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	07/08/2025

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 0600 Level of Harm - 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. (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
	675111	A. Building B. Wing	07/08/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents were free from abuse for 1 of 5 residents (Resident #2) reviewed for abuse.The facility failed to ensure Resident #2 was free from abuse when Resident #1 punched him on 06/21/25, causing Resident #2 to have a laceration to his top lip.This failure could place residents at risk for severe and long-lasting impact for physical, psychological and emotional wellbeing. Findings included: Record review of Resident #2's MDS Assessment, dated 05/26/25, reflected the Resident#2 was a [AGE] year-old male who originally admitted to the facility on [DATE] and readmitted [DATE]. He had no BIMS score recorded. His MDS indicated he had no behaviors. His diagnoses included Autistic Disorder (is a developmental disability caused by differences in the brain), Gastrostomy Status (a feeding tube inserted through the abdominal wall into the stomach), Anxiety Disorder (a group of mental health conditions characterized by excessive, persistent fear and worry that can significantly interfere with daily life), Cerebrovascular Accident (a medical term for a condition where there's a sudden interruption of blood flow to the brain, causing damage to brain tissue). Record review of Resident #2's care plan, revised 08/15/2022, reflected the following: Focus: [Resident#2] has actual mood/behavior problem r/t Autistic Disorder AEB/ crying out loud/ compulsive behavior (will repeatedly ask or call for something)/ yelling out/ disrobes, takes clothes off and throws them on the floor. Interventions: Assist to identify strengths, positive coping skills and reinforce these, Monitor/record/report to MD risk of increased anger, labile mood or agitation threatened by others or thoughts of harming someone, possession of objects that could be used as weapons Review of Resident #2's Progress Notes reflected the following: 06/21/25 4:30 AM - This nurse was notified by the nurse staff on the floor that to come to the resident and check on the resident with urgency. Rushed to the resident's room and observed the resident sitting on the wheelchair with visible bleeding from his mouth on his upper lip. The [CNA A] stated that she observed the resident being hit by the [Resident#1] and separated them and supported the resident back to his room. Assessed the resident bleeding noted from the resident's upper lip, pressure applied, cleaned gauze, an open area noted measuring 2cm and about 0.5 cm deep. V/S BP 122/78, P 74, R 18, TEMP 98.4, OXY SAT 97% RA. Resident denies pain/discomfort. Administrator notified, [NP E] notified new order to transfer resident to ER for further evaluation and treatment. 911 called and [Resident#2] transferred to [local hospital] via on stretcher DON notified, RP notified. This entry was written by RN C. 06/21/2025 09:14AM [Resident#2] returned from ER and 4 stitches noted to upper lips, with dry blood and mild swelling noted. After care instruction noted: to keep the area clean and dry and not to pick at stitches. Monitor surgical wound daily and if bleeding persist sent to er. Wound care consults for stitches care. Resident denies pain or discomfort at this time. Call light in reach and bed in lowest position. This entry was written by LVN D.Record review of Resident #2's hospital records, dated 06/21/25, reflected that Resident #2 was treated in the ER after being hit in the mouth which caused a deep cut on his upper lip. The wound was cleaned and closed with stitches both inside and outside the lip, to help it heal well. Observation and interview on 07/08/25 at 1:57 PM with Resident #2 revealed he was sitting in a wheelchair in his room writing on a piece of paper with a black sharpie . Resident #2 said he was not in pain, laceration to top lip healed. He did not recall the incident, and stated that everyone was good to him and he just wanted to write his sister a letter. Record review of Resident #1's MDS Assessment, dated 05/15/25, reflected the Resident #1 was a [AGE] year-old male who originally admitted to the facility on [DATE]. He had a BIMS score of 09, indicating moderate cognitive impairment. His MDS indicated he had no behaviors. His diagnoses included Traumatic Brain Injury (TBI), Anxiety Disorder, and Non-Alzheimer's Dementia. Record review of Resident #1's care plan, revised 06/21/25, reflected the following: Focus: 6/21/25- [Resident #1] Potential to demonstrate physical behaviors r/t Anger, Dementia 6/21/25 resident to resident incident: Interventions [Resident#1] should remain on 1:1 observation and recommended for him to be transferred to [local hospital] ER for further psych evaluation. Record review of Resident #1's Progress Notes reflected the following: 06/21/25 4:30 AM - This nurse was notified by the nurse staff on the floor to come [Resident#2] room and check on the resident with urgency. Rushed to the resident's room and observed [Resident#2] sitting on the wheelchair with visible bleeding from his mouth on his upper lip. The [CNA A] stated that she observed [Resident#2] being hit by the [Resident#1] and separated them and supported [Resident#2] back to his room [Resident #1] sent back to his room and placed on one-on-one monitoring. On assessment no visible injuries noted. [Resident#1] is alert and oriented x3 verbalizes needs