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 04/23/2026
NAME OF PROVIDER OR SUPPLIER Garnet Hill Rehabilitation and Skilled Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who used psychotropic drugs received gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs for 1 of 5 residents (Resident #2) reviewed for unnecessary medications. The facility failed to ensure a gradual dose reduction was considered for Resident #2's antidepressant, trazadone, in January 2026 after she began the medication in July 2025. This deficient practice could place residents at risk of receiving unnecessary psychotropic medications. Findings include: Record review of Resident #2's Quarterly MDS Assessment, dated 03/03/26, reflected she admitted to the facility on [DATE]. Resident #2 had a BIMS score of 11, which indicated mild cognitive impairment. Resident #2's active diagnoses included anxiety disorder (a mental health condition characterized by excessive, persistent fear or worry that interferes with daily life and is difficult to control), paraplegia (a specific pattern of paralysis that affects the legs, resulting from a problem with the nervous system), and Alzheimer's disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior). Resident #2 was noted to have taken antianxiety, antidepressant, and anticonvulsant medications. Resident #2 had not completed any GDR's for her medications. Record review of Resident #2's, undated, care plan reflected the following: Problems/Strengths: Medication: Potential for discomfort and side effects related to the use of Antidepressant. Resident takes.trazodone [sic]. Interventions: Physician to review medication.Monitor Duration- Prior to discontinuation may need a gradual dose reduction or tapering to avoid a withdrawal syndrome. Record review of Resident #2's progress notes for September 2025, October 2025, and January 2026 did not reflect a GDR was attempted nor was the medication reviewed for a GDR. Record review of Resident #2's April 2026 Physician Orders reflected the following order:Trazodone Hydrochloride 100 MG, 1 tab by mouth at bedtime for Insomnia with a start date of 07/31/25. Record review of Resident #2's April 2026 Medication Administration Record reflected she received her dose of trazodone as ordered each day. Record review of Resident #2's Recommendations for Doctor, dated 01/16/26, reflected the following: Resident is currently prescribed sedative/hypnotic Trazodone [sic] for the treatment of Insomnia since 7/25. According to CMS guidance under F605 (Chemical Restraints). ?For any resident who is receiving a psychotropic medication, the facility must show evidence that a gradual dose reduction has been attempted unless clinically contraindicated.' Please consider a trial dose reduction: If a GDR attempt is not indicated at this time, please indicate reasoning below. There was not an additional document where the provider responded or reviewed the recommendation. During an observation and interview on 04/21/26 at 10:30 a.m., revealed Resident #2 was in bed completing an activity. Resident #2 said she did not want anyone to change her medications because she liked what she was already receiving. Resident #2 said she had no concerns about the medications she received. During an interview on 04/23/26 at 11:29 a.m., the NP and Physician, who were present on the phone only, said the NP was at the facility 4-5 times per week. The NP said Resident #2's GDR review for her trazadone was denied because the resident refused to have any changes to her medications since she felt those medications were (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	working well for her. The Physician said there was likely not a concern with Resident #2's trazadone not being reviewed for a GDR since there were not changes made for her. Interview on 04/23/26 at 12:16 p.m., the DON said GDR's were considered for residents every 90 days. The DON said the facility held a meeting and any necessary medications were reviewed for a GDR. The DON said if a GDR was not considered timely that would put the resident at risk of being on a medication long term that might not be good for them. The DON said the purpose of considering a GDR for a resident was to make sure residents were not on a medication that could contribute to a decline for them. Record review of the facility's Psychotropic Drugs policy, revised 07/27/22, reflected: .3. B. for drug therapy: Within the first year in which a resident is admitted on a psychotropic medication or after the facility has initiated a psychotropic medication: GDR attempts in two separate quarters with at least one month in between the attempts. The GDR must be attempted annually thereafter unless clinically contraindicated.