STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675790	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garland Nursing and Rehabilitation	321 N Shiloh Rd Garland, TX 75042

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 of 6 residents (Resident #6) reviewed for dignity. The facility failed to conceal Resident #6's catheter bag from lying in public view. This failure placed residents at risk of not having their right to a dignified existence and self-determination maintained.Findings included: Record review of Resident #6's Face Sheet, dated 10/30/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #6 had diagnosis of Neuromuscular dysfunction of bladder (impaired bladder). Record review of Resident #6's Quarterly MDS Assessment, dated 10/22/25, reflected Resident #6 had a BIMS score of 99 (unable to complete the interview). The Quarterly MDS Assessment reflected an active diagnosis of a urinary tract infection. Record review of Resident #6's Physician Order, dated 10/30/25, reflected Foley catheter: Size 18 FR 10; Change catheter and drainage bag as needed for indications of blockage increased sediment, infection displacement as needed. In an interview and observation on 10/30/25 at 8:51 AM, LVN H was shown Resident #6's catheter bag hanging from her bed with no privacy bag. She stated the resident should have a privacy bag to cover the catheter bag for the resident's dignity. She stated nurses was required to ensure all residents with catheter bags had a privacy bag. The catheter bag was visible from the hallway. In an interview on 10/30/25 at 9:51 AM, the DON was told about Resident #6 not having a privacy bag for her catheter bag. She stated the resident required a privacy bag for their privacy. She stated she was unsure if a privacy bag was required while the residents was in their bed. She stated the nursing staff always checked to ensure all residents with catheter bags had a privacy bag. Record review of the facility's policy on Dignity, February 2011, revealed Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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 0558 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 residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for three of ten residents (Residents #3, #4, and #5) reviewed for call systems access. The facility failed to ensure the call light system in Residents #3, #4, and #5's rooms was in a position that was accessible to the residents on 10/30/25. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings include: 1. Record review of Resident #3's Face Sheet, dated 10/30/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included lack of coordination and muscle weakness. Record review of Resident #3's Quarterly MDS assessment, dated 10/06/25, reflected a BIMS score of 99, which indicated she was unable to complete the interview. For ADL care, it reflected the resident was dependent on staff to provide all care. She had an active diagnosis of a stroke. Record review of Resident #3's Comprehensive Care Plan, dated 10/13/25, reflected the resident was a fall risk, and included an intervention of encouraging the resident to use the call light. In an observation and interview on 10/30/25 at 8:25 AM, revealed Resident #3 was lying in bed, and her call light was observed on the floor near her nightstand. In an interview and observation on 10/30/25 at 8:30 AM, RN F was shown Resident #3's call light and she stated she was unsure if the resident could use the call light. She stated the call light should be in the resident's reach so she could contact them if she needs help. She stated they should check to ensure the call lights was within the resident's reach when the nursing staff make their rounds. 2. Record review of Resident #4's Face Sheet, dated 10/30/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included muscle weakness and reduced mobility. Record review of Resident #4's Quarterly MDS assessment, dated 10/28/25, reflected a BIMS score of 4, which indicated severe cognitive impairment. For ADL care, it reflected the resident required substantial assistance. Record review of Resident #4's Comprehensive Care Plan, dated 10/30/25, reflected the resident had urinary incontinence (involuntary leakage of urination) and one of the interventions was to ensure call light was within reach of the resident and to encourage the resident to use it. In an observation on 10/30/25 at 8:36 AM, revealed Resident #4 was lying in her bed, her call light was located under the bed, and out of reach of the resident. 