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	03/09/2026

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 - 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 observation, interview, and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 6 residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 was free from abuse on 01/25/2026 when Resident #2 touched Resident #1 between her legs over her pants. This failure could place residents at risk of abuse, humiliation, intimidation, fear, shame, agitation, and decreased quality of life. Findings included: Record Review on 03/09/2026 of Resident #1 MDS assessment, dated 12/23/2025, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. The resident's cognitive status was severely impaired. Her diagnoses included Cerebral Infarction (the blood supply to part of the brain is blocked or reduced), Bipolar Disorder (mental condition marked by alternating periods of elation and depression), and Memory Deficit (a condition where individuals experience difficulties in forming, storing, and recalling memories). Record Review on 03/09/2026 of Resident #1's Care Plan, dated 10/27/2022, reflected:Resident has an ADL self-care performance deficit related to left side paralysis, CVA (a loss of blood flow to the brain).Resident at risk for impaired cognitive function or impaired thought processes r/t cerebral infarct, Bipolar, TIA (a brief blockage of blood flow to the brain), and depression.Resident is a risk for falls r/t TIA, cerebral infarct, left side paralysis has had an actual fall with minor injury related to poor balance.Resident has potential for a psychosocial well-being problem r/t dependent behavior, social isolation.An entry dated 03/09/2026 reflected resident at Risk for Re-traumatization r/t history of trauma from other resident violence. Record Review on 03/09/2026 of Resident #2 MDS assessment, dated 01/27/2026, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. The resident's cognitive status was severely impaired. His diagnoses included Vascular Dementia with Mood Disturbance (conditions that damage blood vessels and block blood flow to brain), Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), Cerebral Infarction (the blood supply to part of the brain is blocked or reduced), and Cognitive Communication Deficit (a condition where a person's ability to communicate effectively is compromised by an underlying impairment in mental processes). Record Review on 03/09/2026 of Resident #2s Care Plan, dated 12/11/2025, reflected:Resident has an ADL self-care performance deficit related to cerebral infarction (the blood supply to part of the brain is blocked or reduced)Resident is at risk for Altered Neurological Status r/t CVA (a loss of blood flow to the brain).Resident is at risk for Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest)Resident is at risk for impaired cognitive function or impaired thought processes r/t vascular Dementia (a group of symptoms affecting memory, thinking and social abilities, Agnosia (a neurological disorder characterized by the inability to recognize familiar objects, people, or sounds, despite having intact sensory functions) Record Review on 03/09/2026 of Resident #1 EMR did not reveal any progress notes, incident reports, or witness statements regarding the allegation of abuse.An interview on 03/09/2026 at 9:30 AM with Resident #3 revealed he was sitting in the dining room and witnessed Resident #2 placing his hand between Resident #1 legs and touching her private area. Resident #3 stated no staff were present at the time (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: 675111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/09/2026

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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of incident. Resident # 3 stated he informed Administrator of the incident. An interview on 03/09/2026 at 12:40 PM with the DON revealed she was informed around the end of January 2026 that Resident #2 attempted to touch Resident #1 while they were sitting together in the dining room. DON stated Resident #2 was friendly and liked to hug and tell everyone he loves them. DON stated the incident was reported by a staff but did not recall who the staff was. An interview on 03/09/2026 at 1:03 PM with the Administrator, the abuse coordinator, revealed he was informed by a staff (not able to recall staff) of an incident involving Resident #1 and Resident #2 in the dining room. Administrator stated it was alleged that Resident #2 touched Resident #1 in her private area. An interview on 03/09/2026 at 1:18 PM with Resident #1 revealed, resident in her room watching television. Resident was observed to be well-groomed and in appropriate clean and fitting clothing. Resident was alert and willing to speak to surveyor. Surveyor asked resident if anyone had touched her or hurt her, Resident stated no and was not able to recall anyone touching her inappropriately. Observation on 03/09/2026 of a video recording dated 01/25/2026, reveled Resident #2 putting his hand between Resident #1 legs and touching her private area.

