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	01/17/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 5 residents (Residents #1 and #2) reviewed for infection control practices. 1. RN A and CNA B failed to wear a gown while providing incontinence care to Resident #1, who was on EBP due to having pressure ulcers on her sacral area and foot.2. RN A failed to wear a gown while providing wound care to Resident #1, who was on EBP due to having pressure ulcers on her sacral area and foot.3. LVN C failed to wear a gown while providing wound care to Resident #2, who was on EBP due to having pressure ulcers on her sacral area and left ankle. These failures could place residents at risk of exposure to infectious agents and could lead to the development of infection.Findings included:1. Record review of Resident #1's Comprehensive MDS Assessment, dated 11/18/25, reflected the resident was a [AGE] year-old female, who was admitted to the facility on [DATE].The resident had severe cognitive impairment with a BIMS score of 0, and her diagnoses included pressure ulcer (a skin injury caused by prolonged and constant pressure on a bony prominence) of the sacral region (the triangular bone located at the base of the spine/lower back), and pressure ulcer on the medial lateral foot (the inner side of the foot from the heel to the big toe).Record review of Resident #1's care plan, dated 01/17/26, reflected: Focus: [Resident #1] Enhanced Barrier Precautions. Staff must wear gowns and gloves during high contact resident care activities that could possibly result in transfer of MDROs to hands and clothing of staff. Goal: [Resident #1] dignity will be maintained over the next 90 days. Interventions: Enhanced barrier precaution: staff must use gowns and gloves during high -contact care activities that could possibly result in transfer of MDROs to hands and clothing of staff. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those who are not confirmed to have an MDRO (e.g . Residents with wounds).Observation on 01/17/26 at 10:43 AM on Resident #1's room revealed a posting on the outside notifying staff and visitors the resident was on EBP and were required to wear a gown and gloves with all direct care of the resident. There was no PPE observed outside Resident#1 room. Observation on 01/17/26 at 10:45 AM revealed RN A and CNA B provided incontinence care to Resident #1. Neither RN A nor CNA B wore a gown as required for providing care to a resident on EBP. They only wore gloves. Observation on 01/17/26 at 11:08 AM revealed RN A prepared all the wound care supplies, and she entered Resident 1's room. RN A washed her hands, put on gloves, but she did not put on the gown. She removed the old dressing on the resident's sacral area, dated 01/16/26. She removed her gloves, washed her hands, and put on new gloves. She cleaned the wound, applied collagen powder to the wound bed, then calcium alginate, and covered the pressure ulcer with a dry dressing. She then washed her hands and put on clean gloves. RN A removed the old dressing on Resident #1's medial foot area. The dressing was observed to have some drainage and was dated 01/16/26. She removed (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gloves, washed hands, and put on new gloves. She then cleaned the wound, applied collagen powder to the wound bed, applied xeroform, and covered the pressure ulcer with a dry dressing. RN A did not wear a gown while providing Resident #1 with wound care.Interview on 01/17/26 at 11:37 AM with CNA B revealed she knew she was supposed to wear PPE when there was an EBP sign on the door. She stated she could not recall seeing an EBP sign at Resident #1's room. She stated she knew she was supposed to put on gloves and a gown when caring for residents with wounds. She stated she forgot because there was no cart with PPE at Resident #1 door. She stated she had done training on EBP. She stated the risk of not wearing a gown and gloves was it could lead to cross contamination.Interview on 01/17/26 at 11:41 AM with RN A revealed she forgot to wear PPE because she was anxious. She stated she was aware she was supposed to wear gloves and a gown while coming into contact with Resident #1. She stated Resident #1 had signage by the door but did not have a bin for PPE. RN A stated she knew staff were supposed to use EBP for all residents with wounds. She stated she did not wear PPE because there was none by the door. She stated failure to use EBP could place Resident #1 at risk of cross contamination. She stated she had done training on EBP. She was asked and also, I had to verify whether she had been trained on EBP.2. Record review of Resident #2's Comprehensive MDS Assessment, dated 12/26/25, reflected the resident was a [AGE] year-old female, who was admitted to the facility on [DATE]. The resident had moderate cognitive impairment with a BIMS score of 10, and her diagnoses included pressure ulcer of sacral region and a pressure ulcer on the left ankle.Record review of Resident #2's care plan, dated 01/17/26, reflected: Focus: [Resident #2] Enhanced Barrier Precautions. Staff must wear gowns and gloves during high contact resident care activities that could possibly result in transfer of MDROs to hands and clothing of staff. Implemented rule out feeding tube. Goal: [Resident #2] dignity will be maintained over the next 90 days. Interventions: Enhanced barrier precaution: staff must use gowns and gloves during high -contact care activities that could possibly result in transfer of MDROs to hands and clothing of staff. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those who are not confirmed to have an MDRO (Bacteria that resist treatment with more than one antibiotic are called multidrug-resistant organisms) (e.g. Residents with wounds).Observation on 01/17/26 at 11:08 AM revealed LVN C prepared wound care supplies and then entered Resident #2's room. LVN C washed her hands and put on gloves, but she did not put on the gown. She removed the old dressing on the resident's sacral area, dated 01/16/26. She removed her gloves, washed her hands, and put on new gloves. She cleaned the wound, applied collagen powder to the wound bed, then applied calcium alginate, and covered the pressure ulcer with a dry dressing. She washed her hands and put on clean gloves. She removed the old dressing on the resident's left ankle. The dressing was observed to have some drainage and was dated 01/16/26. She then removed her gloves, washed her hands, and put on new gloves. She cleaned the wound and applied collagen powder to the wound bed, then applied calcium alginate, and covered the wound with a dry dressing. The gloves were the only PPE that LVN C wore while providing wound care to Resident #2.Interview on 01/17/26 at 12:12 PM with LVN C revealed she forgot to wear PPE, because she was nervous. She stated the facility used to put PPE in a bin by the resident's door, but today there was no PPE by the door. She stated she was aware she was supposed to wear gloves and a gown while coming into contact with Resident #2. She stated failure to use EBP could place Resident #2 at risk of cross contamination. She stated she had done training on enhanced barrier precautions.Interview on 01/17/26 at 3:02 PM with the DON revealed staff were required to wear a gown and gloves when having direct contact with the residents on EBP such as turning, incontinence care, and providing wound care. The DON stated the EBP were in place to protect the residents from exposure to infectious agents that (continued on next page)

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