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	03/12/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 3 out of 5 residents (Residents #1, Resident #2 and Resident #3) reviewed for medication administration. The facility staff did not follow physician orders and administered Resident #1, four Warfarin pills on 03/08/26 and 03/09/26 instead of two. The facility staff did not watch Resident #1 take her medications. The facility staff did not watch Resident #2 take her Melatonin 3MG medication.The facility staff did not watch Resident #3 take his Zolpidem Tartrate 5mg medication. These failures could affect residents that receive medications resulting in adverse reactions to medication, deterioration in their health, exacerbation of their disease process, and/or hospitalization. Findings Included: Record review of Resident #1's face sheet, dated 03/11/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: cerebral infraction (blocked blood flow to the brain), malignant neoplasm of overlapping sites of right bronchus (cancer that spans both the bronchial air passages and lung tissues on the right side), hypoxemia (abnormally low oxygen levels in arterial blood), dysphagia (difficulty swallowing), difficulty walking, cognitive communication deficit (difficulty with verbal or non-verbal communication), iron deficiency anemia secondary to blood loss (chronic) (bleeding depletes iron faster than it could be replaced), type 2 diabetes mellitus (body resist insulin or fails to produce enough), morbid obesity (chronic, complex disease with body mass index of 40 or higher), major depressive disorder (persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), cortical age-related cataract (glare, hazy vision and difficulty with light), hypertension (blood pushing too hard against artery walls), atherosclerosis of coronary artery (disease of the arteries with plaques of fatty material), alcoholic cirrhosis of liver without ascites (heavily damaged liver from chronic alcohol consumption), gastrointestinal hemorrhage (bleeding in in stomach, intestines or rectum), muscle weakness (a reduction in physical strength), prosthetic heart valve (artificial device implanted to replace diseased valve and restore proper blood flow), peripheral vascular disease (slow, progressive circulation disorder which blocks blood vessels outside the heart and brain), hypertensive retinopathy (damage to the retinal blood vessels), bipolar disorder (extreme mood swings), heart failure (condition where the heart cannot pump blood efficiently) and hyperlipidemia (excessive fat levels in the blood). Record review of Resident #1's Quarterly MDS assessment, dated 02/13/26, reflected BIMS score of 15, which indicated cognitively intact. The MDS assessment under Section GG-Functional Abilities, reflected Resident #1 needed setup or clean up assistance with all ADLs. Record review of Resident #1's care plan, date initiated 11/11/25, reflected Resident #1 was at risk for bleeding. Interventions included: evaluating blood in stools, change in level of consciousness, hematemesis (vomiting blood), hematuria (blood in the urine), skin for evidence of impaired coagulation (bruising, petechia, bleeding from orifice (an opening or hole)). Record review of Resident #1's order summary report, dated 03/12/26, reflected in part:Warfarin Sodium Oral Tablet 4mg- give 2 tablets by mouth at bedtime for clotting related to heart failure. Record review of (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

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	03/12/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1's progress notes revealed no documented rationale for not administering medication per physician's order. Record review of Resident #2's face sheet, dated 03/11/26, reflected a [AGE] year-old female who was admitted into the facility on [DATE]. Resident #2 had diagnoses which included: hemiplegia and hemiparesis following cerebral infraction (paralysis and weakness on one side from a stroke), lack of coordination (muscle movements are clumsy or unsteady) iron deficiency anemia (body lacking sufficient iron), diaper dermatitis (skin rash in diaper area), muscle spasms (involuntary, often painful contractions of a muscle), primary insomnia (difficulty falling asleep or staying asleep), generalized anxiety disorder (persistent, excessive and uncontrollable worry), constipation (infrequent bowel movements or difficulty passing stool), muscle weakness (a reduction in physical strength), chronic cough, type 2 diabetes (high blood sugar), vitamin d deficiency (not getting enough sunlight), morbid obesity (chronic, complex disease with body mass index of 40 or higher), hyperlipidemia (excessive fat levels in the blood), major depressive disorder (persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), hypertension (blood pushing too hard against artery walls), aphasia following cerebral infarction (language disorder that affects communication skills), repeated falls and pain. Record review of Resident #2's Quarterly MDS assessment, dated 02/10/26, reflected BIMS score of 15, which indicated cognitively intact. The MDS assessment under Section GG-Functional Abilities, reflected Resident #2 was dependent on staff with some ADLs such as dressing, toileting and putting on/off footwear. Resident #2 also needed substantial assistance with bathing and set up assistance with eating and oral hygiene. Record review of Resident #2's order summary report, dated 03/12/26, reflected in part:Melatonin Oral Tablet 3 MG- give 1 tablet by mouth at bedtime for insomnia. Record review of Resident #3's face sheet, dated 03/11/26, reflected a [AGE] year-old male that admitted into the facility on [DATE]. Resident #3 had diagnoses which included: chronic obstructive pulmonary disease (lung disease), reduced mobility, hypertension (blood pushing too hard against artery walls), muscle spasm (sudden, involuntary and painful contractions) of calf, major depressive disorder (persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), insomnia (difficulty falling asleep or staying asleep), disorder of central nervous system (cognitive, physical and sensory dysfunction), cognitive communication deficit (difficulty with verbal or non-verbal communication), hypokalemia (low serum potassium levels), inflammatory disorders of scrotum (acute pain, swelling and redness in the back of the testicle), difficulty in walking, hypocalcemia (low calcium levels in the blood), constipation (infrequent bowel movements or difficulty passing stool), anemia (lack of healthy red blood cells to carry sufficient oxygen to body tissues) diabetes mellitus (high sugar due to insufficient insulin production), hypo-osmolality and hyponatremia (low serum sodium and reduced plasma), fluid overload (water and salt buildup in the body), and intestinal obstruction (partial or complete blockage of the small or large intestine). Record review of Resident #3's Quarterly MDS assessment, dated 03/03/26, reflected BIMS score of 15, which indicated cognitively intact. The MDS assessment under Section GG-Functional Abilities, reflected Resident #3 needed some setup assistance or independent with his ADLs. Record review of Resident #3's order summary report, dated 03/12/26, reflected in part:Zolpidem Tartrate Oral Tablet 5 MG- give 1 tablet by mouth at bedtime for insomnia. Record review of Resident #3's care plan, dated initiated 01/29/26, reflected Resident #3 was on sedative/hypnotic therapy. Interventions included: evaluating other factors potentially causing insomnia, for example: environment, lighting, inadequate physical activity, facility routines, caffeine/medications. Attempt to modify and control external factors before initiating hypnotic therapy. Monitoring/documenting/reporting PRN for following adverse effects of sedative/hypnotic therapy, preceding or accompanying hypnotic use by other interventions to try to improve sleep. In an interview on 03/11/26 at 2:51 PM, Resident #1 revealed on 03/08/26 and 03/09/26, she received two Warfarin pills in addition to her Tessalon [NAME], totaling four Warfarin pills. Resident #1 stated on 03/08/26, she received two Warfarin pills from CMA C at 7:00 PM, then approximately an hour later she received two more Warfarin pills that were (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	03/12/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered by either CMA C or LVN D. Resident #1 was unsure of the exact staff person. Resident #1 stated it was weird that she had received two additional pills on 03/08/26 but did not say anything to the nurse. Resident #1 stated the exact same administering happened again 03/09/26. Resident #1 stated she received two Warfarin pills, one Trazadone and one cholesterol pill around 7:00 PM, then two more Warfarin pills around 8:00 PM. She stated on 03/09/26 she informed either CMA C or LVN D that she had already received her medication from someone else and was not supposed to receive another dosage. Resident #1 revealed whomever the staff had told her that they knew what Resident #1 was supposed to have administered and proceeded with giving her the medication. Resident #1 stated the medication was given to her and the staff walked off. Resident #1 revealed that instead of taking the medication, she put it under her blanket and waited until the nurse finished with her roommate then pulled the medication from under the cover. She stated she showed the medication to her roommate, Resident #2. Resident #1 stated she held onto the medication and gave it to CMA A the next morning on 03/10/26. Resident #1 told her that she was only supposed to receive two of the pills but a total of four was administered, so she did not take the last two pills administered. Resident #1 stated CMA A took the pills and told her she would speak to the nurse. Resident #1 was unsure of the exact number of times staff did not monitor her not taking medication at the time of administration. In an interview on 03/11/26 at 2:57 PM, Resident #2 revealed that Resident #1 showed her two blue pills after CMA C left their room. Resident #2 stated she witnessed CMA C did not observe Resident #1 take her medication. She stated CMA C administered the medication to Resident #1, then turned to her and took her blood pressure. Resident #2 stated that after CMA C checked her blood pressure, she administered her medication and walked out of their room. She stated she was given her Melatonin pill which CMA C did not observe her taking. She stated she held onto her pill until she was ready to go to bed. Resident #2 stated staff administered her melatonin pill hours before she was ready for sleep, so she held onto it. Resident #2 revealed staff did not always observe her or Resident #1 take their medication. Resident #2 was unaware of the exact number of times staff did not monitor her not taking medication at the time of administration. Resident #2 stated some staff such as CMA C administered her medication and walked off. In an interview on 03/11/26 at 4:14 PM, Resident #3 revealed that staff did not always observe him take his nighttime medication for sleep. Resident #3 stated staff administered his sleep medication early in the evening. He stated he held on to the medication until he was ready for sleep. Resident #3 also stated if staff passed in the hall during the time he was taking his medication, he called them over to show he took his medication. Resident #3 was unable to identify exactly what staff did not observe him taking his medications. He stated he did not know the staff as there were many different staff working at the facility. Resident #3 was unaware of the exact number of times staff did not monitor him not taking his medication at the time of administration. In an interview on 03/11/26 at 5:29 PM, CMA A stated she worked Mondays-Fridays on morning shift 6:00 AM- 2:00 PM. She stated she worked in 500 and 600 halls. CMA A revealed that between 9:00-9:30 AM on 03/09/26 during medication pass, Resident #1 gave her two Warfarin pills. CMA A stated Resident #1 told her it was the extra pills that she had not taken from the night before. CMA A asked Resident #1 why her medication was not taken. CMA A stated Resident #1 told her that staff administered her two Warfarin medications around 5:00 PM, then another staff came around 8:00 PM and two more Warfarin pills. She stated Resident #1 told her, she knew she was not supposed to be taking an additional two pills. CMA A stated that Resident #1 told her that she pretended to take the medication but hid it. CMA A also stated Resident #1 told her she was able to hide the medication because staff did not watch her take it. CMA A also stated Resident #1 told her that she told staff she had already taken the medication, but staff told her she still had to take it. CMA A stated she took the medication and gave it to the floor nurse RN B. She stated she informed RN B of the information provided by Resident #1 then continued administering medications for the day. CMA A stated protocol was to watch residents take the medication that was administered. In an interview on 03/11/26 at 6:04 PM, RN B revealed on 03/09/26 during the early (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	03/12/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	afternoon before 2:00 PM CMA A gave her Resident #1 Warfarin medication. RN B stated CMA A informed her that Resident #1 did not take the medication administered at night on 03/09/26. RN B stated she held the medication until LVN D came into work at 6:00 PM, then gave the medication to her. RN B stated after passing the medication to LVN D, she allowed her to handle. RN B stated she was overworked with her tasks, so she allowed LVN D to handle it. She stated she did not know what the outcome was but figured LVN D handled it the best she could. RN B stated she should have followed up. RN B stated she should have destroyed the unused medication. In an interview on 03/11/26 at 6:36 PM, CMA C stated she worked weekend double shifts from 6:00 AM- 2:00 PM and 2:00 PM- 10:00 PM. She stated she worked double shifts on 03/07/26 and 03/08/26. CMA C stated she worked with Resident #1 on both days. CMA C stated she remembered administering Resident #1 two Warfarin (blood thinner pills) twice in the evening totaling four pills. CMA C stated she gave Resident #1 the medications that were in the system. CMA C stated the medications that Resident #1 was supposed to take popped up on her computer screen. She stated 03/07/26 was the first time she administered the Warfarin to Resident #1. She stated she could not recall how many pills she had given to Resident #1 because she administered it with her other pills. CMA C stated she watched Resident #1 take the medication, then she moved on to take Resident #2's blood pressure. She stated after she got Resident #2 blood pressure, she administered her medications and watched Resident #2 take them. CMA C stated she gave residents their medications in a cup with a cup of water. CMA C stated once the resident took the medication and finished the water, she retrieved the medication cup from the resident then threw it in the trash. CMA C stated she ensured residents took their medication by observing them swallow. CMA C stated she was not aware of Resident #1 not taking her medication. CMA C stated the risks of not taking medication was medication abuse by residents. In an interview on 03/11/26 at 6:50 PM, the