STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675111	A. Building B. Wing	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Gardens Rehabilitation and Healthcare	2135 N Denton Dr Carrollton, TX 75006

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32486 Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for one (Resident #1) of three residents reviewed for baseline care plan. Resident #1s baseline care plan was missing information related to dialysis. This failure could affect newly admitted residents and place them at risk of not receiving continuity of care and communication among nursing home staff to ensure their immediate care needs are met. Findings included: Review of Resident #1's Face Sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's diagnoses included: peripheral vascular disease (narrowed blood vessels which reduce blood flow to the limbs), hyperlipidemia (high levels of fat particles in the blood), depression (depressed mood), diabetes mellitus (too much sugar in the blood) and end stage renal disease (kidneys cease functioning on a permanent basis). Review of Resident #1's Baseline Care Plan, dated 02/02/2024, revealed no focus area for dialysis. Further review of an initial care plan date initiated 02/03/24, revealed no focus area for dialysis. Review of Resident #1's physician orders dated 02/01/24 revealed Hemodialysis 5x/week every Monday-Friday at Provider A at Facility B. Observation and interview with the DON on 02/08/24 at 11:54 AM, the DON confirmed dialysis was not included in the baseline care plan. The DON revealed a care plan worksheet utilized by the facility as a baseline care plan. The DON further revealed the information from the worksheet carried over to the care plan to create the comprehensive care plan. The DON stated the worksheet does not have a dialysis option and does not allow for additional information to be added. The DON stated she was responsible for the completion of the baseline care plan and as the resident's admission continued it was expanded on. The DON acknowledged the importance of care service, such as dialysis, should be included on the baseline care plan. The DON stated it was important for a resident's specialized services to be included on the care plan as a true reflection of the care and services the resident requires, and it provided both . (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Comprehensive Person-Centered Care Planning, revised December 2023, revealed, .The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care . 2.The baseline care plan will include minimum healthcare information necessary to properly care for a resident including, but not limited to: a) initial goals based on admission orders, b) physician orders, c) dietary orders, d) therapy services, 3 social services: and f) PASARR recommendations, if applicable.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32486 Based on interview and record review, the facility failed to ensure residents who require dialysis services, receive services consistent with professional standards of practice, the person-centered care plan and the resident's goals and preferences for one (Resident #1) of three residents, reviewed for in-house dialysis. The facility failed to ensure that Resident #1 was dialyzed Monday-Friday as ordered by the physician. This failure could place residents who received dialysis at risk for complications and not receiving proper care and treatment to meet their needs. Findings included: Review of Resident #1's Face Sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's diagnoses included: peripheral vascular disease (narrowed blood vessels which reduce blood flow to the limbs), hyperlipidemia (high levels of fat particles in the blood), depression (depressed mood), diabetes mellitus (too much sugar in the blood) and end stage renal disease (kidneys cease functioning on a permanent basis). Review of Resident #1's physician orders dated 02/01/24 revealed Hemodialysis 5x/week every Monday-Friday at Provider A at Facility B. Review of nursing progress note dated 02/02/24 written by unknown staff member read Resident #1 was admitted from Hospital E to Facility B at 2250 PM . Review of text message provided by Administrator revealed on 02/01/24 the Administrator had received the following admission alert for Resident #1 from Case Manager D, 6:30 PM pick up from Hospital E and 7:00 PM estimated time of arrival to Facility B. Review of Hospital E progress note dated 01/31/24 for Resident #1 revealed hospital course .on hemodialysis Monday, Wednesday and Friday . Review of Facility's Leaving Facility Against Medical Advice Form revealed Resident #1 was signed out on 02/03/24 by her responsible party. (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/08/24 at 11:54 AM with the DON she stated Resident #1 was supposed to received dialysis from our in-house Provider A on Monday-Friday. The DON stated Resident #1 admitted to the facility on Thursday (02/01/24) very late that evening. The DON stated that Resident #1 admitted after hours on the 02/01/24, therefore Resident #1 was not on Provider A's schedule for dialysis on 02/02/24 and missed dialysis on Friday 02/02/24. The DON stated she had reviewed Resident #1's hospital paperwork and there was nothing stating when Resident #1 was last dialyzed however it read that Resident #1 had been receiving dialysis on Monday, Wednesday, and Friday in the hospital. The DON stated her expectation was for all residents who required dialysis to complete their dialysis as ordered by their physician. The DON stated the adverse effects of a resident not receiving dialysis as ordered could jeopardize their health or care. Interview on 02/08/24 at 12:42 PM with the ADON, she stated Resident #1 admitted to the facility on Thursday (02/01/24) late in the evening. The ADON stated on Friday morning (02/02/24) she was the nurse assigned to Resident #1. The ADON stated she was given report by the night shift LVN B and was told Resident #1 had dialysis at the hospital on 02/01/24 prior to her admission to Facility B . Interview on 02/08/24 at 12:50 PM with Provider A RN F, he stated that Resident #1 was not on the schedule for dialysis on 02/02/24. Interview on 02/08/24 at 1:17 PM with the Administrator, he stated he was aware that Resident #1 had missed her dialysis on Friday according to physician orders, but there was miscommunication with Facility B and Provider A to ensure her in-house dialysis was started on Friday 02/02/24 as ordered regardless of the time of her admission. The Administrator stated his expectation was for the facility to ensure residents received dialysis according to the physician orders. The Administrator stated that the communication the facility had received from Case Manager D with Hospital E was that Resident #1 was going to be picked up from Hospital E at 6:30 PM and arrive at the facility around 7:00 PM. She stated Resident #1 did not arrive until after 10:00 PM, around 11:00 PM. The Administrator stated that LVN C had been given report from Hospital E that Resident #1 had received dialysis on 02/01/24 prior to arrival at Facility B. The Administrator stated the late admission and the communication about Resident #1's last dialysis treatment resulted in the resident missing her dialysis treatment on 02/02/24. The Administrator stated that the hospital paperwork revealed Resident #1 was receiving dialysis Monday, Wednesday, and Friday while hospitalized . Interview on 02/08/24 at 7:15 PM with LVN C revealed he stated that he received report for Resident #1 on 02/01/24. LVN C stated that Hospital E stated, Resident #1 had received dialysis on 02/01/24 prior to discharge from Hospital E . Review of the facility's policy titled Dialysis (Renal), Pre-and Post-care dated December 2023, revealed It is the policy of this facility to: Assist resident in maintaining homeostasis per-and post-renal dialysis; . Participate in ongoing communication and collaboration with the dialysis facility regarding dialysis care and services .