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents received proper treatment and care to maintain good foot health by providing foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition for 1 of 16 (Resident #83) reviewed for foot care. The facility failed to ensure foot care, specifically trimming of toenails, was provided for Resident #83. This failure could place residents at risk for poor personal hygiene, odors and a decline in their quality of life . Findings include:Record review of Resident #83's significant change in status MDS Assessment, dated 03/24/26, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #83 had diagnoses which included Non-Alzheimer's Dementia (problems with memory and thinking), anxiety disorder (excessive fear or worry about a specific situation), and heart failure. Resident #83's BIMS score was 06, which indicated severe cognitive impairment. Section GG - Functional Abilities indicated the resident required substantial/maximal assistances from staff to assist with getting personal hygiene. Resident #83 did not have a diagnoses of diabetes. Record review of Resident #83's care plan, dated 04/23/26, revealed Problems/Strengths: Activities of Daily Living-dependent with all activities of daily living. Goals: Improve or maintain care needs and daily living tasks. Interventions Assist with daily care needs and daily living tasks. Encourage to do as much as possible for self.During an observation and interview on 04/21/26 at 1:37 p.m., revealed Resident #83 was sitting in her wheelchair in a room. Resident #83 stated her only concern was her toenails. The big toenails for both of the resident's feet were approximately an inch past the tip of the toe curved to the side. The other toes nails were approximately a quarter of an inch past the tip of the toe. Resident #83 stated she had been asking staff to trim them or to have podiatry come because she did not like seeing her toenails that long. Resident #83 stated the nurses would tell her that they were not able to cut them and she needed to be seen by podiatry. She stated no one followed up with her regarding podiatry. During an interview on 04/23/26 at 12:09 p.m. CNA B revealed the nurses were responsible for trimming residents' fingernails and toenails. CNA B stated she was aware of Resident #83 toenails being very long and needed to be trim. She stated the nurses were aware of how long Resident #83's toenails were. CNA B stated she was not sure if Resident #83 was being seen by podiatry. CNA B stated she was not sure why Resident #83's toenails had not been trimmed. During an interview on 04/23/26 at 12:11 p.m., LVN A revealed she was aware of Resident #83's toenails being long. She stated she received report about a week ago from previous shift regarding Resident #83 wanting her toenails trimmed but the nurse was unable to trim them due to the thickness of the nails. LVN A stated last week during morning meeting it was reported that Resident #83 needed to be referred to podiatry. LVN A stated the social worker was aware of the referral. She stated the potential risk of not trimming toenails could lead to skin breakdowns or infections. During an interview on 04/23/26 at 12:19 p.m., the Social Worker revealed approximately 6 months ago the facility changed podiatrist. She stated Resident #83 was being seen by the old podiatrist but not the new one. She stated the last time Resident #83 was seen by podiatry was about 6 months ago. The Social Worker stated she was not sure why Resident #83 was not being seen by the new podiatrist. She stated Resident #83 requested to be seen by the podiatrist today (04/23/26), and she had just completed the referral. The Social Worker stated prior to Resident #83's request she had not been notified the resident needed to be referred to podiatry. She stated she attended morning meeting and could not recall anyone mentioning Resident #83 needed a podiatry referral. The Social Worker stated either during morning meetings or the nurses would notify her which resident needs to be referred to podiatry. She stated it was her understanding if the resident was not being seen by podiatry, then the nursing staff were responsible for trimming toenails unless the resident was diabetic. During an interview on 04/23/26 at 3:31 p.m., ADON F revealed Resident #83 was known to refuse care and recently she requested to (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be seen by podiatry. She stated the Social Worker was made aware a week ago and the resident was on the list to be seen by podiatry. She stated the nurses were responsible for trimming residents' toenails unless the resident was diabetic then a podiatry referral needed to be completed. She stated the potential risk of not trimming toenails was that it could lead to pain or bother the resident. During an interview on 04/23/26 at 2:38 p.m., the DON revealed the nurses were responsible for trimming the residents' nails unless the residents were diabetic. The DON stated she was not aware of how long Resident #83's toenails were. She stated during morning meeting it was mentioned that Resident #83 needed to be referred to podiatry and they were trying to put her on the podiatry list. The DON stated Resident #83 was known to refuse care but not aware if the resident refused toenails to be trimmed. She stated toenails needed to be trimmed for comfort. Record review of the facility's 24 Hour Report/Changes of Condition Report, dated 04/20/26, reflected [Resident #83] need podiatry consult/appointment. Record review of the facility's Foot and Toenail Care, Routine policy, reviewed 06/19/2023, reflected the following: Residents will be provided routine foot and toenail care within the professional scope of practice for CNAs, LVN/LPNs and RNs as is dictated per state guidelines and in accordance with standard practice.

