| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455731 | A. Building<br>B. Wing | 09/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Advanced Health & Rehab Center of Garland | 1201 Colonel Drive<br>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) |
|---|---|
| F 0620<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide.<br><br>(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 0620<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to establish and implement an admissions policy for one (Resident #1) of three residents reviewed for admissions.The facility did not provide Resident #1 and his RP with a written admission agreement, consent to treat, resident rights notification, Medicare/Medicaid information or disclosure of services and charges at the time of admission. This failure placed residents at risk of receiving care and services without informed consent, being uninformed of rights and financial obligations and not knowing how to exercise Medicare/Medicaid protections.Findings included:Record review of Resident #1's face sheet dated 08/26/25 reflected he was a 71 year old male admitted on [DATE]. His active diagnoses included nontraumatic intracerebral hemorrhage (bleeding within the brainstem), anxiety disorder (mental health condition causing agitation), colostomy status (surgical opening in the colon for stool elimination), urinary retention with catheter use (inability to empty bladder requiring a tube), and gastrostomy status (feeding tube placed into the stomach). Resident #1 had a family member [RP] listed as his representative.Record review of Resident #1's admission care plan dated 08/20/25 reflected focus areas that included risk for line dislodgement, infection, aspiration, weight loss, and dehydration. Record review of Resident #1's facility documents and clinical chart reflected no evidence of an admission agreement, no consent for treatment, no written notification of resident rights and no documentation that Medicare/Medicaid coverage and service/charge disclosures were provided. An interview with Resident #1's RP on 08/26/25 at 11:45 AM revealed the entire discharge from the hospital, admission to the facility and discharge the next morning to the ER was a really bad experience. The RP said they felt Resident #1 had been discharged to the nursing facility prematurely and he was not ready for a skilled stay. The RP said Resident #1 spoke another language natively and since his stroke, his ability to understand English had decreased significantly. The RP stated that Resident #1 admitted to the facility from the hospital for a planned admission on the evening of 08/20/25 around 6:00 PM. The RP stated, When I went there, they didn't give me anything, I was pissed. All the communication was happening with them and the hospital, but they never went over any admission paperwork with me. The RP stated they asked the facility for Resident #1's hospital clinicals that were sent as well as any hospital discharge documentation, but they did not provide it. The RP stated the facility was trying to get verbal consents for things. The RP stated there was no physical evidence or proof as a result that Resident #1 was admitted to the facility, only the discharge order from the hospital that he was being sent there. The RP stated when he/she came to see Resident #1 the evening of admission, the RP was not provided with an admission packet, no one discussed what the resident's rights were or any required disclosures and facility protocols. The RP stated, I signed nothing and they provided nothing. The RP stated the morning of 08/26/25, she received a phone call from the facility wanting Resident #1's social security information for billing reasons. The RP said she refused to disclose it due to concerns of how Resident #1 was transferred to the ER on [DATE]. An interview with the BOM on 08/26/25 at 1:33 PM, revealed she was responsible for completing the admission documentation for new admissions. The BOM stated when a resident admitted to the facility, We start admission documentation that day. I have to be here. Most important docs are consent to treat and social security. The BOM stated the next step was to ensure there was a POA on file, especially if the resident was not cognitively intact, as well as advanced directives which were included in the admission packet. The BOM stated she was not present the evening Resident #1 admitted to the facility, but had been working earlier that day. When she came to work the following day 08/21/25, she saw that Resident #1 had been sent out to the hospital, so she called his RP to get his social security number and needed the RP to sign his Consent to Treat form. The BOM stated, We still needed it because we still cared for him briefly while he was here, so it is a CYA [cover your ass]. [RP] finally answered me this morning and said no to giving his social until [RP] got what she needed on why he was discharged . The BOM stated Resident #1's RP had come in a week prior to admission to tour the facility but claimed the RP did not come the night he admitted . The BOM said a lot of the required forms at the time of admission could be done electronically, so the person did not have to be at the facility face to face to complete them. The BOM stated by the end of the first week she liked to have all her required admission documentation in place. She stated, I have nothing on him [Resident #1]. I know that is bad, but I did try to get it in my defense. She [Resident #1's RP] could have signed them electronically the day he came in, but I feel like I didn't know he was coming, it was not set in stone. The BOM stated she could not provide any |

