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	02/19/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on interview and record review, the facility failed to consult with the physician when the resident experienced a change in condition for one (Resident #1) of three residents reviewed for a change of condition. The facility failed to notify the responsible party or family of a change in condition for Resident #1 after finding a new wound on her buttocks on 7/22/2024. This failure could affect residents by placing them at risk for a delay in medical treatment, worsening in condition. Findings included: Record review of the face sheet dated 2/13/2025 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke), paranoid schizophrenia (hallucinations, delusions, and disorganized speech), contractures of left and right knee (permanent shortening or tightening of muscles, tendons, ligaments, or skin), dementia (decline in memory, thinking, reasoning, and problem solving). Record review of the face sheet dated 2/13/2025 indicated Resident #1's daughter was her responsible party with a phone number and a directive to please text the daughter. Record review of the quarterly MDS dated [DATE] indicated Resident #1 usually understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS score of 03 which indicated severe cognitive impairment. The MDS indicated Resident #1 required was completely dependent on staff for all activities of daily living. The MDS indicated Resident #1 was dependent with transfers. The MDS indicated Resident #1 was at risk for developing pressure ulcers/injuries. The MDS indicated Resident #1 did not have any unhealed pressure ulcers/injuries. Record review of the discharge MDS dated [DATE] indicated Resident #1 did not have any unhealed pressure ulcers/injuries. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the care plan last revised on 8/05/2024 indicated Resident #1 had the potential for pressure ulcer development due to decreased mobility, incontinence and decreased cognition with interventions that included: 1. Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. 2. Follow facility policies/protocols for the prevention/treatment of skin breakdown. 3. Incontinent care after each episode and apply moisture barrier. 4. Inform the resident/family/caregivers of any new skin breakdown . 6. Notify the nurse immediately of any new areas of skin breakdown: Open area, Redness, Blisters, Bruises, discoloration noted during bath or daily care . Record review of the physician orders dated 7/25/2024 indicated Resident #1 had an order to: 1. Non-pressure-left and right buttocks-cleanse area with normal saline pat dry apply calcium alginate and cover with a dry dressing daily PRN soiled/dislodgement as needed with an order date of 7/23/2024 and an order start date of 7/23/2024. 2. Non-pressure-left and right buttocks-cleanse area with normal saline pat dry apply calcium alginate and cover with a dry dressing daily PRN soiled/dislodgement one time a day with an order date of 7/23/24 and an order start date of 7/24/2024. Record review of Braden Scale for Predicting Pressure Sore Risk dated 8/4/2023 revealed Resident #1's score of 9 which indicated Resident #1 was at high risk for developing a pressure sore. Record review of Weekly Skin Assessment-V 5 dated 7/19/2024 indicated Resident #1 did not have any moisture associated skin damage or pressure, venous, arterial, or diabetic ulcers. Record review of eTransfer Form-V6 dated 7/25/2024 indicated Resident #1 was sent to the hospital for the following: Resident partially opening her eyes to verbal and tactile stimulus. Non verbal. No facial dropping noted. Generalized weakness. Will not squeeze my hands. Rapid shallow breathing noted. Sending out for possible AMS [altered mental status]. The form indicated Resident #1 had special treatments and precautions of: contact infection control precautions for an infection of the buttocks. The form indicated Resident #1 was on EBP (enhanced barrier precautions). The form indicated Resident #1 was receiving wound treatment with a current wound to the buttocks. The form indicated Resident #1's responsible party (daughter) was notified on 7/25/2024 at 9:30 AM of the transfer. Record review of Resident #1's nursing progress note completed on 7/26/2024 as a Late Entry for 7/22/2024 indicated the CNA C informed LVN A that she was doing care on Resident #1 and wanted LVN A to look at Resident #1's bottom. CNA C helped LVN A to assess Resident #1's bottom by rolling her on her side. Resident #1 was noted to have MASD (moisture associated skin damage) to bilateral buttocks. LVN A documented to wound bed was pink in color with no drainage noted. LVN A documented there were no signs or symptoms of infection noted. LVN A documented the edges were attached. LVN A documented he consulted the NP (nurse practitioner) about Resident #1's buttocks with recommendation noted till treatment nurse could assess. LVN A documented cleanse area with soap and water, pat dry and apply clean dry dressing. LVN A documented treatment was initiated at that time. LVN A documented he would advise treatment nurse of findings to follow up on NP (nurse practitioner) recommendation. Record review of Resident #1's nursing progress note completed on 7/26/2024 at 1:32 PM the ADON documented on 7/23/2024 at 1:31 PM Non-pressure-left and right buttocks-cleanse area with N/S [normal saline] pat dry apply calcium alginate and cover with a dry dressing daily PRN soiled/dislodgement as needed. Treatment Administered Daily. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nursing progress note completed on 7/26/2024 at 1:33 PM the ADON documented on 7/23/2024 at 2:32 PM Non-pressure-left and right buttocks-cleanse area with N/S [normal saline] pat dry apply calcium alginate and cover with a dry dressing daily PRN soiled/dislodgement as needed. PRN Administration was: Effective. Dressing was changed after bath. Record review of Resident #1's nursing progress note completed on 7/23/2024 at 10:57 PM, LVN D documented she called residents daughter to give update on resident with no answer. Record review of Resident #1's nursing progress note completed on 7/26/2024 at 1:34 PM the ADON documented on 7/24/2024 at 10:33 AM Non-pressure-left and right buttocks-cleanse area with N/S [normal saline] pat dry apply calcium alginate and cover with a dry dressing daily PRN soiled/dislodgement as needed. Wound care provided by charge nurse and ADON. Record review of Resident #1's nursing progress note completed on 7/25/2024 at 9:49 AM LVN A documented on 7/25/2024 at 9:35 AM Resident this morning presenting with possible AMS [altered mental status]. Resident partially opening her eyes to verbal and tactile stimulus. Resident nonverbal this morning. Residents' tardive dyskinesia [chronic involuntary movement disorder] is generally very active and this morning it is very mild. Resident will not squeeze my fingers on command. No facial Dropping noted. Generalized weakness noted with her extremities and trunk. Rapid shallow breathing noted . Talked to NP [nurse practitioner] and informed of resident's current status with order to send to [hospital emergency room] for eval and tx [treatment] due to AMS [altered mental status]. Daughter .notified and ok with transfer to [hospital emergency room]. 