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	10/05/2023

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Resident #54 FTag Initiation 46403 Based on observation, interview and record review the facility failed to provide the necessary services to maintain grooming and personal care for two (Resident #34 and Resident #54) of four residents reviewed for ADL care in that: Resident # 34 was not provided supervision with a razor for grooming and personal care. The facility failed to provide adequate supervision to Resident #54 while toileting. These failures could place residents requiring supervision with personal care, grooming, and toileting at risk of low self-esteem. Findings include: Record review of Resident #34s quarterly MDS assessment dated [DATE] reflected Resident #34 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses Dementia, depression, schizophrenia, bipolar type schizoaffective disorder, cognitive communication deficit , and stroke (disrupted blood flow to the brain due to problems with the blood vessels that supply it). The BIMS was left blank and Resident #34 required supervision for ADL's. Record review of Resident #34's Comprehensive Care Plan, dated 09/02/23, reflected she had an ADL self-care deficit related to Dementia and stroke. Interventions included personal hygiene and required supervision. The goal was to maintain highest level of grooming and personal care through the review date. Observation on 10/05/23 at 10:45 am revealed Resident #34 pulled a razor from drawer, broke the razor off, and put it back in her drawer. Resident #34 then went out into the hallway and asked the Activity Director for a razor. The Activity Director returned with a razor and gave it to Resident #34. Resident #34 went into the bathroom alone and closed the door. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/05/23 at 11:00 AM, the Activity Director stated, I forgot [Resident #34 was] not supposed to have razors because of her stroke and Resident #34 had trouble with her balance. The Activity Director stated, I would not think there are any risk to [Resident #34] having the razor. If she was in a different mood, I probably would not have given her the razor. She does require supervision. The Activity Director stated, supervision with the one hand to make sure [Resident #34] does not cut herself. Interview on 10/05/23 with CNA P at 2:15 pm revealed Resident #34 should not keep razor in her room. CNA P stated she has never asked her to shave Resident #34. CNA P stated when Resident #34 needed help, she would call out her name. CNA P stated one side of Resident #34's right arm was paralyzed and she could cut herself. Interview on 10/05/23 at 4:34 PM, the DON stated Resident #34 was not allowed to have razors in the room. She has Dementia, and for safety, she was not supposed to have a razor by herself. The DON stated, someone is supposed to be with her to make sure she does not cut herself. The DON stated before giving the residents anything, non-nursing staff and nursing staff should check with the nurse on duty first and Resident #34 was care planned for supervision with ADL's . Review of Resident #54's quarterly MDS assessment, dated 07/26/23, revealed she was a [AGE] year-old female and admitted to the facility on [DATE]. Her diagnoses included hypertension (high blood pressure), hyperlipidemia, Parkinson's disease (involuntary movement disorder), anxiety, and depression. She was usually understood and usually understood others. Her BIMS score of 11 out of 15 revealed she was moderately cognitively impaired. Her functional status section indicated her she required extensive assistance and needed one-person physical assistance with toileting. Review of Resident #54's Care Plan, undated, reflected her focus was an ADL self-care performance deficit due generalized weakness and Parkinson's disease. Her goals were to maintain highest level of function in bed mobility, transfers, eating, dressing, grooming, toilet use, and personal hygiene. Her interventions were toilet use and required one staff participation to use toilet. In an observation of Resident #54 on 10/04/23 at 9:53 AM revealed Resident #54 was in the bathroom by herself without staff supervision. Her wheelchair was placed in front of the open bathroom door. Resident #54's room door was cracked open approximately six inches. She was not visible from the hall. There were no staff located in the hallway. After this observation CNA A exited another resident's room and instructed state surveyor to leave Resident #54's room door completely open. In an interview with CNA A on 10/05/23 at 11:28 AM revealed Resident #54 required total assistance with toileting before 9:00 AM. He stated after 9:00 AM Resident #54 required limited assistance with toilet use. He stated Resident #54 did not require supervision with toilet use depending on the time of day. He stated Resident #54's level of supervision was dependent on whether or not she received adequate sleep. He stated he left Resident #54's room door open to supervise her while toileting. He stated providing supervision meant to visually see Resident #54 while toileting. He stated Resident #54 could not be seen from the hallway while she was using the toilet. He stated Resident #54 preferred to use the toilet unsupervised. He stated Resident #54 would use her call light if she needed assistance while toileting. He stated there were no risks to Resident #54 not being supervised while toileting. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident #54 on 10/05/23 at 2:45 PM revealed staff did not provide assistance or supervise her while toileting. She stated she required assistance from staff to transfer into her wheelchair. She stated she used her call light when she needed assistance with toileting. She stated when staff do not answer her call light she toilets herself. She stated in the past she had fallen but did not sustain any injury. She stated she would like assistance with toilet use. In an interview with RN C on 10/05/23 at 2:53 PM revealed Resident #54 required assistance with toileting. She stated Resident #54 was a fall risk. She stated most of the time Resident #54 was not left unattended while toileting. She stated Resident #54 used her call light when toileting was needed. RN C stated she never left Resident #54 alone while toileting. She stated CNAs were not supposed to leave Resident #54 alone while toileting. She stated if Resident #54 wanted privacy while toileting staff was supposed to stay in her room with the door closed. RN C stated Resident #54 was at risk of falling if left unsupervised while toileting. In an interview with the DON on 10/05/23 at 4:39 PM revealed Resident #54 required assistance and supervision with toileting. She stated CNA A was supposed to stay in Resident #54's room with the door closed while toileting. She stated CNAs were responsible for ensuring Resident #54 received adequate assistance and supervision with toileting. She stated frequently rounding ensures Resident #54 received adequate assistance and supervision with toileting. She stated Resident #54 was at risk of falls due to lack of assistance and supervision during toileting. Record review of the facility policy titled Nursing Services , date revised July 2020, revealed It is the policy of this facility that residents are given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care .2. If a resident is unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, and personal oral hygiene will be provided by qualified staff.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on observation, interview, and record review, the facility failed to ensure a resident received appropriate treatment and services to prevent urinary tract infections for one (Resident #217) of eight residents observed for indwelling urinary catheters. The facility failed to ensure Resident #217's foley catheter drainage bag was not on the floor, and not full beyond capacity. This failure could place residents with urinary catheters at risk for urethral tears, dislodging of the catheter, and urinary tract infections. Findings include: Review of Resident #217's MDS assessment dated [DATE] revealed an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: Pressure ulcer of sacral region stage 4, mild cognitive impairment, heart failure, acid reflux in the esophagus, Diabetes mellitus, depression, enlarged prostate. His BIMS score (11) revealed he had moderately impaired cognition. Further review of MDS reveled Resident#217 had an indwelling foley catheter related to urinary retention. Review of Resident #217's care plan dated 09/14/23, reflected: Focus: Resident#217 had an indwelling catheter: Pressure Ulcer (stage IV to lower back) and BPH (Benign prostate hyperplasia). Goal: Resident#217 Will remain free from catheter related trauma through review date. Intervention: Secure catheter to facilitate flow of urine, prevent kinking of tubing, and accidental removal. Review of Resident #217's physician orders, dated 09/14/23, reflected, Catheter Type:18 FR(French) # 10 ml to closed urinary drainage system-diagnosis for use: urinary retention. Observation on 10/03/2023 at 11:29 of Resident #217 revealed his foley catheter drainage bag covered with a privacy cover was hanging to the bed frame and the front side of the drainage bag was setting on the floor. The foley catheter drainage bag was full beyond capacity and stretched. Resident#217's bed was in a lowered position. Observation on 10/04/2023 at 11:20 am of Resident#217 revealed his catheter drainage bag was hanging to his bed frame and the bottom of the drainage bag was touching the floor. Resident#217's bed was in a lowered position. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/05/23 at 08:29 AM with the ADON, and LVN F assigned to Resident#217 today revealed: The ADON looked at a picture taken the first day of survey showing the foley catheter drainage bag full beyond capacity and setting on the floor. Both staff stated that the foley catheter drainage bag was touching the floor, and full beyond capacity, and that was not acceptable. The ADON stated it was an issue of infection control explaining it would increase risk for development of infection to Resident#217. The ADON stated Resident#217 had the foley catheter in relation to urinary retention. The ADON stated it was the responsibility of the CNAs to empty the foley catheter drainage bag, at the start of their shift, and as needed. The ADON stated it was the nurses assigned to the Hall responsibility to supervise the CNAs and make sure the residents' foley catheter drainage bag was always not full beyond capacity and off the floor. LVN F stated had training about taking care of residents with indwelling foley catheter during orientation to the facility at the hire time three months ago. Interview on 10/05/23 03:31 PM with the DON revealed had been in DON position since 10/02/2023.The DON looked at picture of the Resident # 217's foley catheter drainage bag taken last Tuesday (10/03/23) and responded Resident#217's foley catheter drainage bag was full not drained, and the bed was low, and the foley catheter drainage bag was touching the floor. The DON stated Resident #217 wanted the bed in low position, and it was not acceptable for the foley catheter drainage bag to touch the floor. The DON stated the nurses and CNAs were responsible for ensuring Resident #217's catheter drainage bag was not on the floor and not too full. The DON stated the nurses and CNAs monitor catheter bags throughout their shifts by making rounds, and the DON and ADON make rounds, too. The DON stated staff were aware of the importance of the catheter drainage bag of floor and emptied as needed. The DON stated the risk to Resident#217 was development of urinary tract infection. The DON stated the residents' direct care staff had in service related to indwelling foley catheter care every month, and she brought in the in-service log for the last 3 months. Review of in service dated 07/24/2023 reflected: 1) Foley catheter care every shift. 2) Empty at end of shift or prn (as needed). 3) Privacy bag on at all times. 4) secured to leg to avoid trauma. 5) Keep off the floor and hang to gravity. Review of facility policy, Catheter care- Foley, dated 07/2015, reflected: . It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and PRN for soiling. 47690 Resident #217 Urinary Catheter or UTI no sleeping medication last night, and itching medication, F/c bag too full, c/o staff not give been in the facility for more then on a week (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	colostomy covered with colostomy bag in the left lower quadrant scratch marks on right arm no water at bedside. 10/03/23 11:35 AM aide come to rt room in response to the call light. 10/03/23 11:37 AM the aid give the rt water he asked for. revise it to resident room: 315 B at 12:36: the Foley catheter bag empty and of the floor. Interview on 10/04/23 01:33 PM CNA agency Tiwannia [NAME] The CNA S stated was not assigned to rt in room [ROOM NUMBER] today The process of taking care of resident with foley catheter The CNA stated to empty the resident foley catheter drain bag: wash hand , done glove, got the urinal from the bathroom, open the drain bag outlet, drain the bag into urinal without the drain outlet touching the urinal. CNA S stated close the drain outlet, and take the urinal to the bathroom emptied it rinse it, put in a clean disposable plastic bag and keep it in the bathroom CNA S stated check the residents with foley catheter at 6 am at the start of the her shift, before lunch time noon and before going home in afternoon. Revisit to resident room [ROOM NUMBER] B on 10/04/2023 at 11:20 am foley catheter bag hanging at the bed side and touching the floor. 10/05/23 08:12 AM up on entrained the resident Resident # 217 room LVN F was in the process of attaching the f/c drain bag to bed side frim the bag touching the floor. LVN F remove right hand glove and call the ADON stating do not know where to hang the f/c drain bag. [NAME] Fotsing LVN work with the facility 3 months. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff(ADON) come in to the room sanitize hands, done glove. LVN [NAME] put the bag over the bed, remove glove , sanitize hands, done clean glove both staff pulled rt up in bed, covered rt LVN remove the dirty lining put it in a plastic bag given to her by a CNA that come in to room to check what was going on. both staff (LVN and ADON) adjusted rt bed position. ADON secured the f/c drain bag to the bed frame tightening a knot with the privacy cover straps . ADON remove glove washed hands. LVN remove glove sanitized hands interview on 10/05/23 at 08:29 AM Kavathe, Mwinzi ADON ADON looked at a picture taking the first day of survey showing the f/c drain bag full and started leaking, and setting on the floor; she responded not acceptable Both staff acknowledge that the foley catheter drain bag was touching the floor, and full beyond capacity, and started leaking. ADON stated it was and issue of infection control explaining it would increase risk for development of infection to resident. ADON the resident had the f/c in r/t urine retention. ADON stated it was the responsible of the CNAs empty the foley catheter drain bag, at the start of the shift, and as needed. ADON stated it was the nurses assigned to the hall responsibilities to supervise the CNAs and make sure the residents' foley catheter drain bag was not full beyond capacity and of the floor at all time. LVN F stated for the in service r/t residents' care with the foley catheter: not sure if she had the in-service, and had to verify with the DON. LVN further acknowledged have training about taking care off rt with f/c during orientation to the facility at the hire time three months ago Interview on 10/05/23 03:31 PM with DON Chido Mawoyo-RN Had been in DON position since 10/02/2023: The DOn looked at picture of the Resident # 217 foley catheter drain bag taking last Tuesday and responded the foley catheter drain (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bag was full not drained, and the bed was low and the foley catheter drain bag was touching the floor. DON stated Resident # 217 wanted the bed in low position, and it was not acceptable for the drain bag to touch the floor. DON stated CNAs were usually responsibility of check on residents and emptying the drain bag, and the nurses too, were responsible of checking the foley catheter drain bags to make sure they are of floor, and not too full. DON stated the residents' direct care staff suppose to check the foley catheter bags through out the shifts. DON her expectation from the they suppose to check they should to check, the bag should not be like that. responsible the Don and ADON, we also do rounds in service: Yes, the last done unable to report, and I have to check the log book. the DON brought in the in service for the last 3 months.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42283 Based on observation, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure food was properly stored in the facility's kitchen. This failure could place residents at risk for food-borne illness. Findings Included: Observation of the facility's refrigerator on 10/03/23 at 9:34 AM revealed: - 3 tomatoes withered and 1 tomato with white spots - 2 heads of cabbage with black spots. Observation of the facility's freezer storage on 10/03/23 at 9:37 AM revealed: -1 box of country fried beef steak open and exposed to air - 1 bag of chicken undated; and -1 bag of fries undated. Observation of the facility's prep table on 10/03/23 at 9:40 AM revealed: -1 white onion with black spots. Observation of the facility's dry storage on 10/03/23 at 9:42 AM revealed: -1 container of corn flakes open and exposed to air. In an interview with the Dietary Supervisor on 10/05/23 at 6:02 PM, revealed he and dietary staff checked the kitchen (refrigerator, freezer, dry storage, and prep tables) daily to ensure food was stored properly. He stated he and the dietary staff use a first in and first out system regarding food storage. He stated he and the dietary staff were responsible for ensuring foods were not spoiled or unsealed and exposed to air. He stated improper food storage could cause residents to be exposed to food borne illnesses. Record review of the facility policy titled Infection Control Policy/Procedure: Dietary Services, dated October 2022, revealed It is the policy of this facility to prevent contamination of food products and therefore prevent foodborne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Food and Drug Administration Food Code, dated 2017, reflected, .3-305.11 Food Storage. (A) . food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 46403 Based on observation, interview, and record review, the facility failed to maintain a safe environment for residents who utilized 1(Shower Room A) of 2 shower rooms reviewed. The facility failed to ensure the water temperature was at a comfortable tempetature. This failure could place the residents at risk for an unsafe and uncomfortable environment. Findings included: On 10/04/23 at 10:34 am, during a confidential resident council meeting, a resident stated the shower water was too cold and they had notified staff. The