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	04/24/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations/interviews/record review, the facility failed to protect the resident's right to be free from mental abuse, verbal abuse, physical abuse, sexual abuse, deprivation of goods and services by staff, a resident, a visitor. The facility failed to ensure Resident #1 was free from abuse on 4/13/26, when Resident #2 struck and scratched her, which resulted in multiple bruises to her arm. This failure could place residents at risk of abuse and emotional distress.Findings include: 1.Record review of Resident #1's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: dementia (a decline in memory and cognitive function), psychotic disturbance (delusions or hallucinations), anxiety disorder, and major depressive disorder. These diagnoses indicated impaired cognition, mood instability, and potential for altered perception of events. Record review of Resident #1's care plan dated 01/15/26 reflected interventions related to monitoring adverse reactions to antidepressant therapy. The care plan directed staff to observe changes in behavior, mood, or cognition, including hallucinations or delusions, as well as increased confusion, withdrawal, or decline in functional ability. Additional interventions included monitoring for gait instability, dizziness, and fall risk, reflecting the resident's vulnerability to both physical and cognitive impairment. Record review of Resident #1's MDS dated [DATE] reflected a BIMS score of 03, indicating the resident was severely cognitively impaired. The MDS that the resident had a history of psychotic disturbance. Record review of progress notes dated 04/13/26 indicated Resident #1 reported that Resident #2 clawed and scratched her. Assessment revealed visible injuries including bruising and a hematoma to the right wrist, hand, and arm, as well as bruising to the left eye. The resident denied pain at the time of assessment. Documentation indicated that Resident #1's responsible party was notified, and the decision was made to move the resident to another room with agreement from the family member. Record review of a skin assessment note dated 04/13/26 identified multiple new skin issues following the incident. These included bruising to the right outer forearm, left side of the face, and right medial shin. Additional observations included edema to the right foot and discoloration to the right leg. The documentation indicated that all injuries were acquired in-house and that no signs or symptoms of infection were present at the time of assessment. 2. Record review of Resident #2's face sheet dated 02/24/26 reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included: dementia (a decline in memory and cognitive function), moderate intellectual disabilities (limitations in intellectual functioning and adaptive behavior), Parkinsonism (a condition affecting movement and coordination), generalized anxiety disorder, and major depressive disorder. These diagnoses indicated impaired cognition, decreased safety awareness, and potential for behavioral symptoms. Record review of Resident #2's MDS dated [DATE] reflected a BIMS score of 05, which indicated she was severely cognitively impaired. Record review of Resident #2's care plan dated 12/19/25 reflected interventions related to monitoring adverse reactions to antidepressant therapy, including changes in mood, cognition, hallucinations, withdrawal, and decline in functional ability. Additional interventions included monitoring for gait instability, movement issues, and fall risk. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's care plan dated 04/21/26 reflected interventions to analyze and document triggers, behaviors, and effective de-escalation techniques, indicating a need for behavioral monitoring and intervention. Record review of progress notes dated 04/13/26 indicated it was alleged that Resident #2 scratched her roommate, Resident #1. Additional documentation reflected that a urinalysis and culture and sensitivity were ordered to evaluate for a possible urinary tract infection as a contributing factor. Record review a progress note dated 04/13/26 at 2:33 p.m. reflected Resident #2 received a virtual evaluation and was determined to be safe to discontinue one-on-one monitoring. Record review of progress note dated 04/14/26 at 8:17 a.m. reflected Resident #2 returned to the facility from the hospital. Assessment was completed, vital signs were within normal limits, and the resident denied pain. No new physician orders were noted, and follow-up appointments with medical providers were documented. Interview on 4/23/26 at 10:00 a.m., with the Administrator (Admin) regarding the incident revealed the residents were immediately separated following the event. The Admin stated Resident #2 was placed on 1:1 supervision and a psychiatric evaluation was completed. Following the evaluation, Resident #2 was released from 1:1 supervision. The admin reported that the families of both residents were notified and that the facility followed established policies and procedures. The admin stated this was an isolated incident and reported the residents had been roommates for a period with no prior history of physical alterations. Resident #1 and Resident #2 were separated following the incident and are no longer roommates. The admin indicated both residents have significant cognitive impairment; however, neither is the resident is assigned to a secure or locked unit. The admin stated the residents have not exhibited behaviors such as wandering or elopement that would necessitate placement on a secured unit. The admin noted both residents are experiencing cognitive decline and reiterated that this was an isolated incident. The admin stated that the facility responded appropriately in accordance with policy. Interview and observation on 4/24/26 at 2:30 p.m., with Resident #1 revealed the resident was observed lying in bed at the time of the interview. Visible bruising was noted on the resident's right arm in various stages of healing, extending along multiple areas of the arm. No visible bruising was observed on the resident's face or legs. Resident #1 spoke limited English, and translation services were facilitated through a staff member via phone. The translator stated he had assisted with communication at the time of the incident as well. Through translation, Resident #1 reported that she and her former roommate, Resident #2, had an altercation regarding the room light, stating she wanted the light on while Resident #2 wanted it off. Resident #1 stated that Resident #2 became upset and hit her on the right arm. She denied being hit, scratched, or touched on her face, legs, or any other part of her body. Resident #1 stated that Resident #2 grabbed her arm, causing the bruising observed. Resident #1 reported the area did not currently cause pain. She stated that Resident #2 was no longer her roommate, denied fear of others in the facility, and stated she felt safe. Resident #1 was unable to recall additional details and denied any prior incidents involving Resident #2 or any other residents. Interview on 4/24/26 at 2:45 p.m., the staff (translator) revealed the information provided during translation was consistent with Resident #1's initial report at the time of the incident. The staff member stated there had been no changes in the resident's account and that Resident #1 was unable to recall additional details beyond being struck on the arm. Interview and observation on 4/24/26 at 3:00 p.m., Resident #2 revealed the resident was seated in a wheelchair and appeared pleasant during the interaction. Redirection was required multiple times as the resident frequently discussed unrelated topics. When asked about any altercation, Resident #2 denied recollection of any such incident. The resident denied that anyone had hurt her or that she had placed her hands on anyone else. Resident #2 identified Resident #1 only as a lady down the hall and stated they were friends but no longer shared a room. Resident #2 did not appear to have awareness or recollection of the reported incident. Interview on 4/24/26 at 3:20 p.m., with CNA A revealed she had worked with both residents, including when they previously shared a room. CNA A stated Resident #1 had become more mobile over time and was now independently moving about the room and engaging in activities such as (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	turning lights on and off. CNA A reported she did not witness the incident but was informed of it and believed Resident #2 may have become frustrated. She stated that prior to the incident, Resident #2 had expressed concerns that Resident #1 was blocking the doorway. CNA A reported she had personally observed Resident #1 standing in the doorway, at times limiting Resident #2's ability to exit or access the bathroom. CNA A stated the residents had verbal exchanges in the past; however, she had never observed physical aggression between them or toward others. CNA A described Resident #1 as generally pleasant and noted the residents had differing personalities. CNA A further reported that Resident #2 had occasionally displayed verbal agitation toward staff, including raising her voice, but no prior physical altercations were known. Interview on 4/24/26 at 3:59 p.m., with the DON revealed she did not witness the incident but reported that Resident #1 informed staff of the event and demonstrated her injured arm. The DON stated a psychiatric evaluation was completed for Resident #2 following the incident and that both residents were assessed to be at their baseline. The DON reported Resident #1 had visible bruises and hematoma on the arm, as well as a small red mark near the eye, which contributed to initial documentation referencing multiple injury sites. She explained staff documented all observed marks regardless of severity. However, based on follow-up with Resident #1, the resident consistently reported injury only to the arm and denied any other areas of harm. The DON indicated the initial report may have appeared more severe than the actual injuries observed. Interview on 5/01/26 at 12:30 p.m., with the Psychiatric Nurse Practitioner revealed she completed a virtual psychiatric evaluation of Resident #2 on the date of the incident. She reported Resident #2 did not recall the altercation and only mentioned that her roommate would not allow her to leave the room. She stated it was unclear whether this perception was accurate due to Resident #2's cognitive status. The Psychiatric Nurse Practitioner stated there was no indication that Resident #2 intended to initiate physical harm and described the incident as isolated. She reported that Resident #2 is typically cooperative, mild-mannered, and does not commonly present with behavioral concerns, noting this was the first reported incident of this nature. Interview on 4/24/26 at 1:45 p.m. with RN-A: An attempted phone call was made to RN-A, who previously assessed Resident #1. A voicemail message was left; however, no return call was received. Interview on 5/01/26 at 1:02 p.m., with RN A: An attempted phone call was made; a voicemail message was left. No return call was received. Interview on 4/24/26 at 1:50 p.m., with Family Member #2 (associated with Resident #2): An attempted phone call was made; a voicemail message was left. No return call was received. Interview on 5/01/26 at 1:06 p.m., with Family Member #2 (associated with Resident #2): An attempted phone call was made; a voicemail message was left. No return call was received. Interview on 5/01/26 at 1:10 p.m., with Family Member #1 (associated with Resident #1) revealed he was aware of the incident and reported the facility notified him at the time it occurred. He stated he visited Resident #1 shortly after and had no concerns regarding the care provided or the facility's response. He reported that both residents had been roommates for an extended period without prior incidents and believed the altercation stemmed from a disagreement, possibly related to lighting preferences, compounded by a language barrier. Family Member #1 stated he did not hold any concerns toward Resident #2 and continued to interact with her during visits. He described the incident as isolated and stated the facility responded appropriately by separating the residents and providing notification. He confirmed Resident #1 experienced bruising to the arm but reported she was currently doing well and voiced no concerns. Record review of the facility's undated Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy revealed that residents have the right to be free from abuse, neglect, exploitation, and misappropriation of property. The policy indicated that the facility is responsible for protecting residents from abuse by anyone, including other residents, and for identifying, investigating, and reporting all allegations of abuse. The policy requires implementation of interventions to prevent recurrence and ensure resident safety during and after investigations.