STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455480	A. Building B. Wing	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Convalescent Center	1009 Clyde St Amarillo, TX 79106

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices for 1 (Resident #1) of 6 residents reviewed for medical records. The facility failed to document wound care had been completed on 6 days of the previous 90 days that were reviewed. This failure could place all residents at risk of not receiving appropriate care through inadequate documentation possibly resulting in deterioration in condition, exacerbation of disease process, and increased risk of harm or injury.Findings include: Record review of Resident #1's clinical record revealed a [AGE] year-old-female admitted to the facility originally on 07/23/24 and readmitted on [DATE]. Resident #1's current diagnoses include peripheral vascular disease (a circulatory condition in which narrowed blood vessels recue blood flow to the limbs), atherosclerosis of native arteries of extremities (bilateral legs) (a medical condition where plaque builds up in the arteries that supply blood to the limbs), other injury of unspecified body region (graft site from left thigh). Record review of Resident #1's last MDS revealed an annual assessment completed on 07/11/25 with a BIMS of 12 indicating she was moderately cognitively impaired, she had a functional status of being dependent on staff for most of her activities of daily living, and she had 2 venous and arterial ulcers present. Record review of the care plan with admission date of 09/16/24 for Resident #1 revealed the following: Focus:I have Peripheral Vascular DiseaseFocus: Venous/Stasis Ulcer r/t PVD to LLEFocus: Venous/Stasis Ulcer r/t PVD to RLE-Further review revealed there were no interventions related to completion of wound care noted. Record review of Resident #1's physician orders printed 07/15/25 revealed the following orders:- Lt Calf- Cleanse with wound cleanser. Dry. Apply Mupirocin2%, Adaptec, ABD, and cover with ABD. wrap with Kerlix. wrap with Ace bandage. secure with Tetra-Net size 6 very day shift for wound .-Revision Date: 04/23/2025 - Lt Upper Thigh-Cleanse with wound cleanser. Dry. Apply Mupirocin 2%, Adaptec, ABD, and cover with ABD. wrap with Kerlix. secure with tape. every day shift for wound . -Revision Date: 04/23/2025 - Rt Calf- Cleanse with wound cleanser. Dry. Apply Mupirocin2%, Adaptec, ABD, and cover with ABD. wrap with Kerlix. wrap with Ace bandage. secure with Tetra-Net size 6 every day shift for wound . -Revision Date: 04/23/2025 Record review of Resident #1's WAR's from 04/17/2025 through 07/15/2025 (last 90 days) revealed the following: Left calf wound with a revised order for daily wound care started on 04/23/25. Noted no documentation of wound care completed for 04/27.25, 05/02/25, 05/07/25, 05/31/25, 07/04/25, and 07/13/25. Left upper thigh wound with a revised order for daily wound care started on 04/23/25. Noted no documentation of wound care completed for 04/27. 25, 05/02/25, 05/07/25, 05/31/25, 07/04/25, and 07/13/25. Right calf wound with a revised order for daily wound care started on 04/23/25. Noted no documentation of wound care completed for 04/27.25, 05/02/25, 05/07/25, 05/31/25, 07/04/25, and 07/13/25. During an observation and interview on 07/15/2025 at 09:03 AM Resident #1 was in her room in her bed. Resident #1 was dressed well and appeared in good condition. Resident #1 reported that she had an issue with LVN C but that she had not received any care from LVN C in quite a while. All other staff have been very good at what they have done. Resident #1 reported that all wounds were doing better to include the graft site on her left upper thigh and both lower leg PVI/venous status ulcer wounds. During an interview on 07/15/2025 at 03:05 PM the DON reviewed Resident #1's WAR record and reported that the dates of 4/27/25, 5/2/25, 5/7/25, 5/31/25, 7/4/25, and 7/13/25 were not documented on the WAR that the wound care had been completed for Resident #1's right calf, left calf, and left upper thigh. The DON reported that she knew the wound care had been done because Resident #1 would always tell her if any of her wound care was missed, and Resident #1 did not report any of those dates. During an interview on 07/15/2025 at 03:56 PM the DON reported that she had talked with LVN B, and he reported that he had completed the wound care for Resident #1 on 04/27/25 and reported that he just did not document it. ADON A completed the wound care on 05/02/25 and ADON A reported that Resident #1's wound care was done but she forgot to document it in the resident records. On 05/07/25 Dr [NAME] was in the facility, performed the wound care, and whoever the staff that was with Dr. E did not document the wound care in Resident #1's records and she (the DON) was not able to determine who that was that day. On 05/31/25 Resident #1 refused wound care for LVN C, but LVN C did not document the refusal and LVN C was currently out of town on vacation and unavailable for contact. On 7/04/25 LVN D completed Resident #1's wound care and reported that she (LVN D) forgot to document that she completed the wound care in Resident #1's chart. On 07/13/25 she (the DON) covered the hall Resident #1 was on, and she could not