

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455731	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/16/2025
NAME OF PROVIDER OR SUPPLIER Advanced Health & Rehab Center of Garland		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Colonel Drive Garland, TX 75043	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403</p> <p>Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status that was, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications for 1 of 5 residents (Resident #1) reviewed for Notification of Changes.</p> <p>The facility failed to notify Resident#1's durable power of attorney for healthcare when Resident#1 missed a scheduled dialysis appointment on 03/07/25.</p> <p>This failure could place residents at risk of not receiving treatment when there was a change in their condition, which could lead to worsening of conditions and serious injury or harm.</p> <p>Findings include:</p> <p>Record review of Resident#1 face sheet, dated, 03/12/25, revealed an 84 -year-old male, originally admitted to the facility on [DATE] and readmitted on [DATE] and 02/08/2024. Resident #1 had diagnoses which included Type 2 Diabetes Mellitus without complications (A chronic condition characterized by insulin resistance and elevated blood sugar), end stage renal disease (Gradual loss of kidney function reaches an advanced state) other symptoms and signs concerning food and fluid intake. Resident#1 had a Durable power of attorney for healthcare.</p> <p>A record review of Resident #1's quarterly MDS Assessment, dated 02/14/25, revealed the Resident#1 had a BIMS score of 13, which indicated he was moderately cognitively impaired.</p> <p>Record review of Resident #1's comprehensive care plan, date initiated on 06/10/2020 and revised on 01/09/2023, revealed Resident#1 receives dialysis on Monday, Wednesday and Friday related to end stage renal disease and is at risk for potential complications of dialysis.</p> <p>Resident #1's care plan goals indicated Resident#1 will have no complications from routine dialysis through the next review date.</p> <p>Resident #1's care plan interventions/tasks revealed encourage Resident #1 to attend scheduled dialysis appointments on Monday, Wednesday and Friday.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Progress note, dated 03/08/25 and written by LVN A, revealed:</p> <p>The outgoing Nurse reported to this Nurse that Resident did not go to dialysis yesterday. No char [sic] time reservation was made for the Resident for today and no transportation arrangement was made for the Resident, however, this Nurse called Dialysis Center and they said that the only chair time they have is at 3:20 pm today. This Nurse reserved the open 3:20 PM available today. I was not able to find any transportation to take Resident to Dialysis. I called the facility driver and she said that she has no transportation scheduled for today, Called.</p> <p>[Transportation service#1] and [Transportation service#2] transportation and both said that they are fully booked for today (they have no drivers). This Nurse notified both the Unit Manager and the Administrator about the dialysis issue. The Admin [Administrator] called this Nurse and asked about transportation and Nurse explained to her that I was not able to secure transportation, Nurse Manager asked for the phone numbers of the transportation co [company] that I called earlier and those Numbers were provided to her but no further response was received.</p> <p>Record review of Resident #1's clinical file revealed no progress note dated 03/07/25 which detailed why the resident did not attended dialysis on that (Friday).</p> <p>Attempted on 03/12/25 at 9:30 AM to interview Resident#1 at hospital. Resident was not interviewable at that time.</p> <p>Interview on 03/14/25 at 2:55 PM, RN B stated Resident#1 refused dialysis and the Administrator, Director of Nursing, Assistant Director of Nursing and Medical Doctor were notified.</p> <p>Interview on 03/14/25 at 4:20 PM, the Assistant Director of Nursing stated she was currently over scheduling transportation and verifying dialysis treatment schedules. The Assistant Director of Nursing stated when a resident missed a dialysis appointment the Administrator, Director of Nursing and Medical Doctor were notified immediately. The Assistant Director stated she delegated a nurse to reschedule the appointment.</p> <p>Interview, over the phone, on 03/14/25 at 5:05 PM, the durable power of attorney for healthcare, stated she was not notified of Resident#1 missing their dialysis treatment. Interview, over the phone, on 03/14/25 at 6:16 PM with the Nurse Practitioner revealed the facility notified her and let her know the resident returned to the facility without receiving dialysis treatment because of an incontinent accident on the way to dialysis. The Nurse Practitioner stated he had not refused dialysis care in the past.</p> <p>Interview, over the phone, on 03/16/25 at 12:38 PM, LVN A stated when he came on to his shift the outgoing nurse informed him Resident#1 missed his dialysis appointment on Friday. LVN A called the dialysis center and was informed Resident#1 did not have a reserved chair time but, the dialysis center was able to get him in at 3:20 PM. LVN A called both transportation services and they were fully booked. LVN A then notified the Administrator, Director of Nursing and Assistant Director of Nursing. LVN A stated he was busy and did not call the family member about Resident#1 missing dialysis. LVN A stated it is important to notify family to keep everyone updated with resident's care.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Follow-up interview, over the phone, on 03/17/25 at 9:50 AM with the Administrator, Director of Nursing and Assistant Director of Nursing stated it was important for the responsible party and family members to be called when a resident had a refusal or change of condition for the resident care. Resident could experience a decline, but the resident has the right to refuse.</p> <p>Record review of the facility's Patient Refusal of Care policy, dated 04/25/2014, reflected The resident has the right to refuse treatment as defined as care provided for purposes of maintaining/ restoring health, improving functional level, or relieving symptoms. In the case of a resident who is incapable of making decisions, the representative would make any decisions that have to be made, but the resident should still be told what is happening to him or her. In the case of a competent individual, the facility must still contact the resident's physician and notify interested family members, if known</p> <p>4. Notify the patient ' s physician and family about refusal of care, service and treatment</p>