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	11/26/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824 Based on interview and record review the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment were reported immediately but not later than two hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury or not later than 24 hours to the administrator of the facility, other officials and State Survey Agency for two (Residents #2 and #3) of six reviewed for reporting alleged abuse, neglect, or mistreatment. The facility Administrator failed to report to HHSC an alleged altercation between Resident #2 and Resident #3 on 11/23/2024 after it was reported to him by facility's ADON. This failure could place residents at risk of continued abuse and injuries of unknown origins which could result in emotional anguish, discomfort, medical decline and decreased psycho-social well-being. Findings included: Record review of Resident #2's Face Sheet, dated 11/26/2024 at 1:38 PM, revealed he was [AGE] year-old admitted on [DATE]. Relevant diagnoses included cerebral infarction (blood supply to the brain is blocked or reduced,) and type 2 diabetes (insulin resistance.) Record review of Resident #2's Admission MDS dated [DATE] revealed he was admitted from home/community and was cognitively intact with BIMS score of 15. Resident #2's MDS stated he did not have any recent wandering behavior but was resistive to cares recently. Resident #2 required a walker as a mobility aide. Resident #2 required setup or clean-up assistance or was independent for most cares and was occasionally incontinent of bowel and bladder. Record review of Resident #2's Comprehensive Care Plan dated 11/25/2024 he was documented as resistive to cares at times. Interventions included: -Always ask for help if resident becomes abusive/resistive -Convey acceptance of resident during periods of inappropriate behavior -Encourage diversional activities -Keep environment calm and relaxed (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Redirect resident as needed -Remove from public area when behavior is unacceptable -Staff to continue to educate resident on the importance of cares and interventions Record review of Resident #3's Face Sheet, dated 11/26/2024 at 1:49 PM, revealed he was [AGE] year-old admitted on [DATE]. Relevant diagnoses included cerebral infarction (blood supply to the brain is blocked or reduced,) dementia (decline in cognitive function,) contracture of left hand (abnormal thickening of the tissue beneath the palm and fingers that cause one or more fingers to bend towards the palm of the hand,) and type 2 diabetes (insulin resistance.) Record review of Resident #3's Annual MDS dated [DATE] revealed he was admitted from an acute care hospital and had moderate cognitively impairment with a BIMS score of 12. Resident #3 was assessed as not exhibiting any physical, verbal, or other behavioral symptoms directed towards others. Resident #3 had a motorized wheelchair as a mobility aide. Resident #3 required substantial/maximal assistance for toileting, bathing, dressing, personal hygiene and was frequently incontinent of bowel and bladder. Record review of Resident #3's Comprehensive Care Plan dated 11/26/2024 revealed Resident #3 was a smoker and required assistance lighting cigarettes. Additionally, Resident #3 had a behavior problem as evidenced by propelling wheelchair backwards instead of forwards at times with interventions that included: -Attempt to get resident involved in problem solving -Update family about resident behavior and involve them in problem solving -Educate/re-direct resident when going backwards in wheelchair -Keep areas free of clutter and monitor for proper body alignment -Encourage and monitor for continued independence -Offer assistance as needed -Monitor for changes in mental status -Encourage socialization and activity attendance as tolerated -Educate and monitor resident for proper use of wheelchair (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's Event Report: [Resident #2] dated 11/23/2024 at 10:13 PM written by LVN E stated the event occurred 11/23/224 at 8:37 PM in the TV room. The report revealed Resident #2 reported that [Resident #3] hit him on his right leg with his motorized wheelchair. The report further stated that Resident #3 asked Resident #2 to move out of his way while trying to go outside for smoking, then Resident #3 hit Resident #2 on his right leg while Resident #2 was trying to move out of his way. The document stated Resident #2 was assessed and no signs or symptoms of bruising or swelling was noted, vital signs were taken and within normal limits, pain