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 3 resident (Resident #1) reviewed for abuse reporting. The facility failed to report an allegation of abuse to the State Agency when Resident #1 was sexually abused by another resident. This failure could place residents at risk for not having allegations of abuse reported which could lead to injury or worsening of condition. Findings included: Review of Resident #1 MDS assessment, dated 12/23/2025, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. The resident's cognitive status was severely impaired. Her diagnoses included Cerebral Infarction (the blood supply to part of the brain is blocked or reduced), Bipolar Disorder (mental condition marked by alternating periods of elation and depression), and Memory Deficit (a condition where individuals experience difficulties in forming, storing, and recalling memories). Review of Resident #1's Care Plan, dated 10/27/2022, reflected:Resident has an ADL self-care performance deficit related to left side paralysis, CVA (a loss of blood flow to the brain).Resident at risk for impaired cognitive function or impaired thought processes r/t cerebral infarct, bipolar, TIA (a brief blockage of blood flow to the brain), depression.Resident is a risk for falls r/t TIA, cerebral infarct, left side paralysis has had an actual fall with minor injury related to poor balanceResident has potential for a psychosocial well-being problem r/t dependent behavior, social isolation.An entry dated 03/09/2026 reflected resident at Risk for Re-traumatization r/t history of trauma from other resident violence. Record Review on 03/09/2026 of Resident #2 MDS assessment, dated 01/27/2026, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. The resident's cognitive status was severely impaired. His diagnoses included Vascular Dementia with Mood Disturbance (conditions that damage blood vessels and block blood flow to brain), Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), Cerebral Infarction (the blood supply to part of the brain is blocked or reduced), and Cognitive Communication Deficit (a condition where a person's ability to communicate effectively is compromised by an underlying impairment in mental processes). Record Review on 03/09/2026 of Resident #2's Care Plan, dated 12/11/2025, reflected:Resident has an ADL self-care performance deficit related to cerebral infarction (the blood supply to part of the brain is blocked or reduced)Resident is at risk for Altered Neurological Status r/t CVA (a loss of blood flow to the brain).Resident is at risk for Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest)Resident is at risk for impaired cognitive function or impaired thought processes r/t vascular Dementia (a group of symptoms affecting memory, thinking and social abilities, Agnosia (a neurological disorder characterized by the inability to recognize familiar objects, people, or sounds, despite having intact sensory functions). An interview on 03/09/2026 at 9:30 AM with Resident #3 revealed he was in the dining room and witnessed Resident #2 placing his hand between Resident #1 legs and touching her private area. Resident #3 stated no staff were present at the time of incident. An interview on 03/09/2026 at 12:40 PM with the DON revealed she was informed towards the end of January 2026 that Resident #2 attempted to touch Resident #1 while they were sitting together in the dining room. DON stated Resident #2 was friendly and liked to hug and tell everyone he loves them. DON stated the incident was reported by a staff but unable to recall (continued on next page)

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who the staff was. DON stated if an allegation is validated as abuse, then it is reported to the state. DON stated the allegation was not valid because both residents denied the incident and she did not report to the state. An interview on 03/09/2026 at 1:03 PM with the Administrator, the abuse coordinator, revealed that he was informed by a staff (could not recall which staff) that Resident #1 and Resident #2 were in the dining and that Resident #2 touched Resident #1 in her private area. Administrator stated Resident #1 and Resident #2 were separated immediately and Resident #2 was put on 1:1. Administrator stated Resident #2 was discharged and transferred to another facility the following day. Administrator stated he did not report the incident because both residents had a low BIMS, were confused, and Resident #2 was in the process of being transferred to another facility. An interview on 03/09/2026 at 1:18 PM with Resident #1 revealed, Resident#1 in her room watching television. Resident was observed to be well-groomed and in appropriate clean and fitting clothing. Resident was alert and willing to speak to surveyor. Surveyor asked resident if anyone had touched her or hurt her, Resident stated no and was not able to recall anyone touching her inappropriately. An interview on 03/09/2026 at 2:00 PM with the Administrator Clinical Lead (corporate Administrator) revealed that the Administrator and DON were just suspended for not reporting the abuse incident between Resident #1 and Resident #2. Administrator Clinical Lead stated she and Clinical Cluster Lead (corporate DON) would begin working on the abuse investigation and reported it to the state. Record Review on 03/09/2026 of Resident #1 EMR did not reveal any progress notes, incident reports, or witness statements regarding the allegation of abuse. Review of the facility policy Abuse: Prevention of and Prohibition Against, dated 11/2017 and revised 04/2025 reflected: Reporting / Response 1.All allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator. 2.Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations.5.The Facility will report to the State Nurse Aide Registry or the appropriate licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that an alleged violation involving abuse was investigated for 1 (Resident #1) of 6 residents reviewed. The facility's Abuse Coordinator failed to investigate Resident #1's sexual abuse allegation that occurred on 01/25/2026. This failure could place residents at risk of abuse, neglect, and/or exploitation.Findings included: Review of Resident #1 MDS assessment, dated 12/23/2025, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. The resident's cognitive status was severely impaired. Her diagnoses included Cerebral Infarction (the blood supply to part of the brain is blocked or reduced), Bipolar Disorder (mental condition marked by alternating periods of elation and depression), and Memory Deficit (a condition where individuals experience difficulties in forming, storing, and recalling memories). Review of Resident #1's Care Plan, dated 10/27/2022, reflected:Resident had an ADL self-care performance deficit related to left side paralysis, CVA (a loss of blood flow to the brain).Resident at risk for impaired cognitive function or impaired thought processes r/t cerebral infarct, bipolar, TIA (a brief blockage of blood flow to the brain), depression.Resident a risk for falls r/t TIA, cerebral infarct, left side paralysis has had an actual fall with minor injury related to poor balanceResident had potential for a psychosocial well-being problem r/t dependent behavior, social isolation. Record Review on 03/09/2026 of Resident #2 MDS assessment, dated 01/27/2026, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. The resident's cognitive status was severely impaired. His diagnoses included Vascular Dementia with Mood Disturbance (conditions that damage blood vessels and block blood flow to brain), Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), Cerebral Infarction (the blood supply to part of the brain is blocked or reduced), and Cognitive Communication Deficit (a condition where a person's ability to communicate effectively is compromised by an underlying impairment in mental processes). Record Review on 03/09/2026 of Resident #2's Care Plan, dated 12/11/2025, reflected:Resident has an ADL self-care performance deficit related to cerebral infarction (the blood supply to part of the brain is blocked or reduced)Resident is at risk for Altered Neurological Status r/t CVA (a loss of blood flow to the brain).Resident is at risk for Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest)Resident is at risk for impaired cognitive function or impaired thought processes r/t vascular Dementia (a group of symptoms affecting memory, thinking and social abilities, Agnosia (a neurological disorder characterized by the inability to recognize familiar objects, people, or sounds, despite having intact sensory functions). An interview on 03/09/2026 at 12:40 PM with the DON revealed an investigation was completed by the Administrator. Surveyor informed the DON that there were no documents regarding the abuse or investigation noted in Resident # 1 or Resident #2 chart, DON stated the Administrator should have a copy of the investigation. An interview on 03/09/2026 at 1:03 PM with the Administrator, the abuse coordinator, revealed that he was informed by a staff (could not recall which staff) that Resident #1 and Resident #2 were in the dining and that Resident #2 touched Resident #1 in her private area. Administrator stated Resident #1 and Resident #2 were separated immediately and Resident #2 was put on 1:1. Administrator stated Resident #2 was discharged and transferred to another facility the following day. Administrator stated that he completed a facility investigation of the incident and would provide a copy to surveyor. An interview on 03/09/2026 at 1:18 PM with Resident #1 revealed, Resident #1 in her room watching television. Resident was observed to be well-groomed and in appropriate clean and fitting clothing. Resident was alert and willing to speak to surveyor. Surveyor asked resident if anyone had touched her or hurt her, Resident stated no and was not able to recall the incident. An interview on 03/09/2026 at 2:40 PM with the Administrator Clinical Lead (corporate Administrator) revealed that an investigation was not completed and she and Clinical Cluster Lead (corporate DON) would begin working on the investigation regarding abuse. Record Review on 03/09/2026 of Resident #1 EMR did (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not reveal any reports of abuse being investigated. Record Review on 03/09/2026 of Resident#2 EMR did not reveal reports of 1:1 monitoring or reports of abuse being investigated. Review of the facility policy Abuse: Prevention of and Prohibition Against, dated 11.2017 and revised 4.2025 reflected: Investigation1. All identified events are reported to the Administrator immediately. 2. After receiving the allegation, and during and after the investigation, the Administrator will ensure that all residents are protected from physical and psychosocial harm (See, Protection, below).3. A licensed nurse will immediately examine the resident upon receiving reports of alleged physical or sexual abuse. The findings of the examination shall be recorded in the resident's medical record. 4. All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee.