STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455731	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health & Rehab Center of Garland	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)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident free from physical restraints not required to treat the residents' medical symptoms as was possible for one of five residents (Resident #1) reviewed for physical restraints. The facility failed to ensure Residents #1 had physician orders or a physician assessment for the bolster mattress on her bed. This failure could place residents at risk of not having an environment that was free of restraints which could result in injury.Findings include: Record review of Resident #1's Face Sheet, dated 09/25/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included muscle weakness and unsteadiness on feet. Record review of Resident #1's Quarterly MDS assessment, dated 7/24/25, reflected she had a BIMS score of 00 (severe cognitive impairment). For ADL care, it reflected the resident required extensive assistance and an active diagnosis of muscle weakness. Record review of Resident #1's Comprehensive Care Plan, dated 9/25/25, reflected the resident was a fall risk and interventions included a fall mat placed alongside the bed and the bed in a low position. In an observation on 09/25/25 at 8:46 AM, revealed Resident #1 was observed lying on a bolster mattress on her bed. Record review of Resident #1's physician orders, dated 9/25/25, reflected no physician orders for the bolster mattress. In an interview on 09/25/25 at 12:41 PM, ADON A stated hospice provided the resident the equipment. He stated the resident had not had a fall in a long time. He stated the resident should have had a physician's order for the bolster mattress because staff may not know that she needed it for fall prevention. In an interview on 09/25/25 at 1:39 PM the Administrator stated she was not a nurse, but she would think a physician's order would be needed for the equipment since it was needed for her care. She stated she would follow up with the DON and ADON to ensure a physician's order was obtained. Record review of the facility's policy Restraint Free Environment (10/24/22) reflected It is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints.

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Findings included: Record review of Resident #5's Face Sheet, dated 09/30/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included schizoaffective disorder (psychotic symptoms) and vascular dementia (memory loss). Record review of Resident #5's Quarterly MDS assessment, dated 9/194/25, reflected he had a BIMS score of 13 (intact cognitive response). Active diagnoses included schizophrenia and altered mental status. Record review of Resident #5's Comprehensive Care Plan, dated 8/19/25, reflected the resident required psychotropic medication. Record review of Resident #5's physician's orders, dated 9/30/25, reflected the resident was prescribed the following medication: Ativan Oral tablet 1 MG, give 1 mg by mouth every 8 hours as needed for agitation. Atorvastatin Calcium oral tablet 20 mg, give 1 tablet by mouth in the morning for high cholesterol. Divalproex Sodium oral tablet delayed release 500 mg, give 1 tablet two times a day for mood stabilizer. Ferrous Sulfate oral tablet 325 mg, give 1 tablet by mouth in the morning for iron deficiency Fluphenazine HCL oral tablet 5 mg, give 1 tablet in the morning and at bedtime. Ingrezza oral capsule by mouth at bedtime for involuntary movement. Lisinopril oral tablet 10 mg, give 1 tablet by mouth in the morning for hypertension. Metformin HCl oral tablet 500 mg, give 1 tablet two times a day for type 2 diabetes. Naltrexone HCl oral tablet 50 mg, give 1 tablet by mouth in the morning to treat opioid and alcohol use disorder. Paroxetine HCl oral tablet 20 mg, give 1 tablet by mouth one time a day for depression and anxiety disorders. Risperdal oral tablet 3 mg, give 1 tablet by mouth in the morning and at bedtime related to schizoaffective disorder, bipolar type. Record review of Resident #5's Medication Administration report from 09/12/25 to 09/19/25, reflected the resident was administered all prescribed medication when scheduled. Record review of Resident #5's progress notes from 09/12/25 to 09/19/25 revealed the resident had refused all of his medication. In an interview on 09/30/25 at 12:55 PM, LVN O stated Resident #5 was taking all his prescribed medication until 09/12/25, then he refused all medication from 09/12/25 to 09/19/25. He stated he prematurely coded the medications for Resident #5 as being administered to him, because the medications were already pulled from the medication cart. He stated he documented in the progress notes the resident refused his medication. In an interview on 09/30/25 at 1:03 PM, ADON S stated if a patient refused medication the nurse should input a code indicating the resident refused their medication, and they notified the responsible party and the resident's physician. She was shown the medication administration report for the month of September 2025 for Resident #5, which indicated the resident had received all of his medication from 09/12/25 to 09/19/25; however, the progress notes revealed the resident had refused all medication. The ADON stated LVN O should not have coded the resident's medication administration record until after the medication was administered and he had observed him taking the medication. The ADON stated she was notified each time the resident refused his medication. She stated not charting the medication correctly could result in the resident having a change in condition because they would be unaware the medication was not given. She stated she would be meeting with all nurses to ensure they were charting medication administration accurately. In an interview on 09/30/25 at 1:40 PM, the Administrator was advised of Resident #5's medication administration report indicating he received his medication from 09/12/25 to 09/19/25; however, the