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| F 0627<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>(continued on next page) |

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| F 0627<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure when there is a transfer or discharge of resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge appropriate information is communicated to the receiving health care institution; and the facility failed to provide and document sufficient preparation and orientation in a form and manner the resident could understand for one (Resident #1) of five residents reviewed for hospital transfers. 1. The facility sent Resident #1, who they indicated was having a behavioral emergency (pulling on his g-tube, ostomy and catheter) and was in danger of dislodging them, in a private non-medical transport vehicle and left him without facility staff or a family member to supervise him while in the ER waiting area.2. The facility failed to notify and coordinate with Resident #1's RP prior to sending him out to the ER, which did not allow the RP to select the preferred hospital of her choice or be there in time to supervise him and interpret for hospital staff. 3. The facility failed to provide the hospital ER with any clinical information prior to Resident #1's arrival on [DATE], including what his medical emergency was. 4. The facility did not notify and update the MD/NP that EMS refused to transport Resident #1 to the ER because they felt he was not having a medical emergency after the NP gave a verbal order to send him out. On [DATE] an Immediate Jeopardy (IJ) was identified. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. Findings included:Record review of Resident #1's face sheet, dated [DATE], reflected he was a 71 year old male admitted on [DATE]. Active diagnoses included nontraumatic intracerebral hemorrhage (bleeding within the brainstem), anxiety disorder (mental health condition causing agitation), colostomy status (surgical opening in the colon for stool elimination), urinary retention with catheter use (inability to empty bladder requiring a tube), and gastrostomy status (feeding tube placed into the stomach). Resident #1 had a family member [RP] listed as his representative.Record review of Resident #1's admission care plan, dated [DATE], reflected focus areas included risk for line dislodgement, infection, aspiration, weight loss, and dehydration. The care plan did not address any behavioral concerns. Record review of Resident #1's facility admission orders reflected he was not discharged from the hospital with any routine or PRN psychotropic medications, including anxiety medication. Additionally there were no transfer orders to send Resident #1 to the ER on [DATE]. Record review of Resident #1's admission nursing note written by RN F on [DATE] at 11:11PM reflected the resident was confused and anxious, attempted to pull at his tubes, and required one to one supervision to prevent device removal.Record review of a follow up skilled nursing note on [DATE] at 3:57 AM reflected Resident #1's vitals were all within normal limits and he was in no pain. The skilled nursing note stated, .The resident is disoriented.The resident is unable to speak.Other Observations: Resident new admit day 1/3 alert and confused very agitated, anxious pulling tubes abdominal binder in place to secure g-tube, foley and colostomy. Awake all night resident on one and one. Total care with adl.Record review of Resident #1's nursing progress note, dated [DATE] at 12:31 PM by the DON, reflected, This writer received call from primary nurse that resident was attempting to remove urinary catheter peg tube and ostomy device. We were unable to successfully redirect the resident and he required ongoing higher-level care. Primary nurse was instructed by MD to send resident to ER for evaluation due to unable to keep resident safe in current building due to pulling lines and aggressive behavior. The DON further wrote, Action: 911 was called by primary nurse, upon their arrival this writer spoke with [name redacted] from [Fire Station] who advised this writer that paramedics would not be taking this resident to the hospital as per them he appeared to be medically stable and that the safety aspect of his care would need to be addressed with the [city Police Department or private transportation. This writer then requested nursing staff to arrange private transport via [private transport company] car. Related to RP notification, the DON wrote, Response: [RP] was notified of transfer and requested that resident be sent 'anywhere but [previous hospital]' Resident was transported via [private transport company] to [different nearby hospital]. Information was relayed by this nurse to triage nurse at [nearby hospital], as well as to [ER MD] for continuity of care.An interview with Resident #1's RP on [DATE] at 11:45 AM revealed the entire discharge from the hospital, admission to the facility and discharge the next morning to the ER was a really bad experience. She stated Resident #1 was transferred to the ER without clinical documentation and without a staff escort. The RP reported that upon arrival, the resident's ostomy |