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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** Based on observation, interview and record review the facility failed ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for one of two residents (Resident #6) reviewed for catheter care. The facility failed to ensure Resident #6 had physician's orders for catheter care after he admitted to the facility with a suprapubic catheter. This failure could place residents at risk for infections and improper treatment. Findings include: Record review of Resident #6's admission MDS Assessment, dated 03/26/26, reflected a [AGE] year-old male who admitted to the facility on [DATE]. Resident #6 had a BIMS score of 15, which indicated no cognitive impairment. His MDS indicated he used an indwelling catheter. His diagnoses included Renal Insufficiency/Renal Failure/End-Stage Renal Disease (kidney failure) and diabetes mellitus (occurs when the body cannot properly use blood sugar). Record review of Resident #6's care plan, revised 04/09/26, reflected the following: Problems/Strengths: Urinary catheter- super pubic [sic].Interventions: Assess for bladder distention, small frequent voids, dribbling, resident complaint of bladder feeling full. Complications can include an increased risk of urinary tract infection, blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort, and bleeding. Watch for irritation around the catheter and help me to be sure it is in the right position so I will be comfortable. Care/changing of urinary catheter as ordered. Record review of Resident #6's April 2026 Treatment Record did not reflect any orders or care of his catheter. Record review of Resident #6's Physician Orders for April 2026 reflected there were not any orders for the care of his catheter. Record review of Resident #6's admission Data Assessment, dated 03/22/26, reflected he had a suprapubic catheter. Record review of Resident #6's interdisciplinary progress notes reflected the following:LVN A wrote on 03/22/26 at 12:00 p.m.: @ 12 p.m. Resident [AGE] years old male, arrived to facility via ambulance.Resident noted with s/p catheter in place draining clear urine catheter [sic] site dry and clean and intact. Observation and interview on 04/21/26 at 11:42 a.m. with Resident #6 revealed he was sitting in his wheelchair in his room. Resident #6 said he admitted a few weeks ago and before that he was at the hospital where he had a procedure completed to insert a suprapubic catheter. Resident #6 said he mostly completed his own catheter care but sometimes got assistance from staff as well. During an interview on 04/22/26 at 9:50 a.m., CNA D said she cared for Resident #6 and was familiar with the resident's care. CNA D said Resident #6 admitted to the facility with his catheter. CNA D said she helped him empty his catheter bag when it was too full and documented in his chart how much urine was in the bag. CNA D said sometimes he completed his own catheter care. During an interview on 04/22/26 at 9:55 a.m., LVN E said he cared for Resident #6 and was familiar with the resident's care. LVN E said Resident #6 admitted with his suprapubic catheter. LVN E said sometimes Resident #6 allowed staff to care for his catheter but most of the time he preferred to care for it himself. LVN E said he thought Resident #6 had catheter care orders in his chart, but when he looked in the electronic health record he did not find any. LVN E said the orders usually included emptying the catheter bag, changing the catheter when it was dislodged, flush it if it was not flowing, checking the tubing/line for kinks, and looking at the color of the urine. LVN E said all orders for care come from the doctor or nurse practitioner. During an interview on 04/23/26 at 9:43 a.m., the DON revealed Resident #6 admitted with his suprapubic catheter. The DON said Resident #6 should have orders for catheter care included in his chart. The DON said the nurse who admitted Resident #6 should have ensured he had catheter care orders entered into his chart. The DON said after a resident admitted , the ADON would go through the chart and ensure all orders were entered for the resident. The DON said the purpose of having catheter care orders was to make sure catheter care was being completed. The DON said Resident #6 mostly did his own catheter care, but when he needed assistance, staff would help him. The DON said (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if a resident did not have catheter care orders that could put them at risk of infection if staff were not caring for it. The DON said staff were trained to ensure residents had all care orders included in their chart upon admission. The DON said the orders for catheter care would include draining the catheter bag, checking the skin around the area, the sizing of the catheter, among other things. During an interview on 04/23/26 at 9:58 