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	04/14/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to secure the resident had the right to personal privacy and confidentiality of his or her personal and medical records for two staff reviewed for privacy and confidentiality of records.The facility failed to ensure LVN A locked and secured her laptop which contained private healthcare and confidential information for residents on the 100 Hall on 04/14/26. This failure could place residents at risk of exposure of their personal and medical information disclosed to unauthorized individuals including visitors and other residents, causing embarrassment, frustration, loss of dignity, decreased privacy and psycho-social well-being.Findings include: In an observation on 04/14/26 at 1:31 PM revealed the laptop on the medication cart was unlocked and unattended which displayed residents ' medications that needed to be passed. The laptop on the medication cart was unattended in between 2 resident rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) with the laptop facing the 100 Hallway. Two staff members (LVN A and CNA B) and two residents passed the unlocked and unsecured laptop on the 100 Hall. A female staff member later identified as LVN A stated the laptop on the medication cart belonged to her. LVN A stated she thought she locked the laptop prior to leaving it on the medication cart. LVN A stated she was assisting a resident in their room and was using the outlet in the hallway to charge her laptop . In an interview with LVN A on 04/14/26 at 1:46 PM, she stated she had been employed at the facility for 29 years. LVN A apologized to the State Surveyor for leaving the laptop unlocked on the Medication Cart on the 100 Hall. LVN A stated the state surveyor's observation was the first and only time in 29 years she had been employed at the facility that she left her laptop unlocked on any halls. LVN A stated she was unaware on 04/14/26 at 9:48 AM, the State Surveyor observed the laptop on the medication cart unlocked and unattended. LVN A stated during her employment at the facility, she had taken several In-Service Trainings on HIPPA, PHI and ensuring all patient information was protected, and always locked the laptops, computers and medication carts when they were not in use. LVN A stated HIPAA In-Service Training was conducted annually but was unable to recall the last In-Service Training she had taken on HIPPA and PHI. LVN A stated the risk of having the unlocked and unsecured laptop on the medication cart being left in the hallway outside of an occupied residents room was that it violated HIPAA because the laptop had confidential information regarding health records. LVN A stated leaving the computer unlocked, with residents' information, could give other residents, staff and visitors unauthorized access to residents' medical information. LVN A stated harm could be caused to a resident if unauthorized person(s) viewed their medical records and used the confidential information against them to bully and emotionally hurt them.In an interview with CNA B on 04/14/26 at 1:55 PM, she stated she had been employed at the facility for 2 years. She stated she and LVN worked the 6a-6p shift on 04/14/26 and both were assigned to the 100 Hall. CNA B stated she was unaware on 04/16/26 at 1:31 PM, that the State Surveyor observed the unlocked laptop on top of the medication cart on the 100 Hall in between 2 resident rooms (room [ROOM NUMBER] and room [ROOM NUMBER]). CNA B stated when she walked past the unlocked laptop on the Medication Cart on the 100 Hall in between 2 resident rooms (room [ROOM NUMBER] and room [ROOM NUMBER]), she did not notice that the laptop was unlocked. CNA B stated she did not know what staff member (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	last used the unlocked laptop on the medication cart. CNA B stated the unlocked laptop on the medication cart would have contained patient records which included medical records that should be confidential and should not be seen by unauthorized individuals because it contained several residents personal and confidential information. CNA B stated if she noticed a laptop or computer was unlocked, she would immediately notify her Charge Nurse. CNA B stated the risk of patient confidential information being available to unauthorized people might cause a resident to feel embarrassed that others would know about their health issues, which violated the HIPAA guidelines. CNA B stated during her employment at the facility, she had taken several In-Service Trainings on securing patient information and HIPAA. In an interview with the DON on 04/14/26 at 2:52 PM, she stated she had been employed at the facility for 