assessed, and medication administered, and notification of provider, ADON, DON, and Administrator was completed. Attempts to interview LVN E on 11/25/2024 at 1:35 PM and 11/26/2024 at 11:00 AM were unsuccessful. In interview with Resident #2 on 11/25/2024 at 11:20 AM he stated he was assaulted on 11/23/2024 approximately around 9:00 PM while he was in the day room or common area. He stated Resident #3 came up to him in his motorized wheelchair and ran into his ankle deliberately and on purpose, then Resident #3 took his hand and shoved him. He stated the facility's ADON heard the incident, promptly intervened, and separated Resident #3 from Resident #2. He denied any altercations have occurred since the reported incident on 11/23/2024 but considered Resident #3 a bully and troublemaker. He stated despite the incident, he felt safe at the facility, that staff for the most part treat him well and did not wish to change rooms or facilities as he and Resident #3 were on different halls. In interview with Resident #3 on 11/25/2024 at 1:58 AM he did not recall Resident #2 by name but did recall an incident on 11/23/2024 when a resident did not let him pass as he was trying to go outside to smoke. He stated he bumped this resident's leg with his motorized wheelchair because he wouldn't let him pass. He stated his same resident has been in his way in the past, specifically mentioned the dining room, and stated that he nicely asks him to move and he doesn't. Resident #3 denied hitting or striking Resident #2. He stated despite the incident, he felt safe at the facility, that staff treat him well, and that he did not want to change rooms or facilities as he and Resident #2 were on different halls. In interview with facility's ADON on 11/25/2024 at 1:29 PM she stated she did not observe the altercation on 11/23/2024 but heard residents [Resident #2 and Resident #3] talking loudly. She stated she promptly went over to assess the situation. ADON stated she separated the residents. She stated Resident #2 reported to her that Resident #3 made contact with his right ankle with his motorized wheelchair. She stated Resident #3 reported to her that Resident #2 was not allowing him to pass and was blocked by Resident #2, but he denied any contact with Resident #2. She denied that Resident #2 reported that Resident #3 hit him at this time. She stated she considered this resident-to-resident altercation and promptly reported it to the facility's Abuse Coordinator, the Administrator. In interview with facility's DON on 11/26/2024 at 11:16 AM she stated she received notification from LVN E the evening of 11/23/2024 that stated Resident #3 bumped [with his motorized wheelchair] Resident #2 and slightly hit his leg. DON stated it was the Administrator's responsibility to report and ultimately investigate any allegations of abuse and/or neglect. She stated it was her expectation that the Administrator report any allegations of abuse and/or neglect to HHSC immediately, he was to ensure a thorough investigation was conducted, and findings of the investigation reported to HHSC within the five-day timeline. She stated this was important to ensure safety, prevention of any further damage, and ultimately for the well-being of the residents at the facility. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with facility's Abuse Coordinator and Administrator on 11/25/2024 at 2:01 PM, he stated he received a notification from the ADON and LVN E that Resident #3 ran over [Resident #2's] foot. He stated he did not report this to HHSC or investigate the incident at that time because it was presented to him as an accident. He stated his was his responsibility to report any abuse, neglect, or exploitation incidents, allegations, or suspicions to HHSC per facility policy and it was important because if not, abuse can continue. Record review of facility policy, Abuse, Neglect, and Exploitation, rev 10/2023 stated The facility will provide protection for the health, welfare, and rights of each resident . that prohibit abuse . III. Identification of Abuse, Neglect, and Exploitation . B. Possible indicators of abuse include, but are not limited to: 1. Resident . report of abuse; 6. Physical abuse of a resident observed . IV. Investigation of Alleged Abuse . A. An immediate investigation is warranted when suspicion of abuse . or reports of abuse . VI. Reporting/Response . 