

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Heritage Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident had a right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 18 residents (Resident #15) reviewed for accommodation of needs in that: Resident #15 was not being provided with the correct size of adult brief. This failure could place residents at risk of not having met their needs and a decline in their quality of care and life. Findings included: Record review of Resident #15's face sheet, dated 12/03/2025, revealed a [AGE] year-old female admitted on [DATE] with diagnoses that included, but were not limited to, Chronic Respiratory Failure with Hypoxia (failure of lungs to provide oxygen), Other lack of coordination, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypothyroidism (thyroid underperforming), Type 2 diabetes Mellitus (inability to process sugar), morbid (severe) obesity due to excess calories, anxiety disorder, unspecified (a group of mental illnesses that cause constant fear and worry), myopathy, unspecified (muscle weakness and dysfunction), Essential (Primary) hypertension (abnormally high blood pressure that's not the result of a medical condition), emphysema (sacs in lungs can't switch oxygen and carbon dioxide leaving person breathless), and Chronic obstructive pulmonary disease (COPD refers to a group of diseases that cause airflow blockage and breathing related problems). Record review of Resident #15's quarterly MDS, dated [DATE], revealed a BIMS score of 15 out of 15 which indicated cognition was intact. Resident #15 was dependent and required two-person staff assistance with bed mobility and lower body dressing, total two-person staff dependence with transferring bed to chair, sit to stand and toilet transfer. Resident #15 was always incontinent of bladder and frequently incontinent of bowel. Record review of Resident #15's care plan, dated 10/30/25, revealed, in part, [Resident #15] has bladder incontinence with goal of remaining free from skin breakdown due to incontinence and brief use. Interventions included: prefers to wear 2 briefs and a protective pad for furniture. During an observation on 12/02/25 at 10:03 AM, Resident #15 was lying on her bariatric bed, awake, watching tv. Resident stated that she remembered surveyor from an investigation a few weeks ago. Resident stated that she was wearing 3X briefs, but that the size she needed was 5X. She told the CNAs not to fasten the sides of the 3X briefs because it was too tight and uncomfortable. Resident stated that when surveyor was here last time, the ADM stated she was looking for her 5X briefs but had not heard anything back about it or if they had been ordered. Resident stated that she knew 5X sized briefs were manufactured because she had them at another facility before this one. During an observation on 12/03/25 at 10:29 AM, the supply closet on the hall where Resident #15 resided revealed to have 3X briefs as the largest size. During an interview on 12/03/25 at 10:30 AM, RN F stated she was not sure if the facility had tried to get Resident #15 larger briefs. During an interview on 12/03/25 at 10:33 AM, CNA G stated that he had worked at the facility for 3 1/2 years and was very familiar with Resident #15. He stated that when he changed her, she does not want the sides of the briefs snapped because they are too tight and so CNAs make sure that she was covered but leave the sides unsnapped. CNA G stated that 2 months ago he asked the ADM if they could order her bigger ones, but he stated he was not sure of the status of that, but he stated he had not seen 5X briefs for Resident #15. During an (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observation and interview on 12/03/25 at 10:52 AM, CNA H was observed during incontinent care for Resident #15. CNA H stated that they had been asking for bigger briefs for Resident #15, but administration had not gotten them for her. During an interview on 12/03/25 at 10:53 AM, RN F stated that she felt Resident #15's bottom area could get aggravated due to the briefs they are using for her being too small. RN F stated that the facility cannot find her larger sized ones on the website they use. During an interview on 12/03/25 at 11:01 AM, ADM was asked for Accommodation of Needs Policy. During an interview on 12/04/25 at 9:15 AM, Resident #15 stated that she had lived here almost 2 years and that the management had talked to her once about getting her a larger sized brief. She stated she did not feel like the facility tried to meet her needs in that regard. Resident #15 stated this made her feel like administration wanted her to leave because she had so many health issues and for the resident to possibly buy her own larger briefs, which she could not afford. She stated that the CNAs have asked management to get her larger briefs on several occasions, which she appreciated. During an interview on 12/04/25 at 9:23 AM, LVN I stated that she had worked at the facility for almost a year and was charge nurse for the hall that Resident #15 resided on. She stated she did not feel like it was a problem for Resident #15 to wear smaller briefs. When surveyor asked LVN I if it would affect her if she had to wear pants 2 sizes too small. LVN I stated it would be a problem, and it could cause pain and issues. During an interview on 12/04/25 at 9:32 AM, CNA C stated she had worked at the facility for 1 year and worked the hall Resident #15 resided on. She stated that ADON A told her about a month ago that they were going to order bigger briefs for Resident #15. CNA C stated she felt the smaller sized briefs bothered Resident #15, and that the resident had told her she was uncomfortable. CNA C stated that a possible negative outcome of residents not having their needs accommodated could be that they could suffer abuse. During an interview on 12/04/25 at 