9 years. The DON stated she was unaware of the unlocked and unattended laptop on the medication cart on the 100 Hall. The DON stated computers and laptops should always be locked when unattended. The DON stated this was the responsibility of any nursing staff member who utilized the computer or laptop to access resident information. The DON stated all employees were expected to provide full privacy and confidentiality of all patient information for all residents. The DON stated it was her expectation residents' health information was to always remain private to prevent HIPPA violations. The DON stated she would begin In-Service Training to all staff on privacy and confidentiality of the residents' information and HIPAA protection for residents. The DON stated she would conduct random checks to ensure computers on the hallways were locked and secured when unattended. The DON stated the facility did not have a policy related to HIPAA policies, procedures, and guidelines regarding patient medical records. She stated the facility followed the HIPAA Guidelines in relation to the Health Insurance Portability and Accountability Act of 1966. The DON stated the failure to not protect the resident information may result in there being identity theft. She stated there was a potential of harm if someone who was not authorized to view the patient health records gained access to the records and used the information and caused poor self-esteem and embarrassment for residents. The DON stated personal and medical information about a resident should never be exposed on anything which included a laptop, computer or paper for everybody to see. During an interview with the Operations Manager and the DON on 4/14/26 at 4:37 PM, the Operations Manager and the DON stated the nursing staff should be logging off or closing the computer screen or laptop with resident information when they were walking away from them. Record review of the facility's Staff Schedule for 04/14/25 reflected LVN A and CNA B were assigned various shifts 6a-6p on the 100 Hall. Record review of the facility's In-Service Training records, from 01/01/26 to 04/01/26, reflected there were no In-Service Trainings conducted on residents' privacy during this period.Record review revealed the facility did not have a policy for HIPPA, Protected Health Information (PHI), and/or Safeguarding Electronic Records.Record review of the facility's policy, Resident Rights, revised 01/2022, did not provide any information regarding HIPPA, Protected Health Information (PHI), and/or Safeguarding Electronic Records.Record review of the facility's policy, Content of Medical Record, revised 08/2007, reflected the following:Policy:It is the policy of this facility that a separate medical record shall be maintained for each residentadmitted to the facility and the resident's name will be placed on all medical record forms.Procedures:The resident's medical record shall contain at least the following information:A. Identification Data2. Pertinent identification data to meet the facility's needs and accurately identify the resident is recorded on admission, updated periodically, and includes, but is not limited to, the following items: Resident's name, address and telephone number date of birth Date of admission Physician's name and telephone number Name, address and telephone number of legal representative or interested family member.4. Consents/Authorizations/Acknowledgments. Appropriate consent forms, authorizations and acknowledgments are signed by the resident or legal representative and entered in the medical record, items 1 and 3 may be kept in the financial file. These include, but are not limited to, the following: Consents for care and treatment Consents for generic drug use Authorization to release information for reimbursement purposes Acknowledgement of receipt of advance directive information (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Restraint usage informed consent and notification waiver, if applicable5. Authentication of Diagnoses.6. List of contents of the medical record: admission Record admission Agreement (May be kept in the financial record) Consent Forms (not included in the admission Consent) Advance Directive Acknowledgment Patients Decision making Capacity Transfer Record (admission and Transfer) History and Physical Current Diagnosis Statement that the patient was informed of his/her medical condition Rehabilitation Potential Physician's Orders Physician's Progress Notes TB Screening Laboratory, X-Ray/EKG-EEG Readings Minimum Data Set RAP Summary Care Plan Nursing admission Assessment Dietary Assessment and Progress Notes Activities Assessment and Progress Notes Social Services Assessment and Progress Notes Discharge Planning and Progress Notes Licensed Nurse's Notes Nursing Assistants ADL Flow Sheets Medication and Treatment Records Weight Record Vital Signs Inventory List Discharge Summary Post Discharge Plan of Care Notice of Transfer/DischargeOther miscellaneous records, which may be included in the medical records are: Therapy Evaluations and Progress Notes (P.T., O.T., Speech, Respiratory) Intake and Output Record Pressure Ulcer and Wound Record Other Assessments (Contracture, Physical Restraint, Psychotherapeutic Drug, Bowel and Bladder, Skin, etc .) Restorative Nursing Medicare Certification and Re-certification Consultation Reports IV Record Mortician's Receipt Advance Directive Copies Legal (Conservator /Guardianship Record).Record review of the CMS website reflected, Health Insurance Portability and Accountability Act of 1996. The Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) establishes national standards to protect individuals' medical records and other personal health information. The HIPAA Privacy Rule also gives individuals rights over their health information, like getting a copy of their records and seeking correction. The Rule applies to 3 types of HIPAA covered entities, like health plans, health care clearinghouses, and health care providers that conduct certain health care transactions electronically to safeguard protected health information (PHI) entrusted to them.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 3 of 4 hallways (200 Hall, 300 Hall, and 400 Hall) reviewed for accidents and hazards.The facility failed to ensure 3 of 3 mechanical lifts on 3 Halls (200 Hall, 300 Hall and 400 Hall) were locked and secured when not in use.This failure could place residents, at risk of falls and/or injuriesFindings include:Observation of the 200 Hall on 04/14/26 at 1:13 PM revealed 1 unlocked and unsecured mechanical lift parked on the 200 Hall parked in between room [ROOM NUMBER] and room [ROOM NUMBER].Observation of the 400 Hall on 04/14/26 at 1:27 PM revealed 1 unlocked and unsecured mechanical lift parked on the 400 Hall parked outside of room [ROOM NUMBER].An email was sent to the Administrator on 04/14/26 at 1:59 PM, requested the facility's policy on accidents and hazards and mechanical lifts.Observation of the 300 Hall on 04/14/26 at 2:03 PM revealed 1 unlocked and unsecured mechanical lift parked on the 300 Hall parked outside of room [ROOM NUMBER].Observation on 04/14/26 at 2:10 PM revealed 3 staff members (which included LVN A and CNA B) were standing at the Nurses Station in the center of the 100-400 Halls.Observation on 04/14/26 at 3:46 PM on the 500 Hall revealed all empty rooms. The rooms included several mechanical lifts that were locked and secured, were plugged into the wall socket and were being recharged .In an interview on 04/14/26 at 2:14 PM with LVN A, she stated she had been employed at the facility for 29 years. LVN A stated on 04/14/26, she was assigned to the 100 Hall. She stated she was unaware the 1 mechanical lift on the hallways of 3 Halls (200 Hall, 300 Hall and 400 Hall) were parked and were unlocked and unsecured. LVN A stated she had taken In-Service Trainings on mechanical lift safety and storage. LVN A stated she could not recall when she had previously taken In-Service Trainings on mechanical lift usage, safety and storage. LVN A stated the In-Service Trainings she had taken stated all mechanical lifts were to be always locked when they were not in use. LVN A stated the 3 mechanical lifts were observed on the 3 Halls (200 Hall, 300 Hall and 400 Hall) should have been placed in the storage room on the 500 Hall. LVN A stated the 500 Hall was empty and did not have any residents on the hall and therefore that was the reason why the mechanical lifts were stored in rooms on the 500 Hall. LVN A stated the mechanical lifts were charged in the empty rooms on the 500 Hall when they were not in use. LVN A stated sometimes the staff from the dialysis center housed inside of the facility would leave the mechanical lifts outside of the dialysis center so they had easy access to use it when needed. LVN A stated if she observed an unlocked mechanical lift, she would immediately lock and secure the mechanical lift and then tell the DON there was an unlocked mechanical lift on the hall and the location where the mechanical lift was unlocked and unsecured. LVN A stated harm could be caused to anyone when a mechanical lift was unlocked, when and if someone bumped up against the unlocked mechanical lift, which would cause the mechanical lift to easily move and cause accidents and falls. She stated someone could be harmed by using the unlocked and unsecured mechanical lift and hurting themselves having a serious fall with injuries, such as