resident could not recall the staff names that they had told. The resident said they had three cold showers this month and would not take any more cold showers. Observation and interview on 10/05/23 at 10:39 am revealed Maintenance L checked the temperature for shower room # 1. The water temperature did not get above 77 degrees. Maintenance L stated the water temperatures were checked weekly. Maintenance L stated residents were not at risk because the temperature can be adjusted, at this time it was adjusted to fair down. Maintenance L revealed the hot water temperature should be between 100 degrees and 110 degrees in the resident areas. Maintenance L has not had any complaint about the water not getting hot since the beginning of the summer. Maintenance L revealed the boiler had to be replaced. Record review of weekly checks revealed the water temperature was ranging between 103 degrees to 110 degrees. Interview on 10/05/23 at 04:36 PM with the DON revealed, no residents had complained to her about the water being too cold. Interview on 10/05/23 at 4:40 pm with the Administrator revealed, residents were not in any risk. The Administrator stated they can adjust the temperature on the hot water heater. The Administrator stated maintenance director or designee were responsible for overseeing hot water temperature and completed weekly checks. Record review of facility's policy titled Water Temperature policy (undated) revealed, maintenance director or designee are to perform weekly water temperature checks of the facility no later than Friday of each week. Temperatures in resident area are to range from 100 to no more than 110 degrees .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 46403 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to keep the facility free of pest for one (Hall 300) of four halls. The facility failed to treat the facility flies for Hall 300. This failure could affect all residents by placing them at risk for the potential spread of infection, cross-contamination, food-borne illness, and decreased quality of life. Findings included: Observation and interview on 10/03/2023 at 11:00 am visit to Resident #35 revealed , fruit flies in the room. There was apple cider vinegar in two little cups and fly spray on top of the resident's refrigerator. Resident #35 stated flies were all over his food and staff would try to wave them away. Resident #35 stated the files would try to come in his mouth with the food. Resident #35 stated that he would refuse to eat sometimes because of the files. Observation on 10/03/2023 at 02:02 pm visit to Resident#45 and Resident#27 revealed fruit flies in the room. Observation on 10/03/2023 at 02:10 pm visit to Resident#39 revealed, fruit flies and resident's suctions supplies in plastic bags with wet stain underneath them. Resident # 39 stated there was fruit flies all the time in here. Observations on 10/04/2023 at 12:09 pm LVN B attended to the Resident #45 and Resident#27. LVN B waved the flies from her mobile workstation. LVN B stated oh yes especially in this area we have an issue with files. LVN B stated she worked on Hall 300 yesterday, and today and she noticed flies around. Interview on 10/04/2023 at 01:30 pm with Resident # 10 revealed, she noticed the flies and had seen them for the last 3 weeks. Resident#10 stated she reported it to Maintenance L, and after that they sprayed some product down Hall 300, and in the rooms. She further stated without result, flies were still around. Interview on 10/04/23 at 01:37 PM with Housekeeper M revealed, she noticed the small flies for at least one or two weeks in the Hall 300. Interview on 10/05/23 at 10:38 AM with Maintenance L stated the facility had a company that came out monthly to spray for the fruit flies. Maintenance L stated he does daily walk throughs of the facility to check for insect issues. Maintenance L stated residents should not be complaining about files were they live. (continued on next page)

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	10/05/2023

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the pest prevention service agreement dated 01/09/23 revealed, regular service was scheduled weekly. The last service inspection report on 09/26/23 revealed ,no pest activity found in common area and social workers office. Pervious inspection service on 09/19/23 revealed, target pest was American roach and treated exterior for general pest. Record review of pest prevention service revealed no reports of treatment of flies over the past month. Record review of the facility's policy titled Physical Environment and subject: Pest Control dated revised 05/2020 revealed, It is the policy of this facility to utilize pesticides and rodenticides in a safe and efficient manner to control pests with the least amount of contamination to the environment.