

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2025
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>(continued on next page)</p>

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 2 of 6 residents reviewed for respiratory care. (Resident #1 and Resident #2)1. The facility failed to ensure Resident #1's oxygen concentrator (takes air from the surroundings, extracts oxygen and filters it into purified oxygen for resident to breathe) air intake area (mouth of the oxygen concentrator bringing in the air that will be processed) was not covered in gray fuzzy dust and hair-like particles.2. The facility failed to ensure Resident #1 received the physician's ordered amount of oxygen of 2 LPM by nasal cannula.3. The facility failed to ensure Resident #2's oral suction catheter was stored properly.These failures could place residents at risk of respiratory complications or respiratory infection. Findings included:1. Record review of Resident #1's face sheet dated 7/15/25 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #1 had diagnoses which included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), acute respiratory failure, and heart failure.Record review of Resident #1's quarterly MDS assessment dated [DATE], indicated she had a BIMS score of 15, which indicated she was cognitively intact. The MDS indicated Resident #1 was receiving oxygen therapy.Record review of Resident #1's Care Plan dated 7/15/25 indicated she had a breathing pattern care area/problem with interventions including to administer medications, respiratory treatments, and oxygen as ordered. Record review of Resident #1's Physician Orders dated 7/01/25-7/31/25 revealed an order oxygen at 2 LPM by nasal cannula continuously. There were no orders to change/clean the oxygen filter or air intake area of the concentrator.Record review of Resident #1's Medication Administration and Treatment Administration Records dated 7/01/25-7/31/25 indicated she received oxygen at 2 LPM by nasal cannula continuously. There were no indications of the oxygen air intake area of the concentrator being cleaned.During an observation and interview on 7/14/25 at 11:30 AM, Resident #1 was sitting up in her chair doing a crossword puzzle. Resident #1 was wearing oxygen at 1 1/2 LPM by a nasal cannula. Resident #1's air intake area of her oxygen concentrator was covered in gray fuzzy dust and hair-like particles. Resident #1 said staff changed the oxygen tubing every Wednesday, but she did not know if they cleaned the machine. During an observation on 7/14/25 at 5:00 PM, Resident #1 was sitting up in her chair asleep. Resident #1 was wearing oxygen at 1 1/2 LPM by nasal cannula. Resident #1's oxygen concentrator's air intake continued to be covered in gray fuzzy dust and hair-like particles.During an observation on 7/15/25 at 6:00 AM, Resident #1 was lying in bed asleep. Resident #1 was wearing oxygen at 1 1/2 LPM by nasal cannula. Resident #1's oxygen concentrator's air intake continued to be covered in gray fuzzy dust and hair-like particles.During an observation on 7/15/25 at 9:49 AM, Resident #1 was lying in bed wearing oxygen at 1 1/2 LPM by nasal cannula. Resident #1's oxygen concentrator's air intake continued to be covered in gray fuzzy dust and hair-like particles.During an observation and interview on 7/15/25 at 10:25 AM, LVN C was in Resident #1's room and State Surveyor asked LVN C how much oxygen Resident #1 was receiving. LVN C said Resident #1 was only receiving 1 1/2 LPM and it was supposed to be 2 LPM. LVN C asked Resident #1 who had changed her oxygen and Resident #1 said she did not know but it was supposed to be on 2 LPM. LVN C increased the oxygen to 2 LPM. State Surveyor asked LVN C to observe Resident #1's oxygen concentrator air intake area and LVN C said, It's pretty dirty. LVN C said she would get it took care of and cleaned.During an interview on 7/15/25 at 10:35 AM, LVN C said she had worked at the facility for approximately twelve years and normally worked on the day shift. LVN C said the night shift on Wednesdays were responsible for changing oxygen tubing, water bottles, nebulizers, and she would think they would also be responsible for cleaning the oxygen concentrator filters/air intake areas. LVN C said Resident #1's oxygen concentrator air intake area was pretty dirty. LVN C said if a resident was not receiving the physician's ordered amount of oxygen, it could decrease the resident's oxygen level. LVN C said she did check Resident #1's oxygen level this morning (7/15/25) and it was 97%, which was good. LVN C said it the oxygen concentrator had a dirty filter, or the air intake area was dirty, it could affect the resident's breathing and could contaminate the resident's airway and cause an infection. LVN C said it could also affect how the machine worked, and it could run hot.2. Record review of Resident #2's face sheet dated 7/14/25 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #2 had diagnoses which included quadriplegia (inability to move upper or lower body), shortness of breath, and lack of coordination Record review of Resident #2's quarterly MDS assessment</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 9 residents (Residents #2 and Resident #3) reviewed for infection control practices.1. The facility failed to ensure CNA A and CNA B did not contaminate Resident #2's clothing, draw pad, bedding, pillows, and feeding tube pole after performing incontinent care.2. The facility failed to ensure CNA A and CNA B donned (put on) a gown while performing incontinent care on Resident #2, who was on Enhanced Barrier Precautions (EBP).3. The facility failed to ensure LVN C donned a gown while disconnecting Resident #3's feeding tube, assessing feeding tube placement, and attempting to flush the feeding tube, and the resident was on Enhanced Barrier Precautions. These failures could place residents at risk for cross contamination, at an increased risk of infection, and the spread of infection. Findings included:1. Record review of Resident #2's face sheet dated 7/14/25 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #2 had diagnoses which included quadriplegia (inability to move upper or lower body), shortness of breath, and lack of coordination. Record review of Resident #2's quarterly MDS assessment dated [DATE], indicated he was unable to complete the BIMS score, which indicated he had cognitive impairment. The MDS indicated Resident #2 was dependent on staff for all ADLs. The MDS indicated Resident #2 had a feeding tube. Record review of Resident #2's Care Plan dated 7/14/25 indicated he had a care area/problem of infection control with intervention of Enhanced Barrier Precautions, gown and glove use during high-contact resident care activities, which included providing hygiene, changing briefs, and assisting with toileting. Record review of Resident #2's Physician Orders did not reflect an order for Enhanced Barrier Precautions. During an observation on 7/14/25 at 11:45 AM, Resident #2 was lying in bed with head of bed elevated with tube feeding being infused by an infusion device. There was a blue name tag on the outside of his room, a PPE cart and EBP sign just to the inside of his door in his room. During an observation on 7/14/25 beginning at 1:30 PM, CNA A and CNA B entered Resident #2's room and washed their hands and put on gloves. CNA A and CNA B positioned themselves on opposite sides of Resident #2's bed to perform incontinent care on Resident #2. CNA A pulled a male incontinent pad from between Resident #2's legs and placed it in the trash bag. CNA B was on the window side of Resident #2 and rolled resident toward her and held him on his side while CNA A cleansed the head of his penis with a wipe, then used another wipe to cleanse the shaft of the penis, then another 2 wipes to cleanse down each side of his inner thighs. CNA A then used the same gloves to reposition the resident's pillow, moved his feeding tube pole, placed one hand on his shoulder and one on his thigh and pulled him toward her without changing her gloves. CNA B then cleansed Resident #2's bottom