10:43 AM, ADON A stated that she did not feel the size of Resident #15's brief was causing any issues because they did not snap the sides and CNAs leave them open because fastening them made it uncomfortable for her. ADON A stated she would personally not enjoy wearing underwear that was 2 sizes smaller and stated it would be uncomfortable for sure. ADON A stated that she remembered CNAs asking her to order 5X briefs for Resident #15, but she did not order them and she stated that the ADM could not find that size on the company website that they use. She stated a possible negative outcome for not having a residents needs met could be that they would be unhappy which could cause issues with the family or they could get sick. During an observation on 12/04/25 at 11:01 AM, Amazon.com was observed to sell Adult Briefs for women and men in size 4-5XL with stretchable sides. During an interview on 12/04/25 at 11:21 AM, The ADM stated that she had not ordered the 5X briefs for Resident #15 because no one made that large of a size of brief. Surveyor stated that Amazon sold them and observed them online that morning. ADM responded, really? ADM stated that there was not a negative outcome for a resident who was not getting his/her needs met. ADM stated they did not have an Accommodation of Needs Policy. Record Review of the facility's Resident Rights Policy dated December 2016, revealed in part. Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. A dignified existence. b. Be treated with respect, kindness, and dignity. Record review of the facility's admission packet with Statement of Resident Rights reviewed, not dated, revealed in part. You have a right to: 1. All care necessary for you to have the highest possible level of health. 4. be treated with courtesy, consideration, and respect.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review the facility failed to consider the views of a resident group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility for 5 of 7 anonymous residents. The facility failed to address a grievance put forth by the resident council regarding sheets not being changed on beds. This failure could lead to residents feeling unheard and undervalued in their place of residence. Findings Included: During a resident council meeting on 12/03/25 at 2:00 PM 5 of 7 attendees complained that their bed sheets were not being changed weekly while they were getting their showers, which was what was supposed to happen. One of the anonymous residents stated that she was a new admit and had only resided in the facility for one month. She stated that her bed sheets had only been changed one time since she had moved in. Another of the anonymous residents stated that a nurse would bring her the clean sheets and she would put them on herself and make her own bed. All five anonymous residents stated they had raised their concerns for the last couple of months at the resident council meeting and they had not heard anything back from staff on how this issue was being addressed. Record review of grievances from June 2025-December 2025, revealed no grievance about the sheets not being changed. Record review of the June 2025-December 2025 resident council minutes revealed that on dates 10/7/25 & 11/4/2025, beds were not being made. The AD was the staff in attendance. During an interview on 12/04/25 at 9:52 AM, The AD stated she had been working in the facility for 2 years. She stated that if a resident wanted to file a grievance, they would talk to her and then she reported it to the SW. Together they would fill out a form with the resident, and it was her understanding that an investigation was then started. The AD stated that after the Resident Council meeting each month, she presented the issues from Resident Council at morning meeting the next day, where all department heads were present. Then the SW or that department head with the issue would take that grievance from resident council and deal with it. The AD stated she felt like the issues were being dealt with. The AD stated that she had a resident on Tuesday, December 2nd, 2025, after the monthly resident council meeting, tell the AD that her bed sheets had not been changed in a month. She stated she took that resident straight to the DON. The AD stated she was not sure what happened with that issue because she did not follow up on it. She stated a possible negative outcome of residents' grievances not being resolved could be they would not feel heard or issues not getting better when they complained. During an interview on 12/04/25 at 10:04 AM, The DON stated that when there was a grievance filed in resident council, if it involved the nursing staff, it would be brought to her attention. When told that many residents during the resident council meeting had stated that their bed sheets were not being changed, the DON stated that sheets were getting changed to her knowledge, and she had not heard about that in morning meeting. She stated that the protocol was nurses were to change the bed sheets 3 times a week when residents received a shower. The DON again stated she thought sheets were being changed per protocol. She stated a negative outcome for residents' grievances not being followed up on could be that they would feel unheard and sheets not being changed regularly could lead to skin breakdown, infection issues, and dignity issues. During an interview on 12/04/25 at 10:57 AM, ADON A stated the SW was the grievance officer but that she was new and had only been working at the facility for about a week or two. She stated that when any issues were brought up during a resident council meeting, the SW, DON, & ADON would address them and do an investigation to decide what needed to be done and what to change. ADON A stated that she was not aware that sheets were not being changed but she had not been in morning meeting for a few weeks. She