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	06/11/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 5 of 7 (Residents #1, #2, #3, #4, and #5) reviewed for pharmacy services.1. The facility failed to ensure Resident #1 was not administered a discontinued medication when she was administered the anti-anxiety medication, lorazepam 0.5 mg, on 05/29/26 after it had been discontinued on 04/30/26. 2. The facility failed to ensure accurate documentation and proper administration for the use of Compound ABH Gel for Resident #2 (06/02/26, 06/04/26, 06/08/26, 06/10/26, 06/11/26) and the use of Clonazepam 0.5 mg for Resident #3 on 06/02/26. 3. The facility failed to document the administration of controlled medications in a timely manner for Residents #4 and #5.These failures could place residents at risk for medication error, drug diversion, and delay in medication administration.Findings included: 1. Review of Resident# 1's Annual MDS Assessment, dated 05/20/26, reflected the resident was [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included anxiety disorder and hypertension (high blood pressure). The resident's cognition was severely impaired with a BIMS score of 4. She received antianxiety and antidepressant medications.Record review of Resident #1's physician orders revealed Resident #1 did not have an active order for lorazepam 0.5 tablet given 1 tablet by mouth every 8 hour(s) as needed. The record reflected the lorazepam had been discontinued on 04/30/26. Observation and record review on 06/11/26 at 9:45 a.m. with LVN A, of the Hall 400/Hall 500 nurses' medication cart and the NAR revealed Resident #1's NAR for lorazepam 0.5 mg tablet was last signed off on 05/29/26 for one-tablet given to Resident #1 at 4:00 PM. The NAR reflected there were 17 pills remaining, and 17 pills were in the blister pack.Record review of Resident #1's May 2026 MAR revealed no order for lorazepam 0.5 tablet give 1 tablet by mouth every 8 hour(s) as needed. Also, there was no documentation on the MAR showing that lorazepam 0.5 mg had been administered to Resident #1 at 4:00 PM on 05/29/26. During an observation on 06/11/26 at 9:55 a.m., Resident #1 was in her room, and she stated she received all her medications. Resident #1 was unable to recall which medications she was being administered.During an interview on 06/11/26 at 2:14 p.m., LVN A stated she was the nurse assigned to Resident #1. She stated Resident #1 had an order for PRN Lorazepam 0.5 mg. LVN A reviewed Resident #1's MAR and NAR. She stated on the NAR the medication was signed off on 05/29/26 as administered, but the MAR did not show it was administered and Resident #1 did not have the order for the lorazepam. LVN A stated on the NAR, it looked like her signature, but she was not sure. LVN A stated she was not aware Resident #1's PRN Lorazepam medication was discontinued on 04/30/26. She stated the medication and the NAR should had been removed from the medication cart. LVN A stated she did not know why the medication was not removed from the medication cart when the medication was discontinued. She stated it was the responsibility of the nurse to remove any medication from the medication cart that had been discontinued. She stated there should be an order before administering any medication and the nurses should be checking the orders before administering. LVN A stated the potential risk would be the (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incoming nurse not knowing when the medication was given to the resident. LVN A stated that without a physician order, nurses should not be administering any medication to the residents.2. Record review of Resident #2's Quarterly MDS assessment dated [DATE], reflected the resident was [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included non-traumatic brain dysfunction. The resident's BIMS was not completed due to resident being rarely/never understood. She received antianxiety and antidepressant medications.Record review of Resident #2's physician order dated 11/11/25 revealed an order for Compound ABH Gel for generalized anxiety disorder 0.5 ml which was to be applied topically once daily at 9:00 AM to the resident's inner wrist.Observation and record review on 06/11/26 at 10:46 a.m., with LVN B of the Hall 200/Hall 300 nurses' medication cart and NAR the revealed Resident #2's NAR for the Compound ABH GEL was last signed off as being administered on 06/09/26. The NAR reflected that 1 dose given to Resident #2 at 8:00 AM, for a total of 4 gels remaining, and there were 4 syringes of the Compound ABH Gel on the nurses' medication cart. There was no documentation on the NAR showing that the Compound ABH Gel had been administered to Resident #2 on 06/02/26, 06/04/26, 06/08/26, 06/10/26, and 06/11/26.Record review of Resident #2's June 2026 MAR revealed Resident #2 was administered Compound ABH gel on 06/02/26, 06/04/26, 06/08/26, 06/10/26, and 06/11/26.Observation on 06/11/26 at 12:32 p.m. revealed Resident #2 was in bed, and she was unable to answer any questions. The resident did not display any signs of agitation or pain.Record review of Resident #3's Quarterly MDS assessment dated [DATE], reflected the resident was [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included non-traumatic brain dysfunction. The resident's BIMS was not completed due to resident is rarely/never understood. He received antianxiety medications.Record review of Resident #3's physician order dated 01/20/25 revealed an order of Clonazepam 0.5 mg tablet 1 tablet via Gastrostomy Tube Twice a day [Time: 08:00 AM, 07:00 PM]. Observation and record review on 06/11/26 at 10:46 a.m., of the 200, 300 Hall LVN's medication cart and the narcotic administration record, with LVN B, revealed Resident #3's NAR for Clonazepam 0.5 mg tablet was not signed off as being administered on 06/02/26. The NAR reflected there were 9 pills remaining, and there were 9 pills observed in the blister pack. Record review of Resident #3's June 2026 MAR revealed Resident #3 was administered the clonazepam tablet on 06/02/26 at 8:00 AM. 3. Record review of Resident #4's Quarterly MDS assessment dated [DATE], reflected the resident was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included anxiety disorder. The resident had intact cognition with a BIMS score of 14. He received antianxiety medication.Record review of Resident #4's physician order dated 01/03/25 revealed Lorazepam 