1. Reporting of all alleged violations to the Administrator, state agency . a. Immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824 Based on interview and record review the facility failed to thoroughly investigate alleged violations and report the results of the investigation to the administrator or his or her designated representative to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. The facility Administrator failed to investigate after the alleged altercation was reported to him by facility's ADON between Resident #2 and Resident #3 on 11/23/2024 and failed to report results of the investigation to the administrator or his or her designated representative to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This failure could place residents at risk of continued abuse and injuries of unknown origins which could result in emotional anguish, discomfort, medical decline and decreased psycho-social well-being. Findings included: Record review of Resident #2's Face Sheet, dated 11/26/2024 at 1:38 PM, revealed he was [AGE] year-old admitted on [DATE]. Relevant diagnoses included cerebral infarction (blood supply to the brain is blocked or reduced,) and type 2 diabetes (insulin resistance.) Record review of Resident #2's Admission MDS dated [DATE] revealed he was admitted from home/community and was cognitively intact with BIMS score of 15. Resident #2's MDS stated he did not have any recent wandering behavior but was resistive to cares recently. Resident #2 required a walker as a mobility aide. Resident #2 required setup or clean-up assistance or was independent for most cares and was occasionally incontinent of bowel and bladder. Record review of Resident #2's Comprehensive Care Plan dated 11/25/2024 he was documented as resistive to cares at times. Interventions included: -Always ask for help if resident becomes abusive/resistive -Convey acceptance of resident during periods of inappropriate behavior -Encourage diversional activities -Keep environment calm and relaxed -Redirect resident as needed -Remove from public area when behavior is unacceptable -Staff to continue to educate resident on the importance of cares and interventions (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's Face Sheet, dated 11/26/2024 at 1:49 PM, revealed he was [AGE] year-old admitted on [DATE]. Relevant diagnoses included cerebral infarction (blood supply to the brain is blocked or reduced,) dementia (decline in cognitive function,) contracture of left hand (abnormal thickening of the tissue beneath the palm and fingers that cause one or more fingers to bend towards the palm of the hand,) and type 2 diabetes (insulin resistance.) Record review of Resident #3's Annual MDS dated [DATE] revealed he was admitted from an acute care hospital and had moderate cognitively impairment with a BIMS score of 12. Resident #3 was assessed as not exhibiting any physical, verbal, or other behavioral symptoms directed towards others. Resident #3 had a motorized wheelchair as a mobility aide. Resident #3 required substantial/maximal assistance for toileting, bathing, dressing, personal hygiene and was frequently incontinent of bowel and bladder. Record review of Resident #3's Comprehensive Care Plan dated 11/26/2024 revealed Resident #3 was a smoker and required assistance lighting cigarettes. Additionally, Resident #3 had a behavior problem as evidenced by propelling wheelchair backwards instead of forwards at times with interventions that included: -Attempt to get resident involved in problem solving -Update family about resident behavior and involve them in problem solving -Educate/re-direct resident when going backwards in wheelchair -Keep areas free of clutter and monitor for proper body alignment -Encourage and monitor for continued independence -Offer assistance as needed -Monitor for changes in mental status -Encourage socialization and activity attendance as tolerated -Educate and monitor resident for proper use of wheelchair Record review of facility's Event Report: [Resident #2] dated 11/23/2024 at 10:13 PM written by LVN E stated the event occurred 11/23/224 at 8:37 PM in the TV room. The report revealed Resident #2 reported that [Resident #3] hit him on his right leg with his motorized wheelchair. The report further stated that Resident #3 asked Resident #2 to move out of his way while trying to go out side for smoking, then Resident #3 hit Resident #2 on his right leg while Resident #2 was trying to move out of his way. The document stated Resident #2 was assessed and no signs or symptoms of bruising or swelling was noted, vital signs were taken and within normal limits, pain assessed and medication administered, and notification of provider, ADON, DON, and Administrator was completed. Attempts to interview LVN E on 11/25/2024 at 1:35 PM and 11/26/2024 at 11:00 AM were unsuccessful. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with Resident #2 on 11/25/2024 at 11:20 AM he stated he was assaulted on 11/23/2024 approximately around 9:00 PM while he was in the day room or common area. He stated Resident #3 came up to him in his motorized wheelchair and ran into his ankle deliberately and on purpose, then Resident #3 took his hand and shoved him. He stated the facility's ADON heard the incident, promptly intervened, and separated Resident #3 from Resident #2. He denied any altercations have occurred since the reported incident on 11/23/2024 but considered Resident #3 a bully and troublemaker. He stated despite the incident, he felt safe at the facility, that staff for the most part treat him well and did not wish to change rooms or facilities as he and Resident #3 were on different halls. In interview with Resident #3 on 11/25/2024 at 1:58 AM he did not recall Resident #2 by name but did recall an incident on 11/23/2024 when a resident did not let him pass as he was trying to go outside to smoke. He stated he bumped this resident's leg with his motorized wheelchair because he wouldn't let him pass. He stated his same resident has been in his way in the past, specifically mentioned the dining room, and stated that he nicely asks him to move and he doesn't. Resident #3 denied hitting or striking Resident #2. He stated despite the incident, he felt safe at the facility, that staff treat him well, and that he did not want to change rooms or facilities as he and Resident #2 were on different halls. In interview with facility's ADON on 11/25/2024 at 1:29 PM she stated she did not observe the altercation on 11/23/2024 but heard residents [Resident #2 and Resident #3] talking loudly. She stated she promptly went over to assess the situation. ADON stated she separated the residents. She stated Resident #2 reported to her that Resident #3 made contact with his right ankle with his motorized wheelchair. She stated Resident #3 reported to her that Resident #2 was not allowing him to pass and was blocked by Resident #2, but he denied any contact with Resident #2. She denied that Resident #2 reported that Resident #3 hit him at this time. She stated she considered this resident to resident altercation and promptly reported it to the facility's Abuse Coordinator, the Administrator. In interview with facility's DON on 11/26/2024 at 11:16 AM she stated she received notification from LVN E the evening of 11/23/2024 that stated Resident #3 bumped [with his motorized wheelchair] Resident #2 and slightly hit his leg. DON stated it was the Administrator's responsibility to report and ultimately investigate any allegations of abuse and/or neglect. She stated it was her expectation that the Administrator report any allegations of abuse and/or neglect to HHSC immediately, he was to ensure a thorough investigation was conducted, and findings of the investigation reported to HHSC within the five-day timeline. She stated this was important to ensure safety, prevention of any further damage, and ultimately for the well-being of the residents at the facility. In interview with facility's Abuse Coordinator and Administrator on 11/25/2024 at 2:01 PM, he stated he received a notification the evening of 11/23/2024 from the ADON and LVN E that Resident #3 ran over [Resident #2's] foot. He stated he did not report this to HHSC or investigate the incident at that time because it was presented to him as an accident. He stated his was his responsibility to report any allegation to HHSC, to conduct a thorough investigation of any abuse, neglect, or exploitation incidents, allegations, or suspicions, and report the results of the investigation in accordance with State law, including to the State Survey Agency, within 5 working days of the incident. He stated it was important because if this did not occur, abuse can continue. (continued on next page)

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Garland Nursing and Rehabilitation	321 N Shiloh Rd Garland, TX 75042

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy, Abuse, Neglect, and Exploitation, rev 10/2023 stated The facility will provide protection for the health, welfare, and rights of each resident . that prohibit abuse . III. Identification of Abuse, Neglect, and Exploitation . B. Possible indicators of abuse include, but are not limited to: 1. Resident . report of abuse; 6. Physical abuse of a resident observed . IV. Investigation of Alleged Abuse . A. An immediate investigation is warranted when suspicion of abuse . or reports of abuse . VI. Reporting/Response . 1. Reporting of all alleged violations to the Administrator, state agency . a. Immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse .

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824 Based on observations, interviews, and record reviews, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of two residents reviewed for elopements. The facility failed to ensure Resident #1 received adequate supervision and remained in the facility's secured care unit, which resulted in her elopement from the facility on 10/04/2024. The facility failed to provide adequate supervision to Resident #1 to ensure Resident #2 did not facilitate Resident #1's elopement on 10/04/2024. The noncompliance was identified as PNC IJ. The noncompliance began and ended on 11/25/2024. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk of injury and a decreased quality of life. Findings included: Record review of Resident #1's Face Sheet, dated 11/25/2024 at 9:40 AM, revealed she was a [AGE] year-old female admitted [DATE]. Relevant diagnoses included cerebral infarction (blood supply to the brain is blocked or reduced,) brain and lung cancer that had metastasized (spread,) and Neurocognitive disorder further detailed by unspecified symptoms and signs involving cognitive functions and awareness. She resided in the facility's secured unit. Record review of Resident #1's Admission MDS dated [DATE] revealed she was admitted from home/community and had a severe cognitive impairment with BIMS score of 05. Resident #1's MDS stated she had recent wandering behavior. Resident #1 did not require any mobility aides for ambulation. Resident #1 required setup or clean-up assistance for most cares due to cognitive impairment and was occasionally incontinent of bowel and bladder. Record review of Resident #1's Wandering Assessment completed upon admission 08/29/2024 revealed she was at risk for wandering/elopement and resided in facility's secured unit. Record review of Resident #1's Comprehensive Care Plan dated 11/20/2024 revealed she had neurocognitive disorder and resides in the secure unit due to her wandering and poor safety awareness. 10/04/2024 Resident observed by staff sitting outside on the bench. Interventions included: -Ensure resident was wearing proper fitting and appropriate footwear -To complete wander alert [documents] and place in elopement binder -Take picture of resident every quarter because I may have changed my appearance and/or weight (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Elopement assessments to be completed upon admission, quarterly, and with any significant change of condition -To provide resident with redirection, comfort measures and address basic needs when wandering behavior is exhibited Record review of Resident #2's Face Sheet , dated 11/26/2024 at 1:38 PM, revealed he was [AGE] year-old admitted on [DATE]. Relevant diagnoses included cerebral infarction (blood supply to the brain is blocked or reduced,) and type 2 diabetes (insulin resistance.) Record review of Resident #2's Admission MDS dated [DATE] revealed he was admitted from home/community and was cognitively intact with BIMS score of 15. Resident #2's MDS stated he did not have any recent wandering behavior but was resistive to cares recently. Resident #2 required a walker as a mobility aide. Resident #2 required setup or clean-up assistance or was independent for most cares and was occasionally incontinent of bowel and bladder. Record review of Resident #2's Comprehensive Care Plan dated 11/25/2024 revealed he enjoyed listening to country music, walks outside and playing cards. Additionally, Resident #2 was documented as resistive to cares at times. Interventions included: -Always ask for help if resident becomes abusive/resistive -Convey acceptance of resident during periods of inappropriate behavior -Encourage diversional activities -Keep environment calm and relaxed -Redirect resident as needed -Remove from public area when behavior is unacceptable -Staff to continue to educate resident on the importance of cares and interventions In interview and observation with Resident #1 on 11/21/2024 at 10:58 AM, she was in the facility's secured unit resting in her room on her bed. She was observed with proper fitting and appropriate footwear. She was clean, well dressed, and appeared to not be in any distress. She stated she recalled the elopement incident but did not remember the date, she denied she was injured because of the incident, and stated she went outside because she just wanted to get some sun. In interview and observation with Resident #1 on 11/26/2024 at 9:29 AM, she ambulated in the hallway of the facility's secured unit. She was observed with proper fitting and appropriate footwear. She was clean, well dressed, and appeared to not be in any distress. She reported she was having a good day and had no complaints. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility's Progress Note for Resident #1 by LVN A on 10/04/2024 at 3:44 PM revealed At about 1235, a resident alerted staff by yelling out that, this resident had exited the door and staff immediately chase after this resident while alerting other staff. A staff who was coming back from her break entered the building with the resident and said that, she saw this resident sitting outside on a chair near the main entrance to the facility. Head to toe assessment done and no injury noted. RP, DON, and MD made aware. Elopement watch initiated. Record review of Facility Event Summary with a look-back period of 10/01/2024-11/21/2024 revealed on 10/04/2024 at 12:54 PM, LVN A wrote [Resident #1] observed by staff sitting outside on the bench in front of the building. Head to toe assessment performed and no injuries noted. Resident stated she was 'getting some sun'. Resident [in] line of [sight] observation. Additional documented revealed the physician and RP were notified, and care plan reviewed. DON e-signed the incident status as closed on 10/09/2024. Interviews attempted with LVN A on 11/21/2024 2:44 PM and 11/25/2024 at 2:00 PM were unsuccessful. In interview with CNA C on 11/21/2024 at 11:10 AM revealed she was working the day of Resident #1's elopement, 10/04/2024, and around mid-day she at the facility's parking lot sitting in her car while on her lunch break. She stated she saw Resident #1 outside sitting on the bench near the front door. She stated she immediately went to Resident #1 and re-directed her back inside to her secured unit. CNA C stated Resident #1 was outside approximately 1.5 minutes. CNA C stated that Resident #1 told her upon her return to the facility that a gentleman opened the door, for her and that was how she got outside. In interview with Resident #2 on 11/25/2024 at 11:20 AM he stated he recalled the incident with Resident #1. Resident #2 stated he was watering the plants in the front of the building the day of the incident. He stated he saw the resident sitting on the bench located outside in the front of the facility building. He denied letting Resident #1 out of the building and stated she was not outside for very long. Resident #2 stated after Resident #1's elopement, he was educated by the Administrator and DON on the importance of not opening the facility front door for any residents. He stated at that time of Resident #1's elopement, he was aware of the facility's front door code, but declined to disclose how he obtained the code. He stated after Resident #1's elopement, the facility changed the front door code, and he did not know it currently. (continued on next page)

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	11/26/2024

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In interview with facility's Administrator on 11/25/2024 at 11:01 AM, he stated based on his investigation Resident #1 exited through the secured unit door. He was not able to determine how Resident #1 exited the secured unit; but he determined Resident #1 was let outside the facility's front door by Resident #2 while he was watering the plants in the front of the building. He stated Resident #2 was high functioning, had a BIMS score of 15, resided in an unsecured environment, and was able to sign himself in and out of the facility as he pleased. He stated there was not a way to disable the door alarms without the location/door specific code. He stated both the secured unit and the facility's doors were alarmed with a code that only facility staff had access to. The facility Administrator stated since Resident #1's elopement, all the door codes have been changed and a sign has been placed on the front door to not allow any residents out unassisted. He stated his expectations were for his residents in the secured unit to remain in the secured unit. He further stated it was the responsibility of facility staff to supervise and monitor the residents to identify and re-direct wandering behaviors. Finally, he stated it was nursing leadership's responsibility to ensure any additional and/or resident specific assessments and/or interventions were in place to prevent resident elopements. In interview with facility's DON on 11/26/2024 at 11:47 AM, she stated based on her investigation, CNA C reported to her that she saw Resident #1 outside while she was on her lunch break. DON stated she was not sure how Resident #1 exited the secured unit; but she concluded that Resident #2 let Resident #1 out of the facility's front door while he was watering the plants. She stated there was not a way to disable the door alarms without the location/door specific code and to her knowledge the doors did not malfunction. She stated both the secured unit and the facility's doors were alarmed with a code that only facility staff was permitted to have access to. DON further stated since Resident #1's elopement, all the door codes have been changed probably twice already. She stated after Resident #1's elopement, she ensured proper notification to Resident #1's provider and RP, that Resident #1 was assessed for injury/harm, that Resident #1's Comprehensive Care Plan was reviewed, that maintenance performed a facility-wide inspection of doors for functionality, she conducted a facility-wide elopement drill, and provided In-services to her staff specific to elopements and the prevention of any potential piggy-backing of residents that may get out of the secured unit without staff's awareness. She stated her expectations were for the residents in the secured unit to remain in the secured unit and it was facility staff's responsibility to monitor and supervise the residents. DON