stated a possible negative outcome for a resident not having their grievance followed up on could be they would feel unheard. On 12/04/25 at 11:10 AM, attempted phone interview with SW was unsuccessful. During an interview on 12/04/25 at 11:43 AM, CNA C stated that she had worked at the facility for one year and when a resident had a complaint they wanted to report as a grievance, she would go to the DON. She stated she believed then that the DON would go to the SW with the issue (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and then up the chain from there. CNA C stated that a possible negative outcome of a resident's grievance not being followed up on could result in them not feeling heard or making the resident sad. On 12/04/25 at 12:11 PM, attempted phone interview with SW was unsuccessful. Record review of facility policy titled Resident Rights and dated December 2016 revealed in part: . Federal and state law guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . u. voice grievances to the facility . v. have the facility respond to his or her grievances . Record review of facility policy titled Resident Council and dated December 13, 2016 revealed in part: The facility will consider views of the resident council and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility .		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure refrigerated, freezer, and pantry items were properly stored, labeled, and dated. This failure could place residents at risk of food-borne illness. Findings included: Observation of the freezer on 12/02/25 at 8:33 AM revealed the following: 1. (1) small Ziploc containing French fries, no label or date. 2. (1) small Ziploc containing chicken nuggets, no label or date. 3. (4) boxes of juice, no label or date. Observation of the pantry on 12/02/25 at 8:26 AM revealed the following: 1. (1) Ziploc bag with open cheese sauce mix bag inside, no label. Date on Ziploc was 5/4-6/4. 2. (1) bag of sloppy joe mix - expired December, 2024. DM threw this item in trash. 3. (1) bag opened pork roast gravy mix, not in a sealed container. 4. (1) box Jiffy corn bread mix in Ziploc, no label or date. Expiration date of 5/22/24. Observation of the walk-in refrigerator on 12/02/25 at 8:42 AM revealed the following: 1. (1) Ziploc containing deli meat, no date or label. In an interview on 12/02/25 at 8:45 AM, [NAME] E stated she had worked at the facility for 8 months and was trained by the RD to label and date everything that comes in. She stated it was everyone's responsibility to label and date food and if this was not happening, staff in the kitchen would not know when food was received or opened and it could make residents sick. In an interview on 12/02/25 at 8:48 AM, [NAME] D stated he had worked at the facility since April of 2025 and everyone who worked in the kitchen was responsible for labeling and dating food. He stated a possible negative outcome was they could possibly serve out of date food which could cause residents to become sick. In an interview on 12/02/25 at 8:52 AM, The DM stated it was everyone's responsibility to label and date food, and that if a staff member opens a box, they are to immediately label and date it. He stated that the RD trained staff so everyone would know how to date/label food and so everyone was on the same page. The DM stated a possible negative outcome for not labeling and dating food could be that residents could get sick. In an interview on 12/02/25 at 12:15 PM, the RD stated she wrote the policy for the facility on labeling and dating food and does in services regularly with kitchen staff based on the policy. She stated this was the only policy for the kitchen that the facility had. Record review of facility policy, titled Labeling and Dating Food not dated, revealed the following information in part: - All food must be dated as to when it was received. - When the food item is removed from the original box, each item must be dated, or container must be dated (i.e. tray or tube or pan). - If a food item does not have its own expiration date, and is shelf stable, it may be kept for a year from receipt. - Once you open a food item, you must date it the day it was opened.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure all residents had the right to formulate an advanced directive for 1 (Resident #24) of 24 residents reviewed for advanced directives. Resident #24 had a DNR in her record that was signed incorrectly by the witnesses. The facility's failure to ensure the accuracy of a residents advanced directive could place residents at risk for not receiving healthcare as per their or their legal representatives' wishes. Findings included: Record review of Resident #24's face sheet printed [DATE] revealed she was a [AGE] year-old female resident admitted to the facility originally on [DATE] and readmitted on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interferes with daily functioning), Alzheimer's (a progressive disease that destroys memory and other important mental functions), and renal insufficiency (a condition where the kidneys do not function properly). In the section Advance Directives Resident #24 is listed as a DNR. Resident #24's last MDS was a quarterly assessment completed [DATE] listing her with a BIMS of 05 indicating she was severely cognitively impaired, and she had a functionality from being dependent on staff for assistance with lower body care to requiring supervision/touch assistance with eating and oral hygiene. Resident #24's care plan with admission date of [DATE] revealed the following: Focus: I/responsible family have an order for DNR. Not Resuscitate (DNR). Record review of the clinical record for Resident #24 revealed an Order Summary printed [DATE] with the following order: DNR Active - Revision Date: [DATE]. Record review of the clinical record for Resident #24 revealed a DNR dated [DATE] (signed by Resident #24's MPOA) with the following: Section - Two Witnesses: (See qualification on backside) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician. -Witness #1 was the current activity director and signed the form on [DATE]. (two days before the MPOA)-Witness #2 was the former social worker and signed the form on [DATE]. (two days before the MPOA) During an interview on [DATE] at 09:57 AM LVN L (the nurse responsible for Resident #24 this shift) reviewed Resident #24 electronic chart and verified Resident #24 was listed as being a DNR. LVN L reported Resident #24 had cancer and was a DNR so if an employee reported to her Resident #24 was not breathing or did not have a heart beat she (LVN L) would first verify the resident condition, then notify management, the Dr, then call 911 to let them know they had a resident that had passed away and the Resident was a DNR. LVN L reported she would not start CPR for Resident #24. LVN L then reviewed Resident #24 DNR form that was in her electronic chart and noted the responsible party signed the DNR form on [DATE] and both witnesses signed the DNR form on [DATE]. LVN then stated, this is not a legitimate form. Now you do CPR. LVN L reported if the DNR form was not completed correctly then the residents will not get coded correctly and this could result in the residents' wishes not being honored. LVN L reported the social worker was the person responsible in the facility for ensuring the DNRs' were completed correctly. During an interview on [DATE] at 11:12 AM the DON reported Resident #24 was a DNR and Resident #24's FM M (who was the MPOA that signed the form) lived out of state and FM M signed the form on [DATE] and uploaded it on [DATE] so they (the facility) would have it. (the DON was noted having difficulty seeing the DNR form and identifying the correct date the MPOA signed the form). The DON reported the former SW M and the current AD signed as the witnesses on Resident #24's DNR form. The DON reported if a DNR was not completed correctly then the facility would not be following the residents' wishes. Record review of the facility provided policy titled Patient Self Determination Act undated, revealed the following: The Health Care Center recognizes the right of each Resident to utilize those advanced directive recognized under stated law and will honor advanced directives developed in accordance with stated law. Record review of the facility provided policy titled (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Advanced Directives Policy and Acknowledgment undated, revealed the following: The facility makes every effort to comply with the end-of-life choices made by competent resident or individual with Medical [NAME] of Attorney. Record review of the OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER-TEXAS DEPARTMENT OF STATE HEALTH SERVICES, revised [DATE] revealed the following: -The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals -In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either section B, C, or E,. -Qualified Witnesses: .One of the witnesses must meet the qualifications in HSC 166.003(2), which requires that at least one of the witnesses not: .be an employee of a health care facility in which the person is a patient if the employee is providing direct patient care to the person or is an officer, director, partner, or business office employee of the health care facility.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents the right to a safe, clean, comfortable, and homelike environment including clean bed linens for 2 (Resident #12 and Resident #78) of 18 residents reviewed for environment.1. The facility failed to ensure Resident #12 had clean sheets.2. The facility failed to ensure Resident #78 had clean sheets and a clean, sanitary room.These failures could lead to residents feeling neglected and/or to infection control issues.Findings Included:1. Record review of Resident #12's admission record dated 12/03/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), weakness, need for assistance with personal care, and muscle weakness.Record review of Resident #12's quarterly MDS assessment completed on 10/13/25 revealed a BIMS score of 15 which indicated intact cognition.Record review of Resident #12's care plan completed 09/12/25 revealed no mention of refusing or resisting care.Record review of Resident #12's bathing schedule for December 2025 revealed she was bathed on 12/01/25 and on 12/03/25.During an observation on 12/02/25 at 09:27 AM Resident #12 was in her bed with HOB raised to seated position. Her bottom sheet was soiled with greenish and tan splotches near her left shoulder.During an observation on 12/02/25 at 12:25 PM Resident #12 was seated in her bed. Her bottom sheet was soiled in the same place near her left shoulder with the same pattern of greenish and tan splotches as previously observed.During an observation on 12/03/25 at 08:43 AM Resident #12 was seated in her bed. Her bottom sheet was soiled in the same place near her left shoulder with the same pattern of greenish and tan splotches as previously observed. She stated staff change her top sheet nearly every day and change her bottom sheet every 4 days.2. Record review of Resident # 78's admission record dated 12/03/25 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, weakness and need for assistance with personal care.Record review of Resident #78's quarterly MDS assessment completed on 09/09/25 revealed a BIMS score of 15 which indicated intact cognition.Record review of Resident #78's care plan completed on 09/05/25 revealed no mention of refusing or resisting care.Record review of Resident #78's bathing schedule for December of 2025 revealed he received a bath on 12/02/25.During an observation and interview on 12/02/25 at 09:31 AM Resident #78 was seated on the edge of his bed. His bottom sheet was soiled with what appeared to be blood on the upper right side of the bed in splotches that formed two vertical parallel lines. There was a bloody tissue on the floor of his room as well as one on the windowsill of his room. He stated the tissues were from his arm. He gestured to his right upper arm. He stated his arm would not quit bleeding.During an observation on 12/02/25 at 12:02 PM Resident #78 was not in his room. The bloody tissue was still on his windowsill, and the blood stains were still on his bottom sheet in the same pattern as observed previously.During an interview on 12/02/25 at 03:07 PM Resident #78 was seated in his wheelchair in his room. The bloody tissue was still in his windowsill, and the blood stains were still on his bottom sheet in the same pattern as observed previously. He stated the blood on his sheet was from his upper right arm.During an interview on 12/02/25 at 03:11 PM SNA N stated CNAs and SNAs are responsible for changing resident's sheets. She stated they change them all the time and anytime there are crumbs on the sheets.During an observation and interview on 12/03/25 at 08:45 AM Resident #78 was seated on the edge of his bed eating his breakfast from the bedside table. His bottom sheet was still stained with blood in the pattern observed previously and the bloody tissue was still on his windowsill next to his bed. He stated he did not know when staff changed his sheets or how often they were changed. He stated, Whenever I say so I guess.During an observation on 12/03/25 at 11:03 AM Resident #78 was seated in his wheelchair in his room. His bottom sheet was (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Heritage Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1009 Clyde St Amarillo, TX 79106	
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	still stained with blood in the pattern observed previously and the bloody tissue was still on the windowsill. During an interview on 12/04/25 at 08:48 AM ADON B stated nurses and CNAs were responsible for changing resident sheets. She stated the sheets were changed on resident shower days. She stated if the sheets were soiled or if a resident just wanted fresh sheets staff were to change them even if it was not a shower day. She stated every time she and DON and ADON A do an in-service they cover sheet changes. ADON B stated she would expect her staff to remove soiled or bloody sheets as soon as they were noticed, clean the mattress with disinfectant spray, let it dry, and apply clean sheets. She stated a possible negative outcome to residents of having soiled or bloody sheets was their dignity of course. During an interview on 12/04/25 at 09:00 AM CNA J stated nurses and aides were responsible for changing resident's sheets. She stated, We change them as needed and also on each shower day. She stated a resident could get skin breakdown if their sheets were left soiled. She stated, It is not sanitary. She stated she had not noticed any blood on Resident #78's sheets. During an interview on 12/04/25 at 09:13 AM HSK K stated if she saw a bloody tissue in a resident's room she would ask a CNA to pick it up. She stated a possible negative outcome of not removing a bloody tissue from a resident's room was Germs would spread. During an interview on 12/04/25 at 09:15 AM RN F stated nurses and CNAs were responsible for changing resident's sheets. She stated sometimes housekeeping staff assisted with sheet changes. She stated sheets were changed every shower day and anytime there was a spill or other issue. RN F stated if she noticed a resident had soiled or bloody sheets she would change their sheets. She stated a possible negative outcome for a resident having dirty sheets was the resident would not feel taken care of. She stated she had seen a bloody tissue in Resident #78's room one time. She stated she had seen blood on his sheets but he refused to have his sheets changed. She stated he picked his skin and that is where the blood on the sheets came from. During an interview on 12/04/25 at 09:56 AM DON stated nurse aides were responsible for changing resident's sheets. She stated the sheets were changed on shower days. DON stated staff had been trained on changing sheets. She stated she and ADONs did rounds to ensure staff were following their training. DON stated she expected her staff to change sheets if they were soiled or bloody. She stated, Of course it is a dignity issue as well as an infection control issue, it is just the decent thing to do. During an interview on 12/04/25 at 10:31 AM HSK SUP stated he expected his staff to clean floors and surfaces when cleaning resident rooms. He stated his staff occasionally helped change resident's sheets when nursing staff let them know they needed assistance. He stated he expected his staff to throw away bloody tissues found in resident rooms. He stated a possible negative outcome of not throwing away bloody tissues was contamination. During an observation on 12/04/25 at 10:38 AM Resident #78 was seated in his wheelchair in his room. His bottom sheet was still stained with blood in the pattern observed previously. Record review of facility policy titled Resident Rights and dated December 2016 revealed the following: . Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence . Record review of facility policy titled, Quality of Life - Homelike Environment and dated May 2017 revealed the following: . Residents are provided with a safe, clean, comfortable and homelike environment . 1. Staff shall provide person-centered care that emphasizes the residents' comfort . 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Clean, sanitary and orderly environment; . e. Clean bed and bath linens . Record review of unnumbered page from the facility's admission packet revealed the following: Statement of Resident Rights You, the resident . have a right to: 1. all care necessary for you to have the highest possible level of health 2. safe, decent and clean conditions .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights and including measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 (Resident #1 and Resident #24) of 18 residents reviewed for comprehensive care plans.1. The facility failed to include Resident #1's oxygen therapy in her care plan.2. The facility failed to include Resident #24's skin lesion in her care plan.These failures could lead to residents not receiving necessary care and/or treatment or receiving inaccurate care/and or treatment.Findings Included:1. Record review of Resident #1's admission record dated 12/04/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, paroxysmal atrial fibrillation (irregular heartbeat) and generalized anxiety disorder (inability to control constant worrying).Record review of Resident #1's admission MDS completed on 09/02/25 revealed a BIMS score of 5 which indicated severely impaired cognition. In section J Health Conditions Resident #1 was coded as having shortness of breath with exertion, when sitting at rest, and when lying flat. Section O Special Treatments, Procedures, and Programs indicated she was receiving oxygen therapy intermittently On Admission and While a Resident.Record review of Resident #1's care plan dated 08/28/25 revealed no mention of oxygen therapy. She was to be monitored for shortness of breath due to heart disease and for difficulty breathing due to high blood pressure.Record review of Resident #1's orders dated 12/04/25 revealed the following order for oxygen therapy with a start date of 12/04/25: Oxygen Via N/C 1-2 L as needed. Code number of liters actively using every day and night shift related to PAROXYSMAL ATRIAL FIBRILLATION.Record review of Resident #1's struck out, discontinued, and completed orders revealed no order for oxygen therapy.Record review of Resident #1's oxygen saturation record revealed 16 entries since her admission to the facility on [DATE]. She was receiving oxygen via NC for the following 8 of those entries: 08/20/25, 08/22/25, 08/23/25, 08/24/25, 08/28/25, 09/02/25, 09/05/25, 09/07/25. The last date of oxygen saturation measurement as of 12/04/25 was 10/31/25.During an observation on 12/02/25 at 10:41 AM Resident #1 was lying on her back in bed with the head of the bed elevated. Her eyes were closed and she was snoring softly. She was receiving oxygen via N/C at 2 L/Min.During an observation and interview on 12/04/25 at 07:38 AM Resident #1 stated regarding her oxygen, I wear it when I need it. When I'm having trouble breathing. Her oxygen concentrator was beside her bed, and the N/C tubing was inside a plastic bag.During an interview on 12/04/25 at 10:11 AM LVN L stated resident #1 received O2 PRN for tachycardia (abnormal heart rhythm and fast heart rate).During an interview on 12/04/25 at 10:44 AM MDS LVN stated she was responsible for care plans. She stated when Resident #1 came to the facility in August she was receiving oxygen therapy due to a respiratory issue, but it was not currently on her care plan because she was not receiving oxygen therapy any longer. When asked why Resident #1 was observed receiving O2 via N/C on 12/02/25, MDS LVN stated, I don't have it documented anywhere that she (Resident #1) is using it (O2). MDS LVN stated an inaccurate care plan would not affect a resident's care because nobody really pays attention to it (care plan).2. Record review of Resident #24's admission record dated 12/04/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and acute kidney failure (sudden episode of kidney failure that happens in hours or days).Record review of Resident #24's quarterly MDS completed on 11/03/25 revealed a BIMS score of 5 which indicated severely impaired cognition. Section M Skin Conditions revealed Resident #24 had an Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion).Record review of Resident #24's care plan (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed 10/09/25 revealed no mention of a lesion or sore. Record review of Resident #24's NP progress note dated 06/04/25 revealed the lesion was biopsied prior to that NP visit and results of the biopsy were pending. Record review of Resident #24's NP progress note dated 08/18/25 revealed the following description of the lesion: . She has a mass on the left side of her cheek that is cancerous. Skin lesion to the face-left side of his [sic] face, I can see a dark color pustular ulcerated lesion (a raised open wound that is crater-like with yellowish pus under the skin), around 1 cm diameter, chronic lesion, no bleeding, no purulence (pus). Record review of Resident #24's progress notes revealed a note dated 11/06/25 when nursing staff contacted Resident #24's family member who is also her power of attorney and discussed the lesion on her face. Her family member was in agreement with treatments but specified that he did not want to do anything that would cause Resident #24 to have more health problems. He requested an email from facility following each of Resident #24's appointments with the oncologist. Record review of the most recent NP progress note dated 11/14/25 revealed Resident #24 would continue to follow up with oncology, but family had decided not to proceed with treatment of the lesion. During an observation on 12/02/25 at 12:28 PM Resident #24 was seated at a table in the dining room. She had a large growth (a circle approximately 2.5 to 3 inches in diameter) on her left cheek between her mouth and her ear. During an observation on 12/02/25 at 01:53 PM Resident #24 was lying in bed. She had a large raised, rough, open area to her left cheek. She stated, regarding the area, It is a bad place, and I want it taken off. I have had it for a while. It is getting bigger, and it seeps. During an interview on 12/04/25 at 08:48 AM ADON B stated a resident having