STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676039	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Parks at Garland Healthcare and Rehab	3737 N Garland Avenue Garland, TX 75044

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 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 interview and record review, the facility failed to ensure the right to be free from misappropriation of property for 1 of2 residents reviewed for misappropriation (Resident #2). Based on interview and record review, the facility was unable to account for 11 Soma pills missing from Resident #2's blister pack of physician prescribed Soma (muscle relaxant). This failure could place residents at risk of misappropriation of physician ordered medications. Findings included: Record review of the Quarterly MDS dated [DATE] reflected indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: Congestive Heart Failure (heart pumps slow), Schizoaffective (mental disorder), panic disorder (mental disorder), dementia (confusion), diabetes, (increased sugar), other chronic pain (pain). Resident #2 was severely cognitively impaired and unable to make decisions. Resident #2 requires two staff for activities of daily living. Record review of a Physician's Order dated 12/10/2025 Resident #2 was ordered Soma 325mg three times a day and before bedtime. Record review of the Care Plan dated 12/10/2025 indicated Resident #2 had goals: to assist in control of the chronic pain, by use of the repositioning interventions and the muscle relaxant Soma. Record review of the Medications Administration Record for Resident #2 dated 09/1/2025, indicated Resident #2 missed no doses of Soma 325mg through the month of September. Record review of a pharmacy shipping manifest dated 9/13/2025 indicated 60 Soma 325 mg tablets were delivered for Resident #2 and signed in by LVN C. Record review of a provider investigation report dated 10/01/20235 indicated MA B and RN D noted while performing the count at the end of the shift, there was a count sheet that had the incorrect amount of medication on it and it appeared the count sheet had been written over. The police, the family, the pharmaceutical consultants, and the medical director were all notified. The agency for as needed employee replacement was contacted. An in-service for all staff that had anything to do with distribution of medication concerning the by the two-step system. Continuing, with monitoring by the nursing administration for two weeks after the in-service had occurred on all shifts, to assure compliance. The pharmacy consultant found no other medications discrepancies. The police detective came, and the facility provided the information for the drug diversion, a case number was given. The facility in their investigations could not confirm that the staff or LVN F (agency nurse) had misappropriated the medication. In an interview on 12/09/2025 with the DON revealed she had received a phone call from Medication Aide B and RN D on 09/23/2025 around 10:00 p.m. informing her that around 10:00 pm that 11 Soma tablets were missing for Resident #2. The staff stated to the DON the counting sheets were scribbled over on the original numbers. The DON stated she reported that to the Administrator, who called the agency for as needed employees. The DON stated they checked all the carts the next day and the medication rooms and the shredder box, and the medication was not found. The DON stated the counting sheet for the Soma had numbers that had been written over on the original number from 09/20/2025 all the way until 09/22/2025. All the staff were interviewed that worked with the cart, except for the nurse from the agency LVN E, who had worked on 09/22/2025 at 10:00p.m. to 6:00 a.m. The DON stated she was called multiple times, but no answer and no return call. The DON stated the Medical Director, police and pharmacy consultant were called. The DON stated the police came and the detectives filed a case. The DON stated she initiated an in-service on the two-step counting system in place. The DON stated that was the first time she had ever had something like that happen and she had no problems after. The Agency Supervisor stated the agency had also tried as well as the police to get ahold of LVN E, but LVN E would not return anyone's calls. The police report was requested by the surveyor on 12/09/2025 at 1:00 pm by email. In an interview on 12/09/2025 at 1:00 p.m. with LVN F revealed the count of the medication was conducted on 09/23/2025 at 6:00 a.m., with the off-going nurse, LVN E. LVN E called out the count sheet and LVN F checked the medication, it was the same number of pills, so LVN F did not look at the count sheet. In an interview on 12/09/2025 at 2:15 p.m. with RN D revealed that on 09/23/2025 at 10:15 p.m. the count with MA B, MA B noticed the counting sheet was written over. RN D stated both her and the MA B checked the count sheet and there were some numbers skipped, according to what medications that had been dosed. RN D noticed the count sheet was also signed at 4:00 am, but Resident #2 was not assigned to the nurse who had signed for the medication on the count sheet. Resident #2 did not have a PRN order for Soma. In an interview on 12/09/2025 at 2:30 p.m. with MA B it was revealed he had counted with LVN F on Monday 09/22/2025 at 10:00 p.m. The medication count was right. MA B came back to work on Tuesday 09/23/2205 at 2:00 pm and counted the medicine with