911 initiated and resident was transported per stretcher via ambulance to [hospital emergency room] at this time. All paperwork sent with EMS [emergency medical services] for them and ER [emergency room]. During a phone interview on 2/12/2025 at 12:25pm with Resident #1's RP (responsible party), she said neither she nor her sister had been notified that Resident #1 had developed any kind of skin problem. She said it was not until she got to the hospital emergency room that she was notified that Resident #1 had an unstageable wound to her sacral (upper buttocks) area. During an interview on 2/12/2025 at 3:22 PM the ADON said she was not aware of Resident #1 had a wound until the day on 7/22/2024 when LVN A was notified by CNA C. She said she never notified Resident #1's responsible party or any family. During an interview on 2/13/2025 at 10:30 AM the DON said if a new skin area was identified and the treatment nurse was not available, the residents charge nurse was to notify the MD and Responsible. During a phone interview on 2/13/2025 at 11:58 AM LVN A said he thought he remembered notifying the daughter that night but didn't know who it was that he talked to. He said he notified the wound care nurse to look at it by putting a paper note in her box for the next day for her to address. During an interview on 2/19/2025 at 2:02 PM the Administrator said his expectation was for the nurses to notify the resident's responsible party. Record review of the facility policy Notify the Physician of Change in Status revised on March 11, 2013, indicated: .5. The resident's family member or legal guardian should be notified of significant change in resident's status unless the resident has specified otherwise. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facilities policy Pressure Injury: Prevention, Assessment and Treatment revised on 8/12/2016 indicated: 3. Upon assessment and identification of a pressure sore the staff nurse will notify the treatment nurse/designee. The treatment nurse/designee will: 1. Notify the physician of pressure sore and obtain and follow any orders as directed by the physician. 2. Notify family and dietary department. Document notification .

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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** 47339 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs for 1 of 3 residents (Residents #2) reviewed for care plans. The facility failed to implement Resident #2's care plan by not changing the dressing to her diabetic ulcer on the left second toe daily. On 2/12/2025 Resident #2's dressing was dated for 2/9/2025. This failure could place residents at risk of not receiving appropriate care and interventions to meet their current needs. Findings include: Record review of a face sheet for Resident #2 dated 2/18/2025 indicated that Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: diastolic congestive heart failure (left ventricle of the heart cannot relax normally), protein calorie malnutrition (reduced availability of nutrients), type 2 diabetes mellitus (high blood sugar levels). Record review of an Admission MDS assessment dated [DATE] for Resident #2 indicated she had a BIMS score of 13, indicating intact cognition. Section M of same MDS assessment indicated that she was at risk of developing pressure ulcers/injuries and Resident #2 did not have any diabetic foot ulcers. Record review of a care plan for Resident #2 dated 2/13/2025 indicated Resident #2 had a diabetic ulcer to left second toe with interventions that included: Administer treatments as ordered and monitor for effectiveness. Record review of physician orders for Resident #2 dated 1/17/2025 indicated: Left foot 2nd toe-cleanse area with N/S [normal saline] pat dry apply silvasorb gel to wound with [NAME] peri-wound cover with dry foam and secure with tape PRN [as needed] soiled/dislodgement one time a day. Record review of the treatment administration record dated 2/18/2025 indicated Resident #2 had not received treatment to the left foot 2nd toe on 2/9/2025, 2/10/2025, and 2/11/2025. Record review of physician's progress note dated 2/6/2025 indicated: Patient here with her [family member] very concerned that her mother is not getting good care for her left second toe. She states the bandage is not changed initially . During an observation and interview on 2/12/2025 at 10:10 AM with Resident #2's family member said she was concerned that Resident #2 was not getting wound per the physician's orders. She said on 2/12/2025 Resident #2's dressing to the left foot 2nd toe had not been changed since 2/9/2025. She said Resident #2's dressing changes had not been getting changed daily as ordered. She said she had addressed the issue with the ADON previously. Observation of Resident #2's left foot 2nd toe revealed a dressing dated 2/9/25. (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 2/19/2025 at 1:23 PM the DON said she did not know why Resident #2's treatment to her left 2nd toe had not been done. She said by not having her treatment done per the physician's orders could cause the residents wound to become worse. During an interview on 2/19/2025 at 2:02 PM the Administrator said his expectation was for all wound care to be done as per the physician's orders. He said it just was not done on Resident #2. He said he was told the treatment nurse was out sick but the charge nurse should have completed the wound care. He said by not receiving the wound care per physician orders and the care plan it could cause the wound to become worse. During an interview on 2/19/2025 at 3:15 PM the ADON said she did not know why the wound care had not been completed on Resident #2. Record review of the facilities policy Pressure Injury: Prevention, Assessment and Treatment revised on 8/12/2016 indicated: 3. Upon assessment and identification of a pressure sore the staff nurse will notify the treatment nurse/designee. The treatment nurse/designee will: 1. Notify the physician of pressure sore and obtain and follow any orders as directed by the physician. 2. Notify family and dietary department. Document notification . 6. Nursing Action/Rationale: 1. Prevention: The nurse can assist in the prevention of pressure injuries by performing the following nursing interventions: Note: Add any interventions to care plan . 3. Keep bed clean, dry and free of wrinkles. 4. Encourage physical activity that stimulates circulation such as active and passive range of motion exercises. 5. Maintain body alignment with support for body parts; pillows, cradles, pads, heel/elbow protectors, and mattresses can be used to help relieve pressure . 9. Assess for early signs of skin breakdown and report any abnormal findings. Early signs of pressure sores include redness, tenderness and swelling of the skin. Notify Treatment Nurse/designee of any potential problems by completing Skin Concern Notification Worksheet. 10. Treatment Nurse/designee or Director of Nursing will assess site and evaluate for appropriate stage as listed in this procedure. Notify physician; obtain an order and monitor site daily. Sign off on treatment sheet any treatment completed (i.e., Stage I through Stage IV) .

