting The nursing licensed staff will discontinue oxygen therapy when ordered by physician, and according to practice guidelines. Remove cannula prong or mask from humidifier or regulator. (Discard if oxygen is not to be given again; or place in plastic bag if oxygen is to be administered on a PRN basis. Label and date.)

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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 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. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for one of 3 residents (Resident #1) reviewed for pharmaceutical services. Based interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for one of 3 residents (Resident #1) reviewed for pharmaceutical services. The facility failed to ensure Resident #1's Farxiga medication was in stock. This failure could place residents at risk of not receiving medication as ordered by the physician and having high glucose levels. Findings include: Record review of Resident #1's face sheet, dated 07/16/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident had a diagnosis which included Diabetes. (condition that happens when blood sugar (glucose) is too high and develops when the pancreas doesn't make enough insulin or any at all, or when the body isn't responding to the effects of insulin properly.) Record review of Resident #1's Comprehensive MDS Assessment, dated 07/01/25, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had Diabetes. Record review of Resident #1's Comprehensive Care Plan, dated 07/16/25, reflected the resident had potential for hyperglycemic (high blood sugar) or hypoglycemic (low blood sugar) episodes secondary to Diabetes and one of the approaches was to administer medications as ordered. Record review of Resident #1's Physician's Order, dated 07/16/25, reflected Farxiga 10 mg tablet, 1 tablet by mouth one time daily [Time: 08:00 AM]. In an interview on 07/16/25 at 10:30 AM, Resident #1 stated she was scheduled to take medication to treat her Diabetes daily but was advised this morning the medication was not available and needed to be reordered. In an interview on 07/16/25 at 10:40 AM, LVN S stated she had been at the facility for 2 years. She stated Resident #1 was prescribed Farxiga to take daily. She stated the resident was required to take the medication for her diabetes. She stated the resident was not able to take the medication this morning because the facility did not have it in stock. She stated the medication aide was responsible for re-ordering the medication and did not. She stated she was working on re-ordering the medication for the resident. She stated the risk if not getting medication could cause water in lungs. In an interview on 06/16/25 at 10:45 AM, LVN M stated he was filling in for the medication aide today because he was scheduled off. He stated Resident #1 was unable to receive her medication of Farxiga because it was not in stock. He stated the medication aide was responsible for re-ordering the medication and should have re-ordered it when there were 3 or 4 doses left. He stated he re-ordered the medication for the resident and was waiting for the prescription to be filled. He stated the risk of her not receiving the medication could result in a spike in her sugar level. In an interview on 07/16/25 at 2:17 PM, the DON was advised of Resident #1 not having her Farxiga medication and she stated she checked and found out the medication was only provided 14 days at a time. She stated she did not know why it was not ordered in advance. She stated most medication was 30, 60, 90 days in supply but her insurance only allowed 14 days at a time and it was ordered on the 7/01/25 but was somehow not received. She stated it was the medication aide's responsibility to re-order medication and to follow up to ensure the medication was ordered on 07/01/25. She stated she was unsure of the time period when they should re-order medication when it ran low. She stated the missed medication could impact the resident's sugar level Record review of the facility's policy, Medication Administration revised 01/2023 reflected Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Record review of the facility's policy, Medication Ordering And Receiving From Pharmacy Provider revised 01/12/2020 reflected Staff will order and receive medications from pharmacy providers in accordance with standard practice guidelines.