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (continued on next page)

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F 0644 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 interviews, and record review, the facility failed to incorporate recommendations from a PASRR evaluation report into a resident assessment, care planning, and transition of care for 1 (Resident #1) of 2 residents reviewed for PASRR services. The facility failed to submit a complete and accurate request for NFSS in the LTC online portal within 20 days after the IDT meeting. This failure could place residents who were PASRR positive at risk of not getting the PASARR services for a better quality of life and could lead to a decline in health. Findings included: Record review of Resident #1's quarterly MDS dated [DATE] revealed a [AGE] year-old male, admitted to the facility on [DATE]. He had the following diagnoses: muscle weakness (decreased strength), drug induced movement disorder (involuntary movements), unspecified lack of coordination (unable to control movement), diabetes (increased sugar), genetic related intellectual disabilities (abnormalities in genes or chromosomes), seizure (nerve disorder), schizophrenia (mental illness), Parkinson (muscle weakness). Resident #1 was severely cognitive impaired and unable to make decisions for himself. Resident #1 required the assistance of two staff for activities of daily living. Record review of Resident #1's care plan dated revision date 10/21/2025 revealed Resident #1 is PASRR positive, will participate in quarterly care plan meetings with PASRR representative/social worker, Coordination of PASRR services and Individual Service Plan developed by PASRR representative/social worker. Resident #1's goals will maintain highest level of practice wellbeing. interventions/task Resident has a customized Wheelchair and rehabilitation services of occupation, speech, and physical therapies. Record review of the Resident #1's PCSP dated 01/28/2025 revealed the IDT meeting was held on 01/28/2025. Attendees included the resident, PASRR habilitation coordinator, the MDS nurse, PASSR Evaluator, and Therapy Representative. The following NFSS were identified and confirmed: Customized Manual Wheelchair, speech, occupational, and physical therapy selected as new. Record review of Resident #1's PCSP dated 04/18/2025 revealed the IDT meeting was held on 04/18/2025. Attendees included the resident, the PASRR habilitation coordinator, the Social Worker, MDS RN, and Resident #1. The following NFSS were identified and confirmed: Customized Manual Wheelchair - 3 indicated on-going. Record review of the Resident #1's PCSP dated 01/28/2025 revealed the IDT meeting was held on 01/28/2025. During an interview on 12/09/2025 at 11:00 a.m. with the DOR revealed they had been treating Resident #1 for habilitation services since 2017. The DOR stated she had worked at the facility for the past 3 years and the resident had been on services since that time. The DOR stated she completed the NFSS forms for the past three years. She stated that the services for habilitation services had never stopped, except when the resident was in the hospital. Resident #1 was receiving habitation services for speech, occupation, and physical therapy services since 01/30/2025 seven times a week three times a day for the next 6 months. Record review of the NFSS with the DOR reflected. speech therapy with portal entries dated: 12/05/2025. change requested completed successfully.TMHP; Approved alert sent. speech therapy with portal entries dated: 02/11/2025:. Change requested completed successfully. TMHP: Approval alert sent. Speech therapy with portal dated: 04/09/2025 . change requested completed successfully. TMHP: Approved alert sent. Record review of the NFSS with the DOR reflected. occupational therapy with portal entries dated: 02/15/2025 change requested for therapy services completed successfully.TMHP: Approved alert sent. speech therapy with portal entries dated 10/08/2025 change requested completed successfully. TMHP: Approval sent. Speech therapy with portal entries dated 03/21/2025 change requested completed successfully. TMHP: Approval sent. Record review of the NFSS with the DOR reflected. physical therapy with portal entries dated: 02/15/2025 change requested for therapy services completed successfully.TMHP: Approved alert sent. physical therapy with portal entries dated 10/08/2025 change requested completed successfully. TMHP: Approval sent. physical therapy with portal entries dated 03/21/2025 change requested completed successfully. TMHP: Approval sent. During an interview on 12/09/2025 at 11:30 a.m., the MDS nurse stated it would have been in January of 2025 that she attended a PASRR meeting for Resident #1. During the meeting it was mentioned that therapy would need to continue the process for Resident #1 and coordinate with MDS on that process. She stated the DOR was working on a forms for the process to continue services for habitational therapy. Resident #1 had never missed any of the habilitation services, unless he was in the hospital. The MDS nurse verified during the change of ownership she could not access the portal in order to place the needed information, but she had sent all of her paperwork to the case managers for LIDDA/NF and they were aware of the habilitation