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on interviews and record review, the facility failed to ensure the necessary treatment and services, in accordance with comprehensive assessment and professional standards of practice, to prevent development of pressure injuries was provided for 1 of 3 Residents (Resident #1) reviewed for pressure injuries. The facility failed to implement interventions to prevent Resident #1 from developing a facility acquired unstageable pressure ulcer. The facility failed to identify and treat an unstageable pressure ulcer to Resident #1's sacral area. The facility failed to identify residents who are at risk for pressure ulcer development. An IJ was identified on 2/18/2025 at 3:49 PM. The IJ template was provided to the facility on [DATE] at 3:49 PM. While the IJ was removed on 2/19/2025 at 3:30 PM, the facility remained out of compliance at a severity of no actual harm with the potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for new development or worsening of existing pressure injuries, pain, decreased quality of life, and hospitalization . Findings included: Record review of the face sheet dated 2/13/2025 indicated Resident #1 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke), paranoid schizophrenia (hallucinations, delusions, and disorganized speech), contractures of left and right knee (permanent shortening or tightening of muscles, tendons, ligaments, or skin), dementia (decline in memory, thinking, reasoning, and problem solving). Record review of the quarterly MDS dated [DATE] indicated Resident #1 usually understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS score of 03 which indicated severe cognitive impairment. The MDS indicated Resident #1 required was completely dependent on staff for all activities of daily living. The MDS indicated Resident #1 was dependent with transfers. The MDS indicated Resident #1 was at risk for developing pressure ulcers/injuries. The MDS indicated Resident #1 did not have any unhealed pressure ulcers/injuries. Record review of the discharge MDS dated [DATE] indicated Resident #1 did not have any unhealed pressure ulcers/injuries. Record review of the care plan last revised on 4/25/2023 indicated Resident #1 had the potential for pressure ulcer development due to decreased mobility, incontinence and decreased cognition with interventions that included: (continued on next page)

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	455569	A. Building B. Wing	02/19/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. 2. Follow facility policies/protocols for the prevention/treatment of skin breakdown. 3. Incontinent care after each episode and apply moisture barrier. 4. Inform the resident/family/caregivers of any new skin breakdown . 6. Notify the nurse immediately of any new areas of skin breakdown: Open area, Redness, Blisters, Bruises, discoloration noted during bath or daily care . Record review of Braden Scale for Predicting Pressure Sore Risk dated 8/4/2023 revealed Resident #1's score of 9 which indicated Resident #1 was at high risk for developing a pressure sore. Record review of Weekly Skin Assessment-V 5 dated 7/19/2024 indicated Resident #1 did not have any moisture associated skin damage or pressure, venous, arterial or diabetic ulcers. Record review of Resident #1's clinical record from 7/19/2024 to 7/25/2024 revealed Resident #1 did not have a documented skin assessment with wound measurements or description of sacral wound. Record review of the physician orders dated 7/25/2024 indicated Resident #1 had the following orders: 1. Non pressure-left and right buttocks-cleanse area with normal saline pat dry apply calcium alginate and cover with a dry dressing daily PRN soiled/dislodgement as needed with an order date of 7/23/2024 and an order start date of 7/23/2024. 2. Non pressure-left and right buttocks-cleanse area with normal saline pat dry apply calcium alginate and cover with a dry dressing daily PRN soiled/dislodgement one time a day with an order date of 7/23/2024 and an order start date of 7/24/2024. Record review of the treatment administration record for July 2024 indicated Resident #1 had the following treatment: Non pressure-left and right buttocks-cleanse area with normal saline pat dry apply calcium alginate and cover with a dry dressing daily PRN soiled/dislodgement completed on the following dates: 1. 7/23/24 completed by the ADON 2. 7/24/24 completed by the ADON and RN B 3. 7/25/24 completed by LVN A. (continued on next page)

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	455569	A. Building B. Wing	02/19/2025

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/19/2025 at 3:15 PM the ADON said she provided wound care to Resident #1 prior to her being discharged to the hospital. She said Resident #1 had moisture associated skin damage to her buttocks, but she did not see an unstageable to her sacral area. She said she must have forgotten to sign off on the treatment administration record and that was why on 7/26/2024 she signed the treatment administration record for the dates of 7/23/2024 and 7/24/2024. She said yes it had been discussed in the morning meeting that Resident #1's Responsible party called and said Resident #1 would not be returning to the facility due to Resident #1 receiving the wound while at the facility. Record review of Resident #1's nursing progress note completed on 7/26/2024 as a Late Entry for 7/22/2024 indicated the CNA C informed LVN A that she was doing care on Resident #1 and wanted LVN A to look at Resident #1's bottom. CNA C helped LVN A to assess Resident #1's bottom by rolling her on her side. Resident #1 was noted to have MASD (moisture associated skin damage) to bilateral buttocks. LVN A documented to wound bed was pink in color with no drainage noted. LVN A documented there were no signs or symptoms of infection noted. LVN A documented the edges were attached. LVN A documented he consulted the NP (nurse practitioner) about Resident #1's buttocks with recommendation noted till treatment nurse could assess. LVN A documented cleanse area with soap and water, pat dry and apply clean dry dressing. LVN A documented treatment was initiated at that time. LVN A documented he would advise treatment nurse of findings to follow up on NP (nurse practitioner) recommendation. LVN A did not document that he notified any family or family representative of the new skin breakdown or new order received from the NP (nurse practitioner). Record review of Resident #1's nursing progress note completed on 7/26/2024 at 1:32 PM the ADON documented on 7/23/2024 at 1:31 PM Non pressure-left and right buttocks-cleanse area with N/S [normal saline] pat dry apply calcium alginate and cover with a dry dressing daily PRN soiled/dislodgement as needed. Treatment Administered Daily. Record review of Resident #1's nursing progress note completed on 7/26/2024 at 1:33 PM the ADON documented on 7/23/2024 at 2:32 PM Non pressure-left and right buttocks-cleanse area with N/S [normal saline] pat dry apply calcium alginate and cover with a dry dressing daily PRN soiled/dislodgement as needed. PRN Administration was: Effective. Dressing was changed after bath. Record review of Resident #1's nursing progress note completed on 7/23/2024 at 10:57 PM, LVN D documented she called residents family member to give update on resident with no answer. Record review of Resident #1's nursing progress note completed on 7/26/2024 at 1:34 PM the ADON documented on 7/24/2024 at 10:33 AM Non pressure-left and right buttocks-cleanse area with N/S [normal saline] pat dry apply calcium alginate and cover with a dry dressing daily PRN soiled/dislodgement as needed. Wound care provided by charge nurse and ADON. Record review of CTNR Shower Sheets dated 7/24/2024 signed by CNA E indicated Resident #1 had an open area to her buttocks area. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's nursing progress note completed on 7/25/2024 at 9:49 AM LVN A documented on 7/25/2024 at 9:35 AM Resident this morning presenting with possible AMS [altered mental status]. Resident partially opening her eyes to verbal and tactile stimulus. Resident nonverbal this morning. Residents tardive dyskinesia [chronic involuntary movement disorder] is generally very active and this morning it is very mild. Resident will not squeeze my fingers on command. No facial Dropping noted. Generalized weakness noted with her extremities and trunk. Rapid shallow breathing noted . Talked to NP [nurse practitioner] and informed of residents current status with order to send to [hospital emergency room] for eval and tx [treatment] due to AMS [altered mental status]. [family member] .notified and ok with transfer to [hospital emergency room]. 911 initiated and resident was transported per stretcher via ambulance to [hospital emergency room] at this time. All paperwork sent with EMS [emergency medical services] for them and ER [emergency room]. Record review of eTransfer Form-V6 dated 7/25/2024 indicated Resident #1 was sent to the hospital for the following: Resident partially opening her eyes to verbal and tactile stimulus. Non verbal. No facial dropping noted. Generalized weakness. Will not squeeze my hands. Rapid shallow breathing noted. Sending out for possible AMS [altered mental status]. The form indicated Resident #1 had special treatments and precautions of: contact infection control precautions for an infection of the buttocks. The form indicated Resident #1 was on EBP (enhanced barrier precautions). The form indicated Resident #1 was receiving wound treatment with a current wound to the buttocks. Record review of hospital Disclosure and Consent Medical Care and Surgical Procedure dated 8/4/2024 at 12:16 PM for wound debridement indicated Resident #1's condition was infected wound of the sacral area measuring 3cm x 3.5cm x2cm that was classified as unstageable. Record review of a picture taken at the hospital dated 7/25/2024 at 7:48 PM indicated Resident #1 had an unstageable wound to the sacral area measuring 3cm x 3.5cm x 2cm. Record review of the hospital paperwork dated 7/25/2024 indicated admitting diagnosess of metabolic encephalopathy and pressure injury of sacral region, unstageable. During a phone interview on 2/12/2025 at 12:25pm with Resident #1's RP (responsible party), she said neither she nor her family members had been notified that Resident #1 had developed any kind of skin problem. She said it was not until she got to the hospital emergency room that she was notified that Resident #1 had an unstageable wound to her sacral (upper buttocks) area. She said when she saw the area she took pictures and the wound was horrible. She said she made the decision in the hospital emergency room that Resident #1 would not be returning to the facility due to the unstageable wound she had received while at the facility. During an interview on 2/12/2025 at 3:22 PM the ADON said she was not aware of Resident #1 had a wound until the day on 7/22/2024 when LVN A was notified by CNA C. She said when she saw Resident #1's bottom there was old scar tissue in the sacral area but what she treated was on the actual buttocks area and that was red with spots of blood like a scrape. She said she never saw a wound on the sacrum. She said it was possible that the necrotic tissue could have been mistaken for moisture associated skin damage tissue. She said the treatment nurse was responsible for doing weekly skin assessments. (continued on next page)

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	455569	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/13/2025 at 10:30 AM the DON said she went and looked at Resident #1 buttocks when a CNA asked her to look at the resident because she needed her to put a new dressing on the resident. She said the wound was on the right buttock and seemed like someone had pulled her across the bed and caused the top layer of skin to come off. She said she cleaned the wound and applied calcium alginate to the wound. She said she did not remember anything being on Resident #1's left buttock. She said she only remembered applying a dressing to one buttock on the right side. She said she did not remember seeing anything to Resident #1's sacral area. She said Resident #1 had scarring due to old pressure areas that had healed. The DON said she thought the area to the sacrum could have been missed due to Resident #1's skin coloration. She said she had a conversation with one of Resident #1's family member about the resident being in the bed by 5pm and the family member wanted her up all day and she explained that it was not good for Resident #1. She said she never staged or classified Resident #1's wound. She said she would have classified the wound as MASD (moisture associated skin damage). The DON said a skin notification worksheet was not completed and did not know why. She said the treatment nurse goes to the nurse's station and looked at the 24-hour report to check for any new skin issues every day when she came to work. The DON said if a new skin area was identified and the treatment nurse was not available, the residents charge nurse was to notify the MD and put a treatment in place, if the treatment nurse was at the facility, then it was her responsibility. She said the nurse that initially identified a new wound was supposed to do measurements, but it was not done on Resident #1. She said once the treatment nurse assessed the wound then she was supposed to measure the wound, then the resident should have been seen by the Wound Care Doctor weekly and the Wound Care Doctor would then do the measurements weekly. The DON said she made rounds with the Wound Care Doctor if the treatment nurse was not at the facility and if she was there then she looked at the worst wounds. She said the Wound Care Doctor came every Wednesday to the facility. The DON said the Wound Care Doctor never saw Resident #1 and did not know why. During a phone interview on 2/13/2025 at 11:58 AM LVN A said the CNA C asked him to look at Resident #1's buttocks. He said the wound he saw was in her gluteal fold, low sacral area to the right. He said when he assessed the wound it was not bleeding and looked like moisture associated skin damage red area to him. He said to best of his knowledge he did not see anything that he could remember in the sacral area. He said he wiped and applied barrier cream to the area. He said he did not measure the wound. LVN A said he thought he remembered notifying the family member that night but did not know who it was. He said he notified the wound care nurse to look at it by putting a paper note in her box for the next day for her to address. During a telephone interview on 2/13/2025 at 12:34 PM CNA C said she had been a CNA for [AGE] years and had taken care of a lot of residents with wounds. She said she remembered reporting an open wound on the top of Resident #1's sacrum and reported it to LVN A. CNA C said on the next day when she came back to work, she did not see a dressing on Resident #1's wound. She said she took a picture of Resident #1's wound and took her phone to the nurse's station and showed it to LVN A and told him it was bad. CNA C said the wound on Resident #1 was on the upper middle crease of the residents' buttocks and it was a bad bed sore that was open with dead tissue. She said she never reported the wound to anyone else other than LVN A. During an interview on 2/13/2025 at 1:19 PM CNA E said she worked with Resident #1 prior to her discharging from the facility but was not working the day Resident #1 left the facility. She said Resident #1 had a place on her buttocks that looked like carpet burn like a little scrape on it. She said they were putting barrier cream on it. CNA E said she saw a pink area on her buttocks but never saw an area on her sacrum. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/13/2025 at 1:40 PM CNA F said when Resident #1 discharged from the facility she had a skin tear on her bottom. She said the wound on Resident #1's bottom looked like a burn with pus and redness. She said she had reported it to the Treatment Nurse and the Treatment Nurse was treating the wound. CNA F said it looked like the picture of the residents wound that was showed to the CNA. Said she always reports any skin issues to the nurse or treatment nurse. During a telephone interview on 2/13/2025 at 4:30 PM the Wound Care Doctor said she had never seen Resident #1. During an interview on 2/19/2025 at 9:30 AM MDS LVN said there was a morning clinical meeting every morning and the staff nurses report to the administrative nurses on any resident issues. She said she remembered LVN A said in the morning clinical meeting that he had assessed Resident #1 and she did not have any open areas. The MDS LVN said she was never notified Resident #1 had a skin issue. She said she remembered the BOM said in the morning meeting 7/26/2024 that Resident #1's family member had called said Resident #1 would not be returning to the facility due to her having an unknown wound that she had gotten while at the facility. During an interview on 2/19/2025 at 1:23 PM the DON said her expectation for pressure ulcers was for the nurse to measure, stage, notify the physician, responsible party and dietician. She said the nurse should also make sure treatment orders were in place. Said most of the nurses have gone through the wound care training course. She said LVN's cannot stage or classify a wound so either she or the Wound Care Doctor would stage it or classify the wound by the next day. She said she was not sure how the wound on Resident #1 got missed, she said all she saw was Resident #1's right buttock and did not see the unstageable wound. She said Resident #1's family called the BOM and said they were not bringing Resident #1 back due to the wound that she had received while at the facility. The DON said there was no notification to Resident #1's Responsible Party because they were not aware that Resident #1 had a wound. She said her expectation was if there was an order for a treatment, she expected it to be done and that nurses are responsible for total patient care. During an interview on 2/19/2025 at 2:02 PM the Administrator said skin assessments should be completed on admission/readmission and weekly. He said his expectation was for the nurses to identify and treat wounds per the physicians' orders and plan of care. Record review of Licensed Nurse Proficiency Audit dated 11/09/2024 indicated LVN A had shown satisfactory performance with dressing changes. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facilities policy Pressure Injury: Prevention, Assessment and Treatment revised on 8/12/2016 indicated: 3. Upon assessment and identification of a pressure sore the staff nurse will notify the treatment nurse/designee. The treatment nurse/designee will: 1. Notify the physician of pressure sore and obtain and follow any orders as directed by the physician. 2. Notify family and dietary department. Document notification . 6. Nursing Action/Rationale: 1. Prevention: The nurse can assist in the prevention of pressure injuries by performing the following nursing interventions: Note: Add any interventions to care plan . 3. Keep bed clean, dry and free of wrinkles. 4. Encourage physical activity that stimulates circulation such as active and passive range of motion exercises. 5. Maintain body alignment with support for body parts; pillows, cradles, pads, heel/elbow protectors, and mattresses can be used to help relieve pressure . 9. Assess for early signs of skin breakdown and report any abnormal findings. Early signs of pressure sores include redness, tenderness and swelling of the skin. Notify Treatment Nurse/designee of any potential problems by completing Skin Concern Notification Worksheet. 10. Treatment Nurse/designee or Director of Nursing will assess site and evaluate for appropriate stage as listed in this procedure. Notify physician; obtain an order and monitor site daily. Sign off on treatment sheet any treatment completed (i.e., Stage I through Stage IV). 11. Director of Nursing or designee to inservice nurses and CNAs on above prevention . Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed. 7. Nursing Care Plan. 1. Identify the problem of pressure injuries on the Nursing Care Plan. 2. Under Nursing Intervention, list physician ordered treatments. 