DON and Administrator revealed that they were not aware of the medication errors regarding blood thinners. The DON stated the only resident that took blood thinners was Resident #1. The DON and Administrator stated that when there was a medication error, it was expected to be documented and reported to DON. The DON stated any medication returned by a Resident #1 should be discarded, documented and reported. In an interview on 03/12/26 at 11:01 AM, LVN D stated she worked an alternating shift from 6:00 PM- 6:00 AM. LVN D revealed she worked on 03/10/26 on 500 hall. She stated as soon as she got on shift that evening, RN B gave her two pills that were given by another staff. LVN D stated she asked RN B who the pills belonged to, but RN B stated she did not know. LVN D stated the pills were identified as Warfarin. LVN D stated the medication could only belong to Resident #1, since she was the only resident taking Warfarin. LVN D stated she went to Resident #1 and asked what happened, and why she did not take the medication. She stated Resident #1 told her she received her Warfarin medication from CMA C shortly after she had already taken two pills. LVN D stated on 03/08/26, she had administered Resident #1 two Warfarin pills and one Tessalon [NAME] (Benzonatate). LVN D stated she told Resident #1 she herself watched her take the medications when she administered them. She stated Resident #1 told her after she administered her medications, another nurse administered Warfarin again. She stated Resident #1 told her she did not take them and held onto the pills because she knew she was not supposed to take two more pills. LVN D stated she checked the medication aide cart and found two packs of Warfarin for Resident #1 which should not have been there. She stated Resident #1 also had Warfarin packs on the nurse's cart. She stated she removed the additional packs from the medication aide cart and put them on the nurse's cart. LVN D stated she did not know who put the medication on the med aide cart, but it should have only been on the nurse's cart. LVN D stated she discarded the pills into a sharp container that was given to her by RN B. She stated she did not document it in the medical system. LVN D stated she should have documented and reported it to the DON. In a follow-up interview on 03/12/26 at 12:09 PM, CMA C stated she only worked weekends. She stated both med aides and nurses were responsible for administering blood thinners. CMA C stated on 03/07/26 and 03/08/26 Warfarin popped up on her screen to administer to Resident #1. She stated it was the first (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	03/12/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	time administering the medication Resident #1. She stated she gave Resident #1 the medication at nighttime and did not think anything was wrong. CMA C stated she observed Resident #1 take the medication. She stated she was unaware of Resident #1 not taking the medication and giving it to another nurse. In an interview on 03/12/26 at 12:26 PM, the DON stated the expectation with administering medications was for the nurse to monitor the resident while taking. The DON stated the nurse should never walk away without observing a resident take medication. The DON stated a resident should not have any medication to give back to a nurse because the nurse should have watched the medication being taken. The DON stated nurses should also check the system to ensure residents were given the right medication and dosage. The DON stated risk of giving too much medication could have had adverse effects on the resident. Record review of the facility policy titled, Administering Medications, date revised April 2019, reflected the following in part: Policy heading: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 4. Medications are administered in accordance with prescriber orders, including any required time frame. 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. 27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. Record review of the facility policy titled, Adverse Consequences and Medication Errors, date revised February 2023, reflected in the following in part: Policy heading: The interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects. Medication Errors: 1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's order, manufacturer specifications, or accepted professional standards and principles of the professional(s) services. 2. Examples of medication error include:a. Omission-a drug is ordered by not administered. b. Unauthorized drug-a drug is administered without a physician's order. c. Wrong dose (e.g., Dilantin 12 mL ordered, Dilantin 2 mL given.g. Wrong time. Procedures 1. Review the resident's medication regimen for efficacy and actual or potential medication-related problemson an ongoing basis. 2. When a resident receives a new medication order, review the following:a. The dose, route of administration, duration, and monitoring are in agreement with current clinicalpractice, clinical guidelines, and/or manufacturer's specifications for use.b. A written diagnosis/indication supporting the use of the medication.