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	02/27/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to provide the right to personal privacy which includes accommodations during personal care for one (Resident #1) of ten residents reviewed for Privacy. The facility failed to ensure CNA A and CNA B provided privacy when they transferred Resident #1 in the hallway on 02/27/2025. This failure could place the residents at risk of not having their personal privacy maintained during medical treatment. Findings included: Review of Resident #1's Face Sheet, dated 02/27/2025, reflected a [AGE] year-old female admitted on [DATE]. Resident #1 was diagnosed with muscle wasting (thinning of muscle mass due to disuse) and atrophy (decrease in size of a body part). Review of Resident #1's Quarterly MDS Assessment, dated 01/27/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident was dependent on staff for transfer bed-to-chair transfer. Review of Resident #1's Care Plan, dated 02/27/2025, reflected the resident required an extensive assistance by 2 staff to transfer via mechanical lift (devices used to move a person from one position to another). Observation and interview with CNA B on 02/27/2025 at 10:31 AM revealed CNA B was inside Resident #1's room and was about to transfer the resident via Hoyer lift (device that holds a person in a hammock-type sling to lift and transfer). She said she was waiting for CNA A to assist her with transfer. It was observed that CNA B already placed the Hoyer sling under the resident and the Hoyer lift was already at the left side of the bed. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 02/27/2025 at 10:34 AM revealed CNA A entered Resident #1's room to assist CNA B in transferring the resident to her wheelchair. The CNAs hooked the Hoyer sling to the Hoyer lift and raised the resident. CNA B closed the door before raising the resident. When the resident was already raised, CNA A told CNA B to unlock the bed and push the rear end of the bed towards the right. When the rear end of the bed was already pushed to the right side, both CNAs started to maneuver the Hoyer lift. When asked where the resident's wheelchair was, CNA A said it was in the hallway. CNA B opened the door and both CNAs continued to move the Hoyer lift outside the room and into the hallway. It was observed that the resident's wheelchair was in the hallway, near the adjacent room's door. CNA A and CNA B proceeded to transfer the resident to her wheelchair in the hallway. In an interview with Resident #1 on 02/27/2025 at 10:40 AM, Resident #1 stated that sometimes she would be transferred to her wheelchair inside the room and sometimes outside the room. She said it did not bother her but would be nice if she was transferred inside the room. In an interview with CNA A on 02/27/2025 at 10:46 AM, CNA A stated they closed the door when they were raising the Hoyer lift with the resident in it but did transfer the resident in the hallway. He said transferring the resident in the hallway could be a dignity issue. CNA A said the resident could be embarrassed or their self-esteem could be affected when other people could see that she was dependent on others and the manner she was transferred to her wheelchair. He said the room was tight but could have moved the bed or the bedside table to accommodate the wheelchair inside the room. In an interview with CNA B on 02/27/2025 at 10:50 AM, CNA B stated transferring Resident #1 should be done inside the room to provide privacy to the resident. She said all the care and services done for the resident should be done inside the room. she said she was new in the facility and was in training. In an interview with the ADON on 02/27/2025 at 10:58 AM, the ADON stated all care should be done in the privacy of the residents' room. She said when transferring a resident from bed to wheelchair, it should be done inside the room to provide dignity. She said it did not matter if the resident cared or not, the transfer should still be done inside the resident's room with door closed. She said it was important that the residents feel safe and would not be embarrassed. She said the expectation would be to not transfer a resident to her wheelchair in the hallway. She said she would coordinate with the DON to do an in-service about dignity. In an interview with the DON on 02/25/2025 at 11: 46 AM, the DON stated all care should be done inside the room with the door closed. She said, at least, they should have placed the wheelchair on the doorway to lower the resident. She said all residents had the right for privacy and dignity when given care and when not provided could result in embarrassment. She said the expectation was for the resident to be transferred inside the room and not in the hallway. She said she would start an in-service about privacy during transfer as soon as the interview was over. In an interview with the Administrator on 02/25/2025 at 1:19 PM, the Administrator stated the staff must make sure that the residents were provided privacy when providing care to prevent embarrassment. He said the expectation was for the staff to transfer the resident inside their room and not in the hallway. He said he would collaborate with the DON and the ADON to do an in-service about privacy and dignity. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, Dignity 2001 MED-PASS revised February 2021 revealed Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem . Policy Interpretation and Implementation . 11. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.