3. Staffing definitions recognize the following limitations: . When necrosis is present accurate staging of the pressure injury is not possible until the necrosis has sloughed or the wound has been debrided . Assessment of the pressure injury should also include the site, size, and W x Lx D, of the injury. Surrounding tissue, color, exudate, wound edges, sinus tracts, odor, tunneling and undermining should also be documented at least weekly and upon decline. An Immediate Jeopardy (IJ) was identified on 2/18/2025 at 3:49 PM due to the above failures. The facility Administrator was notified. The Administrator was provided with the IJ template on 2/18/2025 at 3:49 PM. The following plan of removal submitted by the facility was accepted on 2/18/2025 at 5:30 PM: Plan of Removal Problem: F686- Failure to Provide Treatment/Services to Prevent/Heal Pressure Ulcer Interventions: Resident #1 no longer resides in the facility as of 2/18/25. A head-to-toe assessment was completed on all residents as of 2/18/25 by the DON/ADON/MDS/Compliance Nurse. The MD was notified as of 2/18/25 on all residents with pressure wounds by the DON. Orders were received for treatment and implemented as of 2/18/25 by the Treatment and Charge Nurses. Weekly ulcer assessments and non-ulcer assessments were completed as of 2/18/25 to include measurements by DON/ADON/MDS/Compliance Nurse. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Dietician was notified as of 2/18/25 of all residents with pressure wounds by the DON. All residents with pressure wounds have appropriate supplements in place to promote wound healing. Reviewed and completed by the DON and Compliance Nurse as of 2/18/25. The Dietician and Physician will be notified for recommendations/orders when new or worsening pressure wounds are identified by the DON and Treatment Nurse. This will start 2/18/25. All wound care orders were reviewed as of 2/18/25 by DON, ADON, and Compliance Nurse to ensure pressure wound care recommendations are being followed appropriately for all residents. Braden Scale assessments were completed on all residents as of 2/18/25 by the Regional Compliance Nurse and DON. Resident care plans for pressure wounds and skin issues were reviewed and updated to include interventions promoting wound healing. This was completed by the Regional Compliance Nurse and DON as of 2/18/25. The Medical Director was notified of immediate jeopardy on 2/18/25 by the Administrator. An ADHOC QAPI meeting was held with the Administrator, DON, ADON, and Medical Director to discuss the immediate jeopardy and plan of removal as of 2/18/25. Administrator, DON, and ADON were in-serviced 1:1 by the Regional Compliance Nurse as of 2/18/25 on the following topics. o Pressure Injury Prevention, Assessment, staging, and Treatment Policy to include early prevention/treatment whenever a change in skin status occurs. Documentation to include measurements and staging/classifying pressure wounds appropriately with documentation of an accurate description in the weekly ulcer assessment. Completing Braden Scale assessments upon admission, readmission, and as needed to help identify when a resident might be at risk for skin breakdown. o Skin Integrity management Policy to include identifying/documenting skin issues to include staging/classifying pressure wounds appropriately and initiating an appropriate treatment plan. Also to include interventions to help with pressure injury prevention and notifying the charge nurse when a new skin issue is identified or if a dressing is soiled or missing. o Notification of a Change in Condition Policy-to include notifying the physician and family/RP when a new skin issue or pressure wound has been identified with documentation in the weekly skin assessment, weekly non-pressure assessment, weekly ulcer assessment, and care plan. Also including notifying the nurse when a new skin issue has been identified. o Skin Assessment policy to include completing head-to-toe assessments upon admission/readmission and weekly to help identify/document skin issues with physician and family/RP notification and treatment orders. o Abuse and Neglect - failure to identify properly stage pressure wounds, classify skin issues, or provide treatments as ordered can be considered neglect. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In-services: The following in-services were initiated by Regional Compliance Nurse, DON for all charge nurses. Any charge nurses not present or in-serviced as of 2/18/25 will not be allowed to assume their duties until in-serviced. All new hires will be in-serviced during orientation. All agency staff or staff on leave will in serviced prior to assuming their next assignment. Completion date 2/18/25. o Pressure Injury Prevention, Assessment, staging, and Treatment Policy to include early prevention/treatment whenever a change in skin status occurs. Documentation to include measurements and staging/classifying pressure wounds appropriately with documentation of an accurate description in the weekly ulcer assessment. Completing Braden Scale assessments upon admission, readmission, and as needed to help identify when a resident might be at risk for skin breakdown. o Skin Integrity management Policy to include identifying/documenting skin issues to include staging/classifying pressure wounds appropriately and initiating an appropriate treatment plan. Also to include interventions to help with pressure injury prevention and notifying the charge nurse when a new skin issue is identified or if a dressing is soiled or missing. o Notification of a Change in Condition Policy-to include notifying the physician and family/RP when a new skin issue or pressure wound has been identified with documentation in the weekly skin assessment, weekly non-pressure assessment, weekly ulcer assessment, and care plan. Also including notifying the nurse when a new skin issue has been identified. o Skin Assessment policy to include completing head-to-toe assessments upon admission/readmission and weekly to help identify/document skin issues with physician and family/RP notification and treatment orders. o Abuse and Neglect - failure to identify properly stage pressure wounds, classify skin issues, or provide treatments as ordered can be considered neglect. o The following in-services were initiated by Regional Compliance Nurse, DON for all other nursing staff and therapy. Any staff not present or in-serviced will not be allowed to assume their duties until in-serviced. All new hires will be in-serviced during orientation. All agency staff or staff on leave will in serviced prior to assuming their next assignment. Completed as of 2/18/25. o Notification of a Change in Condition Policy- to include notifying the nurse when a new skin issue has been identified. o Skin integrity management and pressure injury prevention, assessment, and treatment. To include interventions to help with pressure injury prevention and notifying the charge nurse when a new skin issue is identified or if a dressing is soiled or missing. The following in-services were initiated by Regional Compliance Nurse, DON for all staff. Any staff who are not present will not be allowed to assume their duties until in-serviced. All new hires will be in-serviced during orientation. All agency staff or staff on leave will in serviced prior to assuming their next assignment. Completed as of 2/18/25. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Abuse and Neglect - failure to identify skin issues or provide treatments can be considered neglect. On 2/19/2025 the Surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Record review of Resident #1's electronic medical record confirmed Resident #1 discharged to the hospital on 7/25/2024 and did not return to the facility. Record review of electronic head to toe assessments date 2/13/2025 through 2/18/2025 with no concerns noted. Record review of weekly ulcer and non-ulcer assessments completed 2/12/2025 through 2/18/2025 with no concerns noted. Record review of attestation dated 2/18/2025 at 3:58 PM confirmed the Dietician was notified of all residents with pressure wounds. Record review of attestation dated 2/18/2025 confirmed all residents with pressure wounds have appropriate supplements in place to promote wound healing. Record review of attestation stating the Dietician and Physician will be notified for recommendations/orders when new or worsening pressure wounds were identified. Record review of all wound care orders were reviewed by the DON, ADON, and Compliance Nurse on 2/18/2025 to ensure pressure wound care recommendations were being followed. Record review of the electronic medical record confirmed all Braden scores had been updated on 2/13/2025. Record review of the electronic medical record confirmed all resident care plans had been reviewed and updated as of 2/18/2025. Record review of AdHoc QAPI meeting minutes confirmed to discuss plan of removal as of 2/18/2025 with the following in attendance: Administrator, ADON, DON, Medical Director, HR, MDS, Dietary Manager, DOR, Activity Director, Housekeeping Supervisor, BOM, and Medical Records. Record review of inservices provided to the Administrator, DON, and ADON dated 2/12/2025 consisted of: Pressure Injury Prevention, Skin Integrity Management Policy, Skin Assessment Policy, and Abuse and Neglect. Record review of inservices provided to Charge Nurses dated 2/12/2025 and consisted of: Pressure Injury Prevention, Skin Integrity Management Policy, Notification of a Change in Condition Policy, Skin Assessment Policy, and Abuse and Neglect. Record review of inservices provided to all staff dated 2/12/2025 and consisted of: Notification of a Change in Condition Policy, Skin Integrity Management, and Abuse and Neglect. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/19/2025 at 12:10 PM CNA E said some wound prevention interventions consisted of: turning and repositioning every 2 hours, elevating legs, changing positions, wedges, pillows to offset pressure points, wheelchair cushions, and movement. She said she would immediately notify the charge nurse and DON of any new wounds or wounds without dressings. She said it could be considered abuse or neglect for not preventing and treating wounds. During an interview on 2/19/2025 at 12:18 PM CNA G said some wound prevention interventions consisted of: turning and repositioning every 2 hours, elevating legs, changing positions, wedges, pillows to offset pressure points, wheelchair cushions, and movement. She said she would immediately notify the charge nurse and DON of any new wounds or wounds without dressings. She said it could be considered abuse or neglect for not preventing and treating wounds.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on interview and record review, the facility failed to provide pharmaceutical services, including procedures that assures the accurate acquiring, receiving, dispensing, and administering of medications for 3 of 5 residents (Resident #3, Resident #4 and Resident #5) and reviewed for pharmacy services. The facility failed to remove discontinued controlled medications from the medication cart for Resident #3, Resident #4 and Resident #5 who had expired. The facility failed to ensure proper destruction of 71 Hydrocodone ,d+[DATE]mg, 103 Lorazepam 1mg, 17 Lorazepam 0.5mg, and 94.75ml Morphine Sulfate 100mg/5ml that were controlled medications for Resident #3, Resident #4 and Resident #5 who had expired. These failures could place residents who received medications, including narcotics at risk for not receiving the intended therapeutic effects of their prescribed medications and experiencing unintended and harmful effects of medications prescribed to others and place the facility at risk for drug diversion. Findings included: 1.Record review of facility electronic face sheet indicated Resident # 3 was an [AGE] year-old female admitted to facility on [DATE]. Resident #3's diagnoses included: malignant neoplasm of liver (liver cancer), and secondary malignant neoplasm of bone (bone cancer). Record review of Quarterly MDS dated [DATE] indicated Resident #3 had a BIMS of 14 indicating no cognitive impairment. Record review of discharge MDS dated [DATE] indicated Resident #3 had expired in the facility on [DATE]. Record Review of comprehensive care plan dated [DATE] indicated Resident # 3 had a terminal prognosis of malignant neoplasm of liver and had received hospice services with interventions that included: .Observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately is there is breakthrough pain . Record review of physician orders for [DATE] indicated Resident #3 had an order for Hydrocodone , d+[DATE]mg give 1 tablet every 6 hours as needed, Lorazepam 1mg give 1 tablet every 6 hours as needed, and Morphine Sulfate 100mg/5ml give 0.25ml-0.5ml every 2 hours as needed. Record review of narcotic count sheets indicated Resident #3 had 31 Hydrocodone ,d+[DATE]mg, 56 Lorazepam 1mg, and 26.75ml of Morphine Sulfate remaining at the time of Resident #3's expiration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.Record review of facility electronic face sheet indicated Resident #4 was an [AGE] year-old male admitted to facility on [DATE]. Resident #4's diagnoses included: metabolic encephalopathy (brain does not function properly), malignant neoplasm of lower lobe, right bronchus or lung (lung cancer), and hypertension (high blood pressure). Record review of admission MDS dated [DATE] indicated Resident #4 had a BIMS of 10 indicating moderate cognitive impairment. Record review of discharge MDS dated [DATE] indicated Resident #4 had expired in the facility on [DATE]. Record Review of comprehensive care plan dated [DATE] indicated Resident #4 had a terminal prognosis of squamous cell carcinoma and had received hospice services with interventions that included: .work with nursing staff to provide maximum comfort for the resident . Record review of physician orders for [DATE] indicated Resident #4 had an order for Hydrocodone , d+[DATE]mg give 1 tablet every 4 hours as needed, Lorazepam 1mg give 1 tablet every 2 hours as needed, and Morphine Sulfate 100mg/5ml give 1ml every hour as needed. Record review of narcotic count sheets indicated Resident #4 had 40 Hydrocodone ,d+[DATE]mg, 30 Lorazepam 1mg, 17 Lorazepam 0.5mg, and 44ml of Morphine Sulfate remaining at the time of Resident #4's expiration. 