

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455569	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/02/2025
NAME OF PROVIDER OR SUPPLIER  Heritage at Longview Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.  (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, or mistreatment, including injuries of unknown source were reported by staff immediately or not later than 24 hours for 2 of 2 residents reviewed for abuse and neglect. The facility failed to report verbal altercation between Resident #45 and Resident #53 during week of 6/23/2025. This failure could place residents at risk for abuse and neglect. Findings included:1. Record review of a face sheet dated 6/30/2025 revealed Resident #45 was [AGE] year-old female who was admitted on [DATE] with diagnoses which included nontraumatic intracerebral hemorrhage (a type of stroke that causes bleeding in the brain), protein-calorie malnutrition (a form of undernutrition is characterized by insufficient intake of protein and calories leading to various health issues), Type II Diabetes (occurs when the body becomes resistant to insulin or when the pancreas fails to produce enough insulin), cerebral infarction (a type of stroke that results from the interruption of blood supply to the brain), and hypertension (a common condition where the force of blood against the artery walls is consistently too high). Record review of a quarterly MDS dated [DATE] indicated Resident #45 was usually able to make self-understood and usually understood others. The MDS indicated a BIMS 10 indicating moderate cognitive impairment. The MDS indicated Resident #45 did not exhibit any physical or verbal behavioral symptoms during the look back period. Further review of MDS revealed Resident #45 was taking an antidepressant for depression. Record review of a care plan last revised on 1/29/2025 indicated Resident #45 required an antidepressant with goal to be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Interventions included to administer antidepressant medication as ordered, monitor and document side effects and effectiveness. Additional interventions included monitoring, documenting and reporting to Physician as needed any ongoing signs and symptoms of depression, unaltered by antidepressant medications such as sadness, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety and constant reassurance. During an interview on 6/30/2025 at 11:19 AM, Resident #45 said a white staff member called her a N word and a B word. Resident stated the incident happened sometime last week. Resident said there were witnesses but could not provide names or description. Resident #45 said she was in the TV room with the incident occurred. Resident #45 had difficulty conveying details and information. During an interview on 6/30/2025 at 1:30 PM, discussed with survey team of Resident #45's report of a white staff member who she reported called her the N word and a B word and the story being difficult to follow. This surveyor notified the DON of Resident #45's report. The ADM was out of the building at the time of report and returned at approximately 1:35 PM. He said Resident #45's story was difficult to follow but would make a self-report and begin investigation. During an interview on 6/30/2025 at 2:44 PM, Resident #45's RP said she had been talking with Resident #45. RP said her Resident #45 had not reported any staff being disrespectful to her. RP said the staff call her with any changes with her mother and did not indicate any verbal altercation with staff or residents.2. Record review of Resident #53's face sheet dated 7/2/2025 revealed Resident #53 was a [AGE] year-old female who was admitted on [DATE] with diagnoses which included heart failure (occurs when the heart muscle does not pump blood as well), chronic venous hypertension with ulcer of bilateral lower extremities (when blood refluxes and starts to accumulate in the lower leg), lymphedema (tissue swelling caused by fluid buildup in the lymphatic system), Type II diabetes (occurs when the body becomes resistant to insulin or when the pancreas fails to produce enough insulin), hypertension (a common condition where the force of blood against the artery walls is consistently too high), chronic atrial fibrillation (an irregular and often rapid heart rhythm that can lead to stroke), and chronic obstructive pulmonary disease (a lung condition caused by damage to the airways that limit airway). Record review of a quarterly MDS dated [DATE] indicated Resident #53 was understood and usually understood others. The MDS indicated a BIMS 12 indicating moderate cognitive impairment. The MDS indicated Resident #53 did not exhibit any physical or verbal behavioral symptoms during the look back period. Further review of MDS revealed Resident #53 was taking anti-anxiety medication. Record review of a care plan last revised on 3/10/2025 indicated Resident #53 used anti-anxiety medication with goal to decrease episodes of signs and symptoms of anxiety. Interventions included to</p>		