| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675650 | A. Building<br>B. Wing | 05/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Terrace Healthcare Center of Fort Worth | 7500 Oakmont Blvd<br>Fort Worth, TX 76132 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the resident has a right to personal privacy and confidentiality of his or her personal and medical records for 3 (Resident #1, Resident #2, and Resident #3) of 3 residents reviewed. The facility failed to obtain resident consent before identifiable health information was sent out via email by the SW to nonresidents. This failure placed residents at risk of personal health Information exposed. Findings include:Record review of Resident #1's face sheet revealed he was admitted on [DATE] and was diagnosed with cognitive communication deficit (a condition where cognitive impairments disrupt person's ability to communicate effectively, despite intact language or speech abilities) and mild cognitive impairment of uncertain or unknown etiology (measurable cognitive decline that does not yet meet criteria for Dementia and lacks a clearly identified cause. Resident#1 was his own responsible party.Record reviews of Resident #1's medical records revealed no authorization for release of information form on file that would allow for the release of medical information. Record review of SW list of emails that she sent out had nonresident name listed as the receiver for Resident #1's information. Record review of Resident #2's revealed she was initially admitted on [DATE] and readmitted on [DATE]. Resident #2 was an [AGE] year-old female and was diagnosed with cognitive communication delict, personal history of transient ischemic attack (TIA) and cerebral infraction without residual deficits. Resident#2 was her own responsible party.Record reviews of Resident #2's medical records revealed no authorization for release of information form on file that would allow for the release of medical information.Record review of SW list of emails that she sent out recipients had nonresident name listed as the receiver for Resident #2's information. Record review of Resident# 3's revealed he was admitted on [DATE]. Resident #3 was a [AGE] year-old female and was diagnosed with Hemiplegia (complete paralysis) and Hemiparesis (partial weakness) following cerebral infraction affecting right dominant side. Resident#3 was his own responsible party.Record reviews of Resident #3's medical records revealed no authorization for release of information form that would allow for the release of medical information. Record review of SW list of emails that she sent out had nonresident name listed as the receiver for Resident # 3's information. During an interview and record review on 05/04/26 at 8:57am SW stated she sends out a welcome letter within three days and sent out 7 days clinical unless a specific date was determined for information to be sent. The SW stated residents under managed care received an outcome prediction which the facility received from the insurance company and current orders are sent to email on file. The SW stated she did not encrypt the messages because some families had a challenging time opening the email and it was a hassle. The SW stated if she typed in the incorrect email address the system would kick it back. The SW stated she asked family and residents if they would like the information emailed and confirmed the email addressed. The SW stated she was not aware of family and/or resident signing a health release form. The surveyor asked the SW to send a sample email with information that was included. The surveyor observed in email: welcome letter, advance directive handout, notice of nondiscrimination, your rights in a nursing facility, current orders, and the home and community care transition prediction outcome which included patient evaluation information, care needs at the NF/SNF, and anticipated discharge information. The social<br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | worker stated she was not able to send the surveyor a list of all the residents whose clinics had been sent out over the last 60 days. The social worker was able to gather some of the emails sent out in the last 30 days. During an interview on 05/04/26 at 9:28 am the MRD stated an authorization for release of information had to be completed before resident personal information could be released. MRD stated he was responsible for the consent forms. The MRD stated family members and/or residents could put in a request for the form. The MRD stated the doctor's office would provide they're on form to fill out and a resident lawyer did not need to complete a consent form. The MRD stated he was not aware that the SW was sending medical record information. The MRD stated residents' personal information needed to be protected.Attempted to interview Resident #2 on 05/04/26 at 11:52 am and she was not able to answer questions about email.Attempted to interview Resident #3 on 05/04/26 at 11:55 am and he was not able to answer questions about email.During an interview on 05/04/25 at 12:00 pm the surveyor attempted to interview Resident#1, and he was not able to answer questions about email. Resident#1 family member stated that she does not receive the emails, but another family member had her email set-up to receive them, and she kept up with the information from the facility. During an interview on 05/04/26 at 12:10 pm the AD stated mediation orders and outcome predications are considered medical records. The AD stated emails are sent out to the email on the resident's face sheets. The AD stated she was not responsible for sending out medical records by email. During an interview on 05/04/26 at 12:30 pm the EDHIM specialist stated the MRD was responsible for sending out the consent form to be signed by resident and/or representative. The EDHIM stated the facility shared an encrypted file and residents' information was protected. The EDHIM specialist stated she was not aware that the SW sent out medical record information. During an interview on 05/04/26 at 12:40 pm the DON stated the SW will assist with sending out the current orders and outcome predictions after the teams had gone over baseline care plans. The DON stated the family members are incredibly involved and some are ill and cannot come to the facility. The DON stated that is why the facility keeps family updated with emails. During an interview and record review on 05/04/26 at 12:45 pm the ED stated she believed the emails are sent securely.Record review of facility policy titled, Disclosure of Protected Health Information (PHI)-Release of Information, revised 04/16/26 reflected .Eash resident has the right to access his or her protected health information contained in the medical record. The resident is assured confidential treatment of his or her medical records and may approve or refuse their release to an individual outside the facility.procedure . 2. When a request is made by a current resident or another party to view or copy the medical records, those request should be directed to the Health Information Management Director/Privacy official.Review of authorization for Release of Information.4.Copies of authorization are kept as a permanent part of the residents medical records |