3. Record review of Resident #5's Face Sheet, dated 10/30/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included displaced fracture of the neck and back and reduced mobility. Record review of Resident #5's Quarterly MDS assessment, dated 9/25/25, reflected a BIMS score of 15, which indicated an intact cognitive response. For ADL care, it reflected the resident required substantial assistance. Record review of Resident #5's Comprehensive Care Plan, dated 10/01/25, reflected the resident was a fall risk, and included an intervention of encouraging the resident to use the call light and keeping call light within reach of the resident. In an observation and interview on 10/30/25 at 8:59 AM, revealed Resident #5 was lying in his bed, and his call light was hanging off a side rail, nearly touching the floor, and out of reach of the resident. The resident was asked if he knew where his call light was and he stated he did not know. In an interview and observation on 10/30/25 at 8:51 AM, LVN H was shown Resident #4 and #5's call lights not within reach of the residents. She stated the CNAs often forget to place the call light back within reach of the residents once they have provided care to the residents. She stated the risk of not having the call light within reach of the residents could prevent them from calling for help. In an interview on 10/30/25 at 9:51 AM, the DON was told about Resident #4 and #5 not having their call lights within their reach. She stated sometimes the staff forgot to place the call light next to the residents when they are done providing care. She stated she and the nursing staff checked to ensure call lights was within the residents' reach throughout their shifts. She stated not having the call light within their reach could result in the residents being unable to call for help. In an interview on 10/30/25 at 1:00 PM, CNA R stated she provided care to the residents on the 600-hall. She was told about Resident #3 not having her call light within reach and she stated the call light needed to be within reach of the resident so they could contact them if they needed help. She stated they checked rooms at least every two hours and they had to check to ensure call lights was within reach. Review of the facility's policy Call System, Residents, 1/2025, reflected Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. 1.Each

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for four of seven residents (Residents #1 and #2) reviewed for respiratory care. The facility failed to ensure Resident #1's nasal canula and CPAP mask was properly stored in a bag when not in use on 10/30/25. The facility failed to ensure Resident #2's nasal canula was properly stored in a bag when not in use on 10/30/25. These failures could place residents at risk of respiratory infection and not having respiratory needs met.Findings include: 1. Record review of Resident #1's Face Sheet, dated 10/30/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included COPD (long-term breathing problems). Record review of Resident #1's Quarterly MDS assessment, dated 9/03/25, reflected a BIMS score of 8, which indicated moderate cognitive impairment. For ADL care, it reflected the resident required substantial assistance. She had an active diagnosis of COPD and respiratory failure (low oxygen). Record review of Resident #1's physician's orders, dated 10/30/25, reflected CPAP: Settings 8cmh2o Apply at HS Via Nasal Pillow with 3 liters of oxygen once a day bedtime and Nasal canula (continuous) 3L/min to keep oxygen at 90% In an observation and interview on 10/30/25 at 8:52 AM, revealed Resident #1's nasal canula for her oxygen tank, attached to her wheelchair, was hanging down the back of the wheelchair unbagged. Resident #1's CPAP mask was observed sitting on top of the nightstand unbagged. Resident #1 stated she had not used the oxygen attached to her wheelchair since last night and she had not used her CPAP machine since waking up earlier today. In an interview and observation on 10/30/25 at 8:30 AM, RN F was shown Resident #1's nasal canula and CPAP mask unbagged. She stated breathing devices should be bagged when not in use. She stated not bagging the devices could result in the resident getting an infection. She stated it was the nurses' responsibility to ensure the devices are bagged when not in use. 2. Record review of Resident #2's Face Sheet, dated 10/30/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnosis included chronic respiratory failure (lungs not functioning properly). Record review of Resident #2's Quarterly MDS assessment, dated 9/01/25, reflected a BIMS score of 15, which indicated the resident had an intact cognitive response. For ADL care, it reflected COPD and respiratory failure (low oxygen). Record review of Resident #2's physician's orders, dated 10/30/25, reflected Nasal canula (continuous) O2 @ (2-6) L/min, titrate oxygen to keep above 93%. In an observation on 10/30/25 at 8:54 PM, revealed Resident #2's nasal canula was observed on the floor, hanging from the wheelchair, unbagged. In an interview and observation on 10/30/25 at 8:51 AM, LVN H was shown the breathing devices for Resident #2 being unbagged when not in use. She stated the devices needed to be bagged to avoid the residents from getting an infection. She stated it was the nurses' responsibility to check to ensure the devices are bagged when not in use. In an interview on 10/30/25 at 9:51 AM, the DON was told about Residents #1 and #2 not having their breathing devices bagged and she stated the devices needed to be bagged to avoid the residents from getting an infection. She stated she and the nurses check for this throughout the day. Review of the facility's policy Oxygen Administration, 10/2010, reflected The purpose of this procedure is to provide guidelines for safe oxygen administration. 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess any special needs of the resident. 3. Assemble the equipment and supplies as needed.