broken bones fractures when a mechanical lift was unlocked and not safely secured when parked. In an interview on 04/14/26 at 2:28 PM with CNA C, she stated she had been employed at the facility for 36 years. CNA C stated on 04/14/26, she had been assigned to the 200 Hall. She stated she was unaware the 1 mechanical lift on the hallways of 3 Halls (200 Hall, 300 Hall and 400 Hall) were parked and were unlocked and unsecured. CNA C stated she had taken In-Service Trainings on mechanical lift usage, safety and storage. CNA C stated she did not remember when she had previously taken In-Service Trainings on mechanical lift usage, safety, and storage. CNA C stated on previous occasions she observed mechanical lifts on the 300 Hall and 400 Hall but did not check to see if they were securely locked and secured while they were parked on the halls. CNA C stated the mechanical lift that was unlocked and unsecured on the 200 Hall was most likely placed in the hall by (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	someone who worked in the dialysis center who was housed inside the facility on the 200 Hall. CNA C stated she was busy in and out of the patients rooms today and did not observe the unlocked and unsecured mechanical lift on the 200 Hall that was observed by the state surveyor. CNA C stated if she observed a mechanical lift on her hall, she would immediately remove it and place it in an empty room on the 500 Hall where the other mechanical lifts were located. CNA C stated mechanical lifts should always be locked and secured when they were not in use. CNA C stated in the future, she would check the mechanical lifts every time she observed them on the hall to ensure they were locked and secured when they were parked. CNA C stated she would immediately notify her Nurse that an unlocked and unsecured mechanical lift was on the hall and most likely every staff member would receive In-Service Training by the ADON or DON about the proper storage for mechanical lifts. CNA C stated if she observed a staff member store the mechanical lift, she would ask them if they ensured the parked mechanical lifts were always locked when they were parked. CNA C stated if a mechanical lift was unlocked, there was a risk of the mechanical lift moving or someone hitting the mechanical lift. She stated another risk of having an unlocked and unsecured mechanical lift on the hall was someone could hit their limbs (ie: arm or leg), or wheelchair on the mechanical lift. CNA C stated someone could be harmed by an unlocked mechanical lift and may have some injuries such as bruises, broken bones, and fractures. In an interview on 04/14/26 at 2:52 PM with the DON, she stated she had been employed at the facility for 13 years. The DON stated she was unaware the 1 mechanical lift on the hallways of 3 Halls (200 Hall, 300 Hall and 400 Hall) that were parked and were unlocked and unsecured. The DON stated her expectation was all mechanical lifts in the building were to be always locked and secured when they were not in use. She stated all mechanical lifts should never be stored on the hallways when they were not in use and should be stored on the 500 Hall, which was the location of the stored mechanical lifts. The DON stated all staff were educated and trained on the proper usage, safety, and storage of mechanical lifts, which included always ensuring they were locked and always secured. The DON stated she could not recall when the staff received their last In-Service Training on mechanical lifts. She stated she would reeducate and retrain all staff with In-Service Trainings on mechanical lifts safety, usage, and storage. The DON stated the In-Service Training for all staff would include reeducation on performing routine checks/audits of all the mechanical lifts in the building. The DON stated there was a risk to anyone to be injured due to unlocked and unsecured mechanical lifts in the building. The DON stated there was potential for harm to anyone who attempted to lift themselves with the unlocked and unsecured mechanical lift, which could cause physical injuries, such as bruises, scrapes, broken bones, and fractures. The DON stated an unlocked and unsecured mechanical lift could also fall over on anyone if it was bumped into. The DON stated the facility did not have any policies related to mechanical lift safety, storage, accidents and hazards.Record review of facility's, undated, policy for Mechanical Lift, did not provide any information regarding accidents and hazards relating to mechanical lift safety and storage.Record review of facility's policy for Incident Reporting, revised 05/2025, did not provide any information regarding accidents and hazards relating to mechanical lift safety and storage .