

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Heritage Gardens Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970</p> <p>Based on observations, interviews, and record review, the facility failed to provide treatment and services to prevent complications of enteral feeding for 1 (Residents #1) of 4 residents reviewed for tube feeding management.</p> <p>The facility failed to ensure Resident #1's Piston syringe for G tube flushing was changed daily. (A piston syringe is a small, cylindrical piece that fits inside the barrel of a syringe. It is typically made of plastic or metal and moves back and forth within the barrel to draw in or expel fluids for tube feedings.)</p> <p>These failures could place residents at risk un-sanitized treatment and infections.</p> <p>Findings included :</p> <p>Record review of Resident #1's face sheet dated 03/08/24 reflected a [AGE] year-old male admitted on [DATE] with dx dysphagia, oropharyngeal phase dysphagia (the inability to empty material from the esophagus i.e. stomach) following cerebral infarction.</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 3 indicating he was severely impaired cognitively. Section K enteral feeding list.</p> <p>Record review of Resident #1's Care plan dated 01/12/24 reflected Will remain free of side effects or complications related to tube feeding through review date . Flush g-tube with 30-50 ml of water before and after medication administration flush tubing with 5ml-10ml water between each medication administration.</p> <p>Record review of Resident #1's Physician orders report dated 03/08/24 reflected, .Enteral Feed every shift rinse syringe after each use Enteral Feed .Enteral feed every shift change syringe.</p> <p>An observation on 03/07/24 at 08:45 AM revealed a piston syringe on the bed side table dated 03/05/24. Resident #1 was not interviewable.</p> <p>(continued on next page)</p>

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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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with DON on 03/07/24 at 9:31 AM she stated the piston syringe should be changed every shift. The nurses were expected to check the date and condition of the resident's Piston syringe during rounds to assure equipment for treatment was performed. In the event the syringe was not changed and dated, she expected the nurse to change and date the new one. The residents could get infections when syringes aren't changed daily or as needed.</p> <p>In an interview with the ADM on 03/07/24 at 9:45 AM he revealed he expected the nursing staff to follow policy and procedure for resident care . ADM stated that he expects the DON and ADON to monitor all nursing task to ensure no complications with the resident.</p> <p>In an interview with LVN S on 03/08/24 at 1:00 PM she revealed she was not the assigned nurse on 03/07/24. LVN S said resident tubing was changed on 03/07/24, but she did not know what time. The nurses should change piston syringe daily, and the change occurred during the 10PM to 6 AM shift. LVN S tubing was checked during rounds by nursing staff. LVN S stated if a piston syringe was observed undated, the nurse would change immediately. LVN S stated that all nurses were responsible for checking resident devices and equipment during rounds. S stated that failing to change the piston syringe daily or as needed could lead to bacterial infection.</p> <p>In an interview with the ADON on 03/08/24 at 2:06 PM she revealed the piston syringes should be dated to assure that the tubing was changed. The ADON said nurses were expected to change piston syringe daily during the night shift, as needed, and when observed with dates that are more than 24 hours. The ADON stated that the nurses should be monitoring tube supplies in the resident's room during rounds, upon arrival to shift . ADON stated that failing to change piston tube could lead to infection.</p> <p>Record review of facility Inservice dated 03/08/24 reflected policy listed below for all nursing staff.</p> <p>Record review of the facility's Policy titled, Gastronomy Tube Care Management, dated January 2022, reflected, Syringe Storage and Replacement: Syringes used for gastrostomy care will be stored at the bedside; the plunger will be removed after use and stored separately. b. The syringe will be discarded and replaced on a daily basis .</p>		