0.5 mg tablet 1 tab by mouth every 4 Hours as needed for anxiety or agitation. Observation and record review on 06/11/26 at 10:46 a.m., of 300 Hall LVN's medication cart and the narcotic administration record, with LVN B, revealed Resident #4's NAR for lorazepam 0.5 mg tablet was signed off as being administered on 06/01/26 at 8:00 AM and 06/10/26 at 8:00 AM. The NAR reflected there were 36 pills remaining, and 36 pills were observed in the blister pack.Record review of Resident #4's June 2026 MAR revealed, for the dates of 06/01/26 and 06/10/26, the MAR was blank. There was no record for the administration of the lorazepam on 06/01/26 and 06/10/26 to Resident #4. During an interview on 06/11/26 at 12:34 p.m., Resident #4 stated he was doing well. Resident #4 stated he received all of his medications. He was unable to state which medications he was receiving. Record review of Resident #5's admission MDS assessment dated [DATE], reflected the resident was [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included hypertension, thyroid disorder, and benign prostatic hyperplasia. The resident had intact cognition with a BIMS score of 15. He received PRN pain medication regimen.Record review of Resident #5 physician order dated 05/07/26, revealed Hydrocodone Bitartrate-Acetaminophen for Pain, unspecified for Pain ([START 05/07/26] 1 TABLET by mouth Every 6 Hours as needed)Observation and record review on 06/11/26 at 2:42 p.m., of 600 Hall RN's medication cart and the narcotic administration record, with RN D, revealed Resident #5's NAR for (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hydrocodone-Acetaminophen 5-325 mg was signed off as being administered on 06/02/26 at 8:00 PM. The NAR reflected there were 12 pills remaining, and 12 pills were observed in the blister pack.Record review of Resident #5's June 2026 MAR revealed the MAR was blank for 06/02/26.During an observation and interview on 06/11/26 at 3:57 p.m., Resident #5 was in his room. He stated he received his pain medication when he requested it, and he denied being in any pain. During an interview on 06/11/26 at 1:37 p.m., LVN B stated he was the nurse assigned to Resident #2, Resident #3 and Resident #4. He stated he administered medications to Resident #2, Resident #3 and Resident #4. LVN B stated Resident #2 had an order for ABH Gel 1 time a day. LVN B reviewed Resident #2's MAR and NAR, he stated there was a discrepancy. LVN B stated Resident #2's MAR showed that medication was administered for the following days: 06/02/26, 06/04/26, 06/08/26, 06/10/26, 06/11/26. However, the medication was not signed off on the NAR for those days. LVN B stated he could not recall if the medication was administered. LVN B stated Resident #3 was at the hospital since 06/09/26. He stated Resident #3 had an order for clonazepam 0.5 mg tablet twice a day. LVN B reviewed Resident #3's MAR and NAR. He stated LVN C administered the medication on 06/02/26, but did not sign off the medication on the NAR. LVN B reviewed Resident #4's MAR and NAR. He stated on the NAR for Lorazepam 0.5 mg, he signed off the medication on 06/01/26 and 06/10/26, but did not document on the MAR that the medication was administered. LVN B stated he did administer the medication, but forgot to document that it was administered. He stated after he administered the medication, he should have documented on the MAR in a timely manner. LVN B stated it was important to document when medication was administered, sign the medication out for accountability, and to make sure the next nurse knew when the medication was administered. He stated the potential risk to the residents would be residents receiving double dose. During an interview on 06/11/26 at 1:56 p.m., LVN C stated she was the nurse assigned to Resident #2 and Resident #3 on 06/02/26. She stated she administered medications to both residents. LVN C reviewed Resident #2's MAR and NAR. She stated she documented on 06/02/26 that she administered ABH Gel on 06/02/26, however, she did not sign off the medication on the NAR. She stated she did not think she administered the ABH Gel to Resident #2 on 06/02/26. LVN C stated she did not know why she did not administer it. She stated it was her first time working with Resident #2, a lot was happening on that day, and she did not ask for help. LVN C reviewed Resident #3's MAR and NAR. She stated she documented that she administered Clonazepam 0.5 on 06/02/26 but did not sign off the medication on the NAR. She stated she could not recall if she did or did not administer the medication. LVN C stated if she had given the medications, she would had signed off the medication on the NAR. She stated it was important to document correctly. She stated depending on the medication, the potential risk would be the resident having an adverse effect. During an interview on 06/11/26 at 2:51 p.m., RN D stated she was the nurse assigned to Resident #5. She stated Resident #5 had a PRN order for hydrocodone. RN D stated she administered medication to Resident #5. RN D reviewed Resident #5's MAR and NAR, she stated she was not the nurse assigned to Resident #5 on 06/02/26. She stated on the resident's NAR, the nurse signed off the medication on 06/02/26, however, the nurse failed to document on the resident's MAR. RN D stated she was aware of the discrepancy because she also failed to document Resident 5's MAR for the month of May. She stated she was in-serviced about signing off controlled medication on the count sheet and MAR. She stated she could not recall the date of the in-service. She stated the potential risk of not documenting on the MAR in a timely manner would be incoming staff not knowing when the medication was given, and that could cause an overdose. During an interview on 06/11/26 at 4:21 p.m., the ADON stated the expectation was for the nurses to document on the resident's MAR after administering the medication and to sign off the medication on the NAR. She stated she was not aware the nurses were not documenting on the residents MAR or signing off the medication on the NAR. She stated she used to complete audits with the old system, but with the electronic record system it made it harder to audit. She stated when a medication was discontinued, it should be removed from the medication cart and not be administered. She stated nurses should have an order (continued on next page)

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