stated it was nursing leadership's responsibility to ensure the Elopement Binder was at the secured unit's nurses' station, the documents were completed and quarterly updated, and any other resident specific interventions were in place to prevent resident elopements. In interview with Resident #1's RP on 11/25/2024 at 10:07 AM, she stated she was Resident #1's RP and that her family member resides in the secured unit at [Facility.] She stated she was notified by LVN A on 10/04/2024 about Resident #1's elopement. Resident #1's RP denied any successful elopements from the facility prior to 10/04/2024, but stated she had elopements from home prior to her admission which necessitated her admission to the facility's secured unit. In interview with facility's Maintenance on 11/25/2024 at 9:30 AM revealed after Resident #1's elopement on 10/04/2024, he ensured all the doors at the facility were operating as required. In observation of facility's front door on 11/21/2024, 11/22/2024, 11/25/2024, and 11/26/2024 at approximately 9:00 AM revealed a sign posted on the front door that stated, Please do not let our residents out unassisted. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In observation of facility's secured unit front and back doors and facility main entrance/exit door on 11/21/2024 at 9:29 AM and 2:00 PM, doors demonstrated appropriate function and were secured with a multi-digit code for entry and exit. In observation of facility's Elopement Binder located at the secured unit's nurses' station on 11/26/2024 at 9:26 AM, revealed Resident #1's Wander Alert documents with relevant identification and notification details in the binder with a recent, recognizable photograph of Resident #1. In interview with CNA C on 11/21/2024 at 11:10 AM she stated the importance of proper footwear for Resident #1, stated the location and purpose of the facility's Elopement Binder at the secured unit's nurses' station, and the importance of providing Resident #1 with redirection and comfort measures to address basic needs when wandering behavior is exhibited. In interview with CNA D on 11/26/2024 at 9:26 AM she stated the importance of proper footwear for Resident #1, the location and purpose of the facility's Elopement Binder at the secured unit's nurses' station, and the importance of providing Resident #1 with redirection and comfort measures to address basic needs when wandering behavior is exhibited. In interview with LVN B on 11/21/2024 at 11:15 AM he stated the importance of proper footwear for Resident #1, stated the location and purpose of the facility's Elopement Binder at the secured unit's nurses' station, the requirement of an accurate wandering/elopement assessment to be completed upon admission, quarterly, and upon a resident's change of condition, and the importance of providing Resident #1 with redirection and comfort measures to address basic needs when wandering behavior is exhibited. In interview with facility's DON on 11/26/2024 at 11:47 AM stated the importance of proper footwear for Resident #1, that the facility's Elopement Binder was located at the secured unit's nurses' station and was required to be created upon admission, updated quarterly, and/or upon a change of condition, and that she was responsible to ensure resident wandering/elopement assessments were completed upon admission, quarterly, and with any significant change in condition. DON stated the importance of all staff providing Resident #1 with redirection and comfort measures to address her basic needs when wandering behavior is exhibited as stated in her Comprehensive Care Plan. In interview with facility Administrator on 11/25/2024 at 11:01 AM he stated the importance of proper footwear for Resident #1, that the facility's Elopement Binder was located at the secured unit's nurses' station and both the Elopement Binder and wandering/elopement assessments were required to be updated upon a resident's admission, quarterly, and in response to a resident's change of condition. Administrator also stated the importance of his staff to provide Resident #1 with redirection and comfort measures to address her basic needs when wandering behavior is exhibited. Record review of Resident #1's Comprehensive Care Plan dated 11/20/2024, reviewed on 11/25/2024 at 9:00 AM revealed sufficient identification of Resident #1's wandering/elopement behaviors and detailed list of multiple interventions prior to investigation. Record review of Resident #1's Wandering Assessments reviewed on 11/25/2024 at 9:30 AM revealed sufficient assessment of Resident #1's risk for wandering/elopement that necessitated her need to reside in facility's secured unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility Inservice titled, Elopement/Wandering .Secured Unit/Missing Resident, dated 10/04/2024 conducted by facility's DON revealed facility policy, protocols, and procedures which specifically included to ensure no resident exits behind you when entering or exiting the secure unit. Please wait till the door is locked before walking away . Document revealed multiple staff signatures. Record review of facility document titled, Elopement Drill dated 10/10/2024 conducted by facility's