an inaccurate care plan could negatively impact the resident's care. During an interview on 12/04/25 at 09:00 AM CNA J stated a resident's care could be negatively impacted by having an inaccurate care plan in many ways depending on the care the resident required. She stated the care plan included a lot of things we need to know about each resident. During an interview on 12/04/25 at 09:15 AM RN F stated, Honestly, I don't give a rat's ass about a care plan. That is something the state makes us do, we are going to care for them (residents) no matter what and probably do a better job than that care plan. During an interview on 12/04/25 at 09:56 AM DON stated MDS LVN is responsible for care plans. She stated nursing staff contacted MDS LVN when something needed to be added to a care plan. DON stated an inaccurate care plan could result in residents' needs not being met and in correct observations not being done. During an interview on 12/04/25 at 10:44 AM MDS LVN stated she was responsible for care plans. She stated she did not know why she had not included Resident #24's facial lesion in her care plan. Record review of facility policy titled Care Plan - Resident and dated 4-2022 revealed the following: . It is the policy of this home that staff must develop a comprehensive care plan to meet the needs of the resident. Concerns and Problems . Sources are, but not limited to: . 10. All problems identified on all assessments. Remember the resident care plan is the tool used to coordinate all care provided to the resident to be sure care is necessary, appropriate and planned to meet the individual needs of the resident consomant [sic] with the physician's plan of care for the resident. The resident care plan must be kept current at all times.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 remains as free of accident hazards as is possible for 1 (Resident #11) of 18 residents reviewed for accident hazards. The facility failed to ensure Resident #11 did not have a tube of medicated cream and an aerosol can of sanitizing spray in her room. This failure could lead to harm if a resident was to ingest the cream and/or spray their skin with the sanitizing spray. Findings Included: Record review of Resident #11's admission record dated 12/03/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), COPD (inflammation of lung tissue due to non-infectious causes, which results in cough without mucus or phlegm, shortness of breath, and fatigue), and need for assistance with personal care. Record review of Resident #11's quarterly MDS completed on 11/13/25 revealed a BIMS score of 13 which indicated intact cognition. Section GG Functional Abilities revealed Resident #11 was dependent on staff for toileting; bathing and showering; lower body dressing; footwear application and removal; and for all mobility and transfers. Section H Bladder and Bowel revealed she was always incontinent of urine and frequently incontinent of bowel. Section J Health Conditions indicated Resident #11 had shortness of breath with exertion, when sitting at rest, and when lying flat. Record review of Resident #11's care plan completed on 11/13/25 revealed no mention of self-administration of medication. Record review of Resident #11's orders revealed no order for the medicated ointment found on her bedside table. During an observation on 12/02/25 at 10:25 AM Resident #11 was in her bed with HOB raised to seated position. She had a can of sanitizing spray on one bedside table and a tube of medicated ointment on the other bedside table. During an observation on 12/03/25 at 08:53 AM the can of sanitizing spray and the tube of medicated ointment were still on the bedside tables in Resident #11's room. She was not in the room. During an interview on 12/04/25 at 08:48 AM ADON B stated residents could not have sanitizing sprays or medicated creams in their rooms. She stated a possible negative outcome was possible ingestion of the medicated cream or sanitizing spray. During an observation and interview on 12/04/25 at 09:09 AM Resident #11 was in her bed with HOB raised to seated position. She stated she used the medicated ointment on her bottom. She stated she used the sanitizing spray to spray in the air when it smells like poop. During an interview on 12/04/25 at 09:15 AM RN F stated residents were not to have sanitizing spray in their rooms. She stated if the resident could demonstrate to her that they knew how and where to apply a medicated cream she was fine with them having one in their room. She stated, If they (residents) are cognitively there and can demonstrate proper use of it (medicated cream) I feel that is their right to have it there. She stated there was one resident who wandered on Resident #11's hall. RN F stated if a wandering resident who was not cognitively intact ingested a medicated ointment it could result in anything from bellyache to convulsions. Here she mimed holding a phone in her left hand up to her ear and said, Poison Control? During an interview on 12/04/25 at 09:56 AM DON stated residents were not to have sanitizing sprays or medicated creams in their rooms. She stated a possible negative outcome was, They could apply it where they wanted it instead of where it needed to go and if a wanderer got into their room they could get ahold of it. During an interview on 12/04/25 at 01:57 PM ADM stated the facility did not have an accident hazards policy but that the environment policy she provided addressed accident hazards. Record review of the label of the sanitizing spray revealed the following: Hazardous to Humans and Domestic Animals. Caution: Avoid contact with skin or clothing. If on skin. Call a poison control center or doctor for treatment advice. Store in original container in areas inaccessible to small children. Record review of the Safety Data Sheet of the sanitizing spray with revision date of 10/15/19 