STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455569	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage at Longview Healthcare Center	112 Ruthlynn Dr Longview, TX 75605

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 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** 49019 Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 1 of 10 residents reviewed for care plans. (Resident #24) 1.The facility failed to initiate intervention for a fall mate on the comprehensive person-centered care plan for Resident #24 by not including intervention for a fall mat. 2. The facility failed to develop a person-centered Hospice care plan for Resident #24 to meet medical, nursing, mental and psychosocial needs. These failures could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services. Findings include: Record review of Resident #24 Admission Record indicated she was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included encephalopathy (a broad term for any brain disease that alters brain function or structure) , Nontraumatic intracerebral hemorrhage (most commonly results from hypertensive damage to blood vessel walls) , malignant neoplasm of temporal lobe (Brain tumor of the temporal lobe) , protein-calorie malnutrition (an energy deficit due to deficiency of all macronutrients, but primarily protein) , Diabetes with hyperglycemia (high levels of blood glucose) ,age-related osteoporosis (causes bone become weak and brittle) and muscle weakness. Record review of Resident #24's MDS dated [DATE] revealed that the resident had a BIMS score of 01 which indicated cognition was severely impaired. The MDS also revealed, Resident #24 required extensive assistance for transfers and bed mobility. The MDS did not indicate Resident #24 was on hospice or at risk for falls. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #24's Care Plan dated 7/24/2024 revealed the facility-initiated fall precautions on 4/23/2023 related to deconditioning, gait/balance problems, psychoactive drug use and vision and hearing problems. The care plan interventions included anticipation and meet the needs of the resident, resident call light within reach and encourage to use for assistance, keep furniture in locked position, staff x1 person with transfers, and needs of a safe environment with: even floors, free from spills and/or clutter, adequate, glare free light; a working and reachable call light, the bed in low position at night; handrails on walls, personal items within reach. Further review of the care plan revealed hospice care was not addressed. Record Review of Physician's Telephone/Verbal Orders dated 7/11/2023 at 5:00 p.m., indicated Resident #24 had orders faxed from Hospice company to admit for services with Diagnosis of Hemorrhagic CVA by Hospice Physician B. Hospice Physician B discontinued all non-comfort meds, code status DNR, may pleasure feed pureed diet, skin prep every shift to bilateral heels, may crush all meds and give sublingual and new medication Lorazepam 1 mg to be administered every 4 hours by mouth or sublingual for anxiety or agitation, Levsin 0.125 mg 1 tablet by mouth or sublingual every 4 hours as needed for secretions, Ondansetron 4 mg 1 tablet by mouth or sublingual every 4 hours as needed for nausea or vomiting, Bisacodyl 10 mg 1 suppository every 12 hours as needed for constipation and acetaminophen 650 mg 1 suppository every 4 hours as needed for fever. Record Review of Physician Certification of Terminal Illness consent dated 7/11/2023 was signed and dated by RP on 7/11/2023. During an interview on 5/21/2024 at 3:07 p.m., LVN A said Resident #24 had gotten out bed and was on the floor. He reported Resident #24 caught the corner of the bed and was found on the floor mat in place. LVN A said she was already on hospice care for cancer. LVN A said Resident #24 was sent out for evaluation. During an interview on 5/22/2024 at 11:28 a.m., the RP said she did not think Resident #24 was on hospice until after her fall. The RP stated the decision was made to place her mother on Hospice care and return to the facility. During an interview on 5/22/2024 at 1:49 p.m., the MDS said currently the ADON will put in the admission care plan and then she would do follow-up and update the acute care plan or anything additional that would come up in the care plan meetings. The MDS nurse said the care plans should be updated within 24 hours of occurrence and if a resident was placed on hospice care, the care plans should be updated immediately. The MDS nurse said she had 14 days to complete the significant change in condition. During an interview on 5/22/2024 at 2:06 p.m., the DON said she believeds Resident #24 had a fall mat in place but was not sure if Resident #24 was a fall risk and she was not sure if the resident had a care plan for falls. The DON said Resident #24 was placed on Hospice care before her last fall. The DON said when a resident was placed on Hospice care, it would be care planned and the MDS coordinator was responsible for updating the care plan. The DON said she did not think the facility had the same MDS coordinator and the current MDS coordinator had only been at the facility for a few months. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2024 at 2:28 p.m., the ADM said Resident #24 had fall interventions in place. The ADM said Resident #24 attempted to get up and fell , hitting her head on the bedside table. The ADM said Resident #24 had a brain tumor. The ADM was not sure if Resident # 24 was on hospice prior to her falling and hitting her head. The ADM said when Resident #24 went to the hospital, it was determined she had a brain bleed. The ADM said he would assume if a resident was on hospice care, it would be care planned. The ADM said the facility had stand-up meetings and care plans were discussed daily on what needed to be updated on the care plans. The ADM said he does not know if the facility would have care planned or how the care plan was entered. Record review of a facility policy undated titled 'Comprehensive Care Planning revealed The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . The facility will establish, document, and implement the care and services to be provided for each resident to assist in attaining or maintaining his or her highest practical quality of life. Resident's preferences and goals may change throughout their stay, so facilities should have ongoing discussions with resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.