DON revealed facility's elopement drill was completed. Document revealed multiple staff signatures. Record review of facility's Inservice titled, Elopement Drill dated 10/10/2024 conducted by facility's DON revealed facility's elopement policy, protocols, procedures, provided to staff. Document revealed multiple staff signatures. Record review of facility's documentation of Maintenance of the doors, dated 10/04/2024, revealed that he personally ensured all doors were operating as required. Review of facility policy, Wandering and Elopements, dated 09/01/2023 revealed The facility will ensure that residents who exhibit wandering behavior and/or at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care . Monitoring and managing residents at risk for elopement or unsafe wandering . a person-centered care plan will be developed based on the risk factors identified in the risk assessment . adequate supervision will be provided to help prevent accidents or elopements . The noncompliance was identified as PNC IJ. The noncompliance began and ended on 11/25/2024. The facility had corrected the noncompliance before the investigation began.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42824 Based on observation, interview, and record review the facility failed to ensure food was stored, prepared, distributed and served in accordance with professional standards for food service safety for the facility's only kitchen reviewed for kitchen sanitation. The facility failed to ensure the beverage dispenser, prepared for residents, was cleaned and changed out in a timely manner in observation on 11/21/2024 at 12:30 PM. These failures could place residents at risk for food-borne illnesses. Findings included: In observation of lunch dining service at 11/21/2024 at 12:30 PM, two beverage containers were observed in the dining area. Multiple residents were observed sitting in the dining room with cups of pink and clear liquids present in front of them at the tables. -One container with pink liquid, the label stated, Item Peach Juice . Date 11/20/24 . Emp [INITALS]. No time was observed documented on the label. -One container with clear liquid, the label stated Item Ice Water . Date 11/20/24 . Emp [INITALS]. No time was observed documented on the label. In observation and interview of DA on 11/21/2024 12:34 PM, she removed the two beverage containers from the dining room. She stated it was her initials on the beverage labels and she was the staff member that filled each container yesterday morning [11/20/2024.] She stated she did not write a time on the label but did not state the reason. She further stated it was her responsibility to clean, properly label with date and time, and change out the beverage inside the container in the morning each day. She stated she had a busy morning and had not changed out the beverage containers yet. She stated it was important to clean, properly label with date and time, and change out the beverage inside the containers once a day each morning because germs can grow and cause people to be sick. In interview with DM on 11/26/2024 at 9:51 AM, she stated it was the kitchen staff's responsibility to ensure the beverage containers were cleaned, properly labeled with a date and time, and the beverage inside the container changed out once per day in the evenings. DM stated she was not aware that DA stated she changed out the beverage containers in the morning at the time of the interview. She stated it was important to clean, properly label with date and time, and change out the beverage containers once a day as important as it can lead to sickness if not completed. She stated that writing a date and time on the label was important so staff understand when the beverage container needed to be cleaned and changed out. In interview with ADON/ICP on 11/26/2024 at 9:35 AM, she stated it was the kitchen staff's responsibility to ensure the beverage containers were cleaned, properly labeled with a date and time, and the beverage inside the container changed out once per day. She stated this was important because you don't want to get mold and mildew in the beverage served to the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In interview with facility's DON on 11/26/2024 at 11:16 AM she stated she expected the beverage containers to be cleaned and changed out daily. She stated it was the kitchen staff's responsibility to ensure the beverage containers were cleaned, changed out daily, and properly labeled with date and time. She stated this was important for infection control purposes, so we give people fresh stuff. In interview with facility's Administrator on 11/26/2024 at 12:52 PM he stated the facility did not have a Food Storage and Labeling policy specifically for beverage containers. Record review of U.S. Food Code Section 3-501.17, rev. 02/09/2023, reflected that ready-to-eat, time/temperature control for safety (TCS) food prepared in a food establishment and held longer than a 24 hour period shall be marked to indicate the date or day by which the food is to be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. These time/temperature parameters are intended to help control for growth of Listeria monocytogenes.