3.Record review of facility electronic face sheet indicated Resident #5 was an [AGE] year-old male admitted to facility on [DATE]. Resident #5's diagnoses included: atrial fibrillation (irregular heartbeat), malignant neoplasm of prostate (prostate cancer), and dementia (decline in mental ability). Record review of admission MDS dated [DATE] indicated Resident #5 had a BIMS of 04 indicating severe cognitive impairment. Record review of discharge MDS dated [DATE] indicated Resident #5 had expired in the facility on [DATE]. Record Review of comprehensive care plan dated [DATE] indicated Resident #4 had a terminal prognosis and had received hospice services with interventions that included: .if receiving hospice services, work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met . Record review of physician orders for [DATE] indicated Resident #3 had an order for Lorazepam 1mg give 1 tablet every 6 hours as needed, Morphine Sulfate 20mg/ml give 0.25ml every 2 hours as needed, and Morphine Sulfate 20mg/ml give 0.5ml every 2 hours as needed. Record review of narcotic count sheets indicated Resident #5 had 17 Lorazepam 1mg, and 24ml of Morphine Sulfate remaining at the time of Resident #5's expiration. (continued on next page)

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	02/19/2025

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 12:21 PM LVN H said when a resident had expired, they count the residents remaining narcotics with the hospice nurse. She said she counted the remaining narcotics the night Resident #3 and Resident #4 expired with the hospice nurse and then locked the medications in the cart to give to the DON. She said the next evening on [DATE] when she came in to work and counted the cart with LVN A he told her he had thinned out the cart and turned the medication in with the count sheets to the DON. She said the hospice sheets were still on the cart in the back of the book, but the narcotic count sheets were missing from the book. She said the following day [DATE] the DON called her and woke her up asking where the narcotics where and she told her that LVN A had said he had thinned the cart out and turned them in to the DON. During a phone interview on [DATE] at 11:58 AM LVN A said he had been passing pills and was tired and frustrated that day, so he decided to lighten his load by destroying the expired residents' medications. He said he wasted the medication in the 100-hall guest room bathroom. LVN A said he poured the medications in a cup and then flushed them in the toilet. LVN A said he had been a nurse for [AGE] years and knew he was supposed to give the medication to the DON and the Pharmacist was supposed to destroy them. He said in hindsight he knew it was not his best idea. Said he was suspended and terminated. He said he had worked for the facility on and off for ,d+[DATE] years and had never destroyed medications before. He said the facility had in the past educated him on the proper way to destroy medications. During an interview on [DATE] at 1:23 PM the DON said on Tuesday [DATE], she went to get the expired residents narcotics out the medication cart. She said LVN H told her they were not on the cart and LVN A had said he gave them to the DON to destroy. She said she did not remember LVN A giving her the medications but went and checked her locked medication cabinets for medications in case she had forgotten but did not find the medications. She said she called LVN A he told her that he had destroyed the medications by flushing them down the toilet in the family room bathroom because he needed space on the cart. The DON said LVN A told her he had the count sheets in his personal bag and needed to find someone to sign with him that he had destroyed the medications. She said she told LVN A he was not going to find anyone to sign with him if they had not witnessed the destruction. She said LVN A did return the count sheets to the facility. She said LVN A told her he just was not thinking straight. The DON said she called and reported the incident to the Administrator immediately and LVN A was suspended and ultimately terminated. She said her expectation was for the nurses to turn in medications to her to be destroyed with the pharmacy consultant. During an interview on [DATE] at 2:02 PM the Administrator said his expectation was for nurses to turn in all discontinued narcotic medications to the DON for destruction with the pharmacy consultant. During an interview on [DATE] at 2:02 PM the Administrator said when he spoke with LVN A he asked him to take a drug test. He said when the results of the drug test where positive LVN A told him he had prescriptions for the positives on the drug test. He said he asked LVN A to provide the prescriptions to the facility, but LVN A never provided any prescriptions. He said LVN A was suspended and ultimately terminated. The Administrator said the expectation for drug destruction would be for the nurses to hand over discontinued narcotics to the DON. He said the DON and the pharmacy consultant should reconcile the drugs and then destroy them according to facility policy. Record review of a urine drug screen dated [DATE] for LVN A indicated positive for cocaine, opiates, codeine, and hydrocodone. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy Discontinued Medications undated indicated: 1. The nurse that received the order to discontinue a medication is responsible for: .Removing the medication from the medication storage, filling out the form to be attached to the medication that discontinued, if applicable, personally giving the form and medication to the DON or ADON . Record review of facility policy Drug Destruction Policy dated [DATE], indicated: It is the policy of this facility to destroy dangerous and controlled medications according to the State of Texas law . 2. Drugs to be destroyed will be destroyed under the supervision of a consultant pharmacist and at least one of the following: Director of Nursing, Assistant Director of Nursing, or Administrator. 3. Nursing staff will submit to Director of Nursing any medication and any applicable log that has expired, been discontinued by physician or that had been prescribed to a resident who no longer resides at the facility. 4. The nurse submitting the discontinued medication, will verify along with the Director of Nursing that the amount of medication remaining matches the log. After verification, both the nurse and the Director of Nursing will sign the log. 5. The nurse will make a copy of the signed log and provide to the administrator. The Director of Nursing will maintain the original log and medication .