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure that each resident received food that is palatable, attractive, and at a safe and appetizing temperature for 1 of 1 lunch meals tested for nutritive value, flavor, and appearance: The facility failed to provide palatable food served at an appetizing temperature to residents, during lunch on 12/09/2025. This failure could affect the residents who ate food from the facility kitchen by placing them at risk of poor food intake and/or dissatisfaction of the meals served. The findings included: During an interview on 12/09/2025 at 9:58 a.m., CNA A stated she had received complaints from residents that the food was cold, but not often and only for residents who ate in their room. The CNA stated that trays were passed when the cart was on the hall. The CNA stated that it could take 10 minutes to pass all trays. During an interview on 12/09/2025 at 10:10 a.m., CNA G stated she had received complaints from residents stating that the food was cold. The CNA G stated that they asked the residents if they would like their tray to be reheated and residents were usually fine once the tray was reheated. The CNA stated that it could take a while to pass trays, just dependent on what was going on, staff could have assisted another resident with care and it was only one person on the hall to pass tray. During an observation on 12/09/2025 at 11:18 a.m., the DM who conducted temperature check of the barbeque, revealed the thermometer read 208 degrees Fahrenheit. For the okra the thermometer read 188 degrees Fahrenheit. For the potato salad the thermometer read 40 degrees Fahrenheit. The state surveyor requested a test tray. Observation of test tray provided to the state surveyor on 12/09/25 at 12:38 p.m., the state surveyor revealed barbeque meat was placed between two buns, the outside edges of the meat was cool to taste but the center was lukewarm; the okra was cold and the potato salad was no longer cold. No facility staff member was present. During an interview on 12/09/2025 12:57 p.m., Resident #2 revealed that the food is often cold. Resident #2 stated the trays often sit on the halls for approximately five minutes before staff pass then out. Resident #2 stated she had received her tray in her room today and the food was not cold, but not it was not hot. During an interview on 12/09/2025 at 3:59 p.m., the DM revealed that residents on halls 100 and 200 had expressed concerns about food being cold. The DM stated that they tried to ensure that the food was cooked and was hot as it could safely be. He stated they covered the plates, utilized plate warmers and had enclosed carts. The DM stated that the dietary staff delivered the cart on time to the hall and announced that the cart was on the hall, but the assigned hall staff did not start passing trays right away. The test tray provided on the last cart was delivered to the hall at 12:22 p.m. but was still on cart at 12:35p.m., that was 13 minutes after that cart had been delivered to the hall and that is unacceptable. The DM stated that he informed the clinical staff when trays would be delivered so they would be ready, but 13 minutes would cause food to be cold. During an interview on 12/09/2025 at 4:15 p.m., the DON revealed that her expectation was for the staff to disperse the trays as soon as they hit the hallway to ensure residents who ate in their room received warm meals. The DON stated that staff were notified by dietary that carts were on the hall and that there were enough staff to pass trays, they just had to find a way to have the carts delivered timely to the residents. The DON stated that she had spoken with the ADM on having staff member sign for cart and put what time cart was accepted and pass completed to be able to hold their staff accountable for getting food out on time. During an interview on 12/09/2025 at 436 p.m., the ADM stated his expectation was that food be served to residents at a safe and appetizing temperature. The ADM stated that the nursing staff was responsible for ensuring food trays were delivered as soon as the dietary staff brought the trays to the hall so that the residents who ate in their rooms received meals at appetizing temperatures. The ADM stated if food was not served at an appetizing temperature, it could have caused residents to not want to eat their food which could have led to weight loss. The ADM stated what led to failure was the staff not following facility policies. Record review of facility policy titled Meal Service dated October 2021 revealed: The facility believes that all residents should be treated with dignity and respect at all times. A respectful, positive dining experience is essential to residents' quality of life and helps to identify residents' needs attended to during meal service.Procedure:12. Room service trays will be delivered promptly upon reaching the floor.