revealed the following: . HAZARD IDENTIFICATION . Compressed Gas (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	WARNING . Contains gas under pressure; may explode if heated .Record review of the label of the medicated ointment revealed the following: Keep out of reach of children. In case of accidental ingestion contact a physician or Poison Control Center immediately. Active ingredients were lanolin, menthol, petrolatum, and zinc oxide.Record review of an unnumbered page of the facility's admission packet revealed the following: Items Not Allowed in Resident Room . Medications: (included all prescription and Over-the-Counter drugs. Any medicated creams or powders. NOTE: A good rule of thumb has been established by the Food and Drug Administration whereby any products labeled Keep out of reach of children or carries any type of caution label is merchandise that contains ingredients which are harmful if taken without supervision or used in a way not designated. Many of our residents, due to mental impairments or poor eyesight might inadvertently drink or eat some of the above items causing irreparable harm. SAFETY HAZARDS: Aerosol cans of any product that are combustible.Record review of facility policy titled, Quality of Life - Homelike Environment and dated May 2017 revealed the policy did not mention accident hazards, but it did state, . Residents are provided a safe.environment.Record review of an unnumbered page in the facility's admission packet revealed the following: Statement of Resident Rights . 2. Safe, decent and clean conditions .		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice for 1 (Resident #1) of 5 residents reviewed for respiratory care. -Resident #1 was receiving oxygen with no orders for her therapy. This failure could affect residents by placing them at risk for respiratory compromise and associated complications such as shortness of breath, confusion, respiratory failure, infection, and exacerbation of their condition. Findings included: Record review of Resident #1's face sheet dated 12/02/2025 revealed an [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), dementia (a group of thinking and social symptoms that interferes with daily functioning), generalized anxiety disorder (a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and seizures (sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain). Record review of Resident #1's admission MDS completed 8/27/2025 listed her with a BIMS of 5 indicating she was severely cognitively impaired, she had a functionality of being dependent on staff for most of her activities of daily living and was listed on oxygen therapy on admission and while a resident. Record review of Resident #1's care plan with admission date 8/20/2025 revealed no care plan for oxygen use. Record review of Resident #1's order summary report printed 12/04/2025 revealed the following: Oxygen via N/C 1-2L as needed. Code number of liters actively using. Every day and night shift related to Paroxysmal Atrial Fibrillation (I48.0). Start Date: 12/04/2025 at 6:30 PM. -No other orders for oxygen therapy noted. Record review of Resident 1's MAR for the following revealed: December 2025 (current)-no documentation of oxygen therapy. August 2025 (admission)- no documentation of oxygen therapy. During an observation on 12/02/2025 at 10:41 AM Resident #1 was sleeping in her bed with the HOB elevated. Resident #1 was snoring softly and wearing her O2 via NC at 2L/min. During an observation and interview on 12/04/2025 at 7:38 AM Resident #1 was in bed under her covers with her HOB elevated. Resident #1 was awake and alert. Noted was her O2 concentrator next to her with her tubing stored in a plastic bag. Resident #1 stated. I wear it when I need it, when I'm having trouble breathing and I'm doing good this morning. Resident #1 was unable to remember how long she had been in the facility but stated she had been using oxygen, a while. During an interview on 12/04/2025 10:11 AM LVN L reviewed Resident #1 chart and reported she could not find an order for Resident #1 oxygen therapy. LVN L reported Resident #1 received oxygen currently PRN and could have oxygen continuously if needed for tachycardia (a heart rate that is too fast, generally over 100 beats per minute at rest, caused by problems with the hearts electrical signals, making it less efficient at pumping blood). LVN L reported that administering a medication such as oxygen without an order was a medication error and can be considered practicing medicine without a license. LVN L reported she was the individual responsible for verifying all orders for this unit and she will need to verify all of Resident #1's orders and charting again to make sure she did not miss anything else. During an interview on 12/04/2025 at 11:07 AM the DON reported she had been made aware they had an issue with Resident #1 not having an order for her oxygen therapy and to her understanding Resident #1 was not receiving the medication for respiratory needs, it was being given for poor cardiac function. The DON reported the nurse who took the order for the oxygen therapy was responsible for writing the order and including it in the resident's chart, but it would be impossible to determine the nurse who took Resident #1's oxygen order because she (Resident #1) had been on it a while. The DON reported that the facility does a quarterly review to ensure all orders and resident needs are being met. The DON reported that if a resident was receiving medication, they did not have an order for, they could have a negative reaction that could affect their condition. Record review of the facility provided policy titled, Oxygen Safety (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effective 4/2022, revealed the following: Policy:It is the policy of this home to ensure all oxygen administration is conducted in a safe manner.		