resident's progress notes revealed the resident had refused all medication. She stated she was not very familiar with the process, but she would think accurately tracking if the resident had received his medication or not was very important. She stated she would be meeting ADON and LVN O to address the concern and ensure correct coding when charting medication administration was used. In an interview on 09/30/25 at 2:19 PM, LVN E stated she was the Charge nurse for Resident #5. She was told about the medication administration report for the month of September 2025 for Resident #5, which indicated the resident had received all of his medication from 09/12/25 to 09/19/25; however, the progress notes revealed the resident had refused all medication. She stated they should check off that the medication was administered to the resident after the resident was witnessed taking the medication. She stated they would then place a code that the medication was administered and their initials. She stated if the resident refused the medication, a code would be used indicating the resident refused. She stated she would also notify the RP, the physician, and the ADON. She stated the medication administration had to be charted correctly because if they did not, it could be bad for the patient. Record review of facility policy, Medication -Treatment Administration and Documentation Guidelines, revised 02/10/2020, revealed To provide a process for accurate, timely administration and

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident call system was accessible to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member of to a centralized staff area for four of ten residents (Residents #1, #2, #3, and #4) reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Residents #1, #2, #3, and #4's rooms were in a position that was accessible to the residents on 09/25/25. 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 #1's Face Sheet, dated 09/25/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included muscle weakness and unsteadiness on feet. Record review of Resident #1's Quarterly MDS assessment, dated 7/24/25, reflected a BIMS score of 00 (severe cognitive impairment). For ADL care, it reflected the resident required extensive assistance and an active diagnosis of muscle weakness. Record review of Resident #1's Comprehensive Care Plan, dated 9/25/25, reflected the resident was a fall risk and interventions included call light being within reach of the resident. In an observation on 09/25/25 at 8:46 AM, Resident #1 was observed lying in her bed and her call light was observed on the floor, under the fall mat. 2. Record review of Resident #2's Face Sheet, dated 09/25/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included muscle weakness and unsteadiness on feet. Record review of Resident #2's Quarterly MDS assessment, dated 09/02/25, reflected a BIMS score of 00 (severe cognitive impairment). For ADL care, it reflected the resident required total assistance. Active diagnoses included unsteadiness on feet and lack of coordination. Record review of Resident #2's Comprehensive Care Plan, dated 08/26/25, reflected the resident was a fall risk 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 09/25/25 at 8:31 AM, Resident #2 was observed lying in bed and her call light was located at the foot of her bed, out of reach of the resident. 3. Record review of Resident #3's Face Sheet, dated 09/25/25, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included a history of falling and unsteadiness on feet. Record review of Resident #3's Quarterly MDS assessment, dated 09/11/25, reflected a BIMS score of 15 (intact cognitive response). For ADL care, it reflected the resident required substantial assistance. Record review of Resident #3's Comprehensive Care Plan, dated 09/15/25, reflected the resident was a fall risk 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 09/25/25 at 8:31 AM, Resident #3 was observed lying in bed and her call light was located hanging over the headboard of the bed, out of reach of the resident. 4. Record review of Resident #4's Face Sheet, dated 09/25/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included a lack of coordination and unsteadiness on feet. Record review of Resident #4's Quarterly MDS assessment, dated 09/02/25, reflected a BIMS score of 15 (intact cognitive response). For ADL care, it reflected the resident required substantial assistance. Record review of Resident #4's Comprehensive Care Plan, dated 08/31/25, reflected the resident was a fall risk 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 09/25/25 at 8:31 AM, Resident #4 was observed lying in bed and her call light was located hanging over the bottom bed frame, near the headboard, and out of reach of the resident. In an interview and observation on 09/25/25 at 8:33 AM, CNA M stated she was the CNA for the 600-hall. She was shown Resident #3 and #4's call light location in their rooms and she repositioned the call lights to be within reach of the residents. She stated she did not know why the call lights were moved. She stated they normally clipped them on the bed, near the resident. She stated the residents could not contact anyone if they needed help, if the call lights were not within their reach. She stated they normally made their rounds every two hours to ensure that the call lights were within the resident's reach. In an interview and observation on 09/25/25 at 8:35 AM, CNA C stated she was the CNA for the 100-hall. She was shown pictures of Resident #1 and #2's call light not being within reach of the residents. She stated she had already repositioned the call lights within the residents reach. She stated they checked on the residents at least every two hours to ensure the call lights were within reach of the residents. She stated the call lights needed to be within reach of the residents in case they needed assistance. In an interview on 09/25/25 at 12:20 PM 8:35 AM, RN O stated she was the nurse for the 600-hall. She was shown pictures of Resident #3