a.m., ADON F revealed Resident #6 admitted to her side of the building with a suprapubic catheter. ADON F said normally she would go behind the nurse after a resident was admitted to the facility to make sure all orders were entered into their chart regarding their care. ADON F said normally a resident who used a catheter would have orders that addressed monitoring the output, when to change the catheter, and would be put on enhanced barrier precautions. ADON F said Resident #6 was on her side of the building for only one night so that was why she did not go through his chart and make sure the catheter care orders were included after he was admitted . Record review of the facility's provided policy, revised 01/12/20, and titled Care and Removal of an Indwelling Catheter did not reflect the need for physician orders addressing catheter care.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 2 residents (Resident #85) reviewed for intravenous fluids . 1. The facility failed to change and maintain the integrity of the dressing on Resident #85's midline catheter (an intravenous (IV) catheter inserted into a peripheral vein in the upper arm, with the tip positioned near the axilla, used for intermediate-term IV therapy) per professional standards.2. The facility failed to have physician orders to change Resident #85's midline catheter dressing, flushing, and to monitor for infection infiltration.These failures could place residents at risk for infections and cross-contamination.Findings include:Record review of Resident #85's admission MDS Assessment, dated 02/06/26, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #85 had diagnoses which included Non-Alzheimer's Dementia (problems with memory and thinking), hypertension (high blood pressure), acute respiratory failure with hypoxia (lungs cannot adequately transfer oxygen to the blood), chronic obstructive pulmonary disease (prevents airflow to the lungs), and heart failure. Resident #83's BIMS score was 07, which indicated severe cognitive impairment. The MDS did not address the use of antibiotics. Record review of Resident #85's care plan, dated 02/09/26, revealed Problems/Strengths: Resident incontinent of urine. Goals: Will be clean, dry and odor free daily. Interventions: Observe urinary frequency, color, odor, blood and report abnormalities to MD with follow up as indicatedRecord review of Resident #85's physician order, dated 04/08/26, revealed Invanz 1 GM Powder for solution (Ertapenem Sodium) for Urinary tract infection, site not specified for ESBL ([Start 04/08/26] 1 gram Injection One time daily [Time: 08:00AM] [Stop 04/18/26 12:00]) There was no order to change the PICC/Midline dressing using sterile technique every 7 days, and as needed, no orders for flushing and to monitor for infection and infiltration.During an observation and interview on 04/21/26 at 11:09 a.m., revealed Resident #85 was in his room, lying in bed. Resident #85 stated he was doing well. Resident #85 had a midline catheter in his upper left arm, and the dressing had a date of 04/12. Resident #85 stated he could not recall how long he had the midline. The resident denied any pain or discomfort. During an interview on 04/21/26 at 1:56 p.m., RN C revealed Resident #85 completed his antibiotic therapy. RN C reviewed Resident #85's physician orders and stated Resident #85 received antibiotics from 04/08/26 to 04/18/26. RN C stated Resident #85 did not have physician orders for midline dressing change, to flush the line or to monitor for infections. RN C entered Resident #85's room, observed Resident #85's midline dressing and stated the dressing was dated 04/12. She stated the dressing should be changed every 7 days but needed to obtain physician orders first. She stated she was not aware Resident #85 had no orders for his midline. RN C stated the nurses were responsible for obtaining physician orders, putting them in the system and the ADONs were responsible for following up to ensure the physician orders were correct. She stated the potential risk of not having physician orders was it could lead to infection. During an interview on 04/23/26 at 12:31 p.m., ADON F revealed the expectation was for nurses to obtain physician orders from the doctor that addressed midline dressing changes, flushing before and after medication, and monitor for any infection. She stated Resident #85 was receiving antibiotics and completed his treatment on Sunday (04/19/26). She stated the midline dressing should be changed every 7 days and once antibiotics were completed the assigned nurse should contact the doctor and obtain orders to remove the midline. ADON F stated if no physician orders to remove were obtained then nurses should still monitor the midline and change the dressing every 7 days. She stated it was the responsibility of the nurses to obtain physician orders and the ADONs to follow up to ensure orders were obtained. She stated the potential risk of not having physician orders would be bleeding or infection. During an interview on 04/23/26 at 2:36 p.m., the DON revealed midline (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressing should be changed every Friday. She stated there should be orders for dressing change, flushing and monitoring. She stated she reviewed Resident #85's physician orders and she could not locate any physician orders pertaining to the midline. She stated it was the responsibility of the nurses to obtain orders and put them in the system. The DON stated it was the responsibility of the ADONs to ensure orders were obtained and for overseeing to ensure midline dressings were being changed. She stated the potential risk of not having physician orders would be treatment not getting done. During an interview on 04/23/26 at 4:27 p.m., the NP revealed she was aware Resident #85 was receiving antibiotics but was not aware the resident did not have physician orders. She stated the expectations were for physician orders to be obtained and be put in the system. She stated nurses should monitor the midline and dressing should be changed every 7 days or as needed. The NP stated there were several risks for not monitoring the site. Record review of the facility's Assessment of the Resident Receiving IV Therapy policy, dated October 2024, reflected the following: To enable the nurse administering infusion therapy to recognize and utilize appropriate interventions for infusion related problems or complications. Residents receiving infusion therapy will be monitored at established intervals based on prescribed therapy, and age, and conditions of resident and type of IV catheter. Check for integrity of the system and the dressing, correct infusate, accurate flow rate, and for expiration dates of the infusate, the dressing and the administration set.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the attending physician documented in the resident's medical record that the identified drug irregularity had been reviewed and what, if any, action had been taken to address it and if there was to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record for 1 of 5 residents (Resident #2) reviewed for psychotropic medications. 1. The facility failed to ensure Resident #2's attending physician addressed the pharmacist's recommendation to consider a gradual dose reduction. Resident #2 had been receiving trazadone (an antidepressant) 100 MG every day since 07/31/25. 2. The facility failed to ensure Resident #2's attending physician addressed the pharmacist recommendation to review Resident #2's cyclobenzaprine (a muscle relaxer) Resident #2 had been receiving cyclobenzaprine 10 MG every day since 09/25/25. These deficient practices could place residents at risk of receiving a higher medication dose than necessary and result in adverse side effects.Findings include: Record review of Resident #2's Quarterly MDS Assessment, dated 03/03/26, reflected a female who admitted to the facility on [DATE]. Resident #2 had a BIMS score of 11, which indicated mild cognitive impairment. Resident #2's active diagnoses included anxiety disorder (a mental health condition characterized by excessive, persistent fear or worry that interferes with daily life and is difficult to control), paraplegia (a specific pattern of paralysis that affects the legs, resulting from a problem with the nervous system), and Alzheimer's disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior). Resident #2 was noted to have taken antianxiety, antidepressant, and anticonvulsant medications. Resident #2 had not completed any GDR's for her medications. Record review of Resident #2's, undated, care plan reflected the following: Problems/Strengths: Medication: Potential for discomfort and side effects related to the use of Antidepressant. Resident takes.trazodone [sic]. Interventions: Physician to review medication.Monitor Duration- Prior to discontinuation may need a gradual dose reduction or tapering to avoid a withdrawal syndrome. Record review of Resident #2's progress notes for September 2025, October 2025, and January 2026 did not reflect any pharmacy recommendations were acted upon. Record review of Resident #2's April 2026 Physician Orders reflected the following:Trazodone Hydrochloride 100 MG, 1 tab by mouth at bedtime for Insomnia with a start date of 07/31/25.Cyclobenzaprine 10 MG, 1 tab by mouth three times a day for other muscle spasm with a start date of 09/25/25. Record review of Resident #2's April 2026 Medication Administration Record reflected she received her dose of trazodone as ordered each day as well as her doses of cyclobenzaprine each day as ordered. Record review of Resident #2's Recommendations for Doctor, dated 09/17/25, reflected the following: This patient [sic] is receiving Cyclobenzaprine is contiraindicatied [sic] in geriatric patientis [sic] due [NAME] [sic] it is [sic] stirong [sic] and anti-cholinergic effectis [sic] and risk off [sic] producing cognitive impairmenttiweakness [sic] and urine retiention [sic]. Please consider switching [NAME] [sic] a differenti [sic] antispasmodic such as tizanidine or bacloffen [sic] iff [sic] you ffeel [sic] iti [sic] is appropriatie [sic] tiherapy [sic]. There was not an additional document where the provider responded or reviewed the recommendation. Record review of Resident #2's Consultant Pharmacist's Medication Regimen Record review Recommendations Pending a Final Response, dated 10/21/25, reflected the following: This patient [sic] is receiving Cyclobenzaprine is contiraindicatied [sic] in geriatric patientis [sic] due [NAME] [sic] it is [sic] stirong [sic] and anti-cholinergic effectis [sic] and risk off [sic] producing cognitive impairmenttiweakness [sic] and urine retiention [sic]. Please consider switching [NAME] [sic] a differenti [sic] antispasmodic such as tizanidine or bacloffen [sic] iff [sic] you ffeel [sic] iti [sic] is appropriatie [sic] tiherapy [sic]. There was not an additional document where the provider responded or reviewed the recommendation. Record review of Resident #2's (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 04/23/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Recommendations for Doctor, dated 01/16/26, reflected the following: Resident is currently prescribed sedative/hypnotic TRAZODONE [sic] for the treatment of INSOMNIA [sic] since 7/25. According to CMS guidance under F605 (Chemical Restraints). ?For any resident who is receiving a psychotropic medication, the facility must show evidence that a gradual dose reduction has been attempted unless clinically contraindicated.' Please consider a trial dose reduction: If a GDR attempt is not indicated at this time, please indicate reasoning below. There was not an additional document where the provider responded or reviewed the recommendation. During an observation and interview on 04/21/26 at 10:30 a.m., revealed Resident #2 was in bed completing an activity. Resident #2 said she did not want anyone to change her medications because she liked what she was already receiving. Resident #2 said she had no concerns about the medications she received. During an interview on 04/23/26 at 11:10 a.m., ADON G said she was not sure how the pharmacy recommendations for Resident #2 were missed. ADON G said the pharmacist sent the emails with the recommendations to her and ADON F, then they printed them out and provided the recommendations to the providers (NP and Physician). ADON G said once the providers decided on the recommendations, they provided them back to her and ADON F. ADON G said then they changed or updated any orders based on what the response was for the pharmacy recommendation. ADON G said then the signed recommendation response was put back in the pharmacy recommendation binder or uploaded to the resident's chart. ADON G said she would have been responsible for ensuring Resident #2's pharmacy recommendations were completed and reviewed. ADON G said she did not have any proof and could not recall if Resident #2's pharmacy recommendations were reviewed back in September 2025, October 2025, or January 2026. ADON G said she would have the NP review them now and update the orders if needed. During an interview on 04/23/26 at 11:29 a.m., the NP and Physician, who were present on the phone only, said they received the pharmacy recommendations monthly and reviewed them at that time. The NP said once the recommendations were reviewed and an answer was provided on the forms, they were given back to ADON F and ADON G. The NP said she could not recall if Resident #2's pharmacy recommendations from September 2025, October 2025, and January 2026 were reviewed by her or not. The NP said she reviewed all the forms that were given to her, and she was at the facility 4-5 times per week. The NP said she reviewed the recommendations today for Resident #2 and did not make any changes because Resident #2 did not want her medications changed in any way. The NP said she could not say without looking at the situation further if there was any concern the pharmacy recommendations were not reviewed timely for Resident #2 and her medications. During an interview on 04/23/26 at 12:16 p.m., the DON said the ADONs were responsible for making sure the pharmacy recommendations were provided to the providers and followed up on. The DON said no one else ensured the pharmacy recommendations were followed up on by the providers or the ADONs. The DON said the ADONs were trained to ensure the pharmacy recommendations were followed up on and the recommendations were provided to the providers timely. The DON said she expected the ADONs to provide the recommendations to the providers and then update the orders if needed. The DON said if the pharmacy recommendations were not followed up on, any risk or concern to the resident would depend on the medication that was being reviewed. The DON said the purpose of following up on the pharmacy recommendations was to make sure the resident was on an appropriate medication, dose, and to consider reducing medications if needed. Record review of the facility's Medication Regimen Review and Reporting, policy, revised January 2024, reflected: .2. The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated.6. Resident-specific MRR recommendations and findings are documenta and acted upon by the nursing care center and/or physician.8. The nursing care center follows up on the recommendations to verify that appropriation action has been taken. Recommendations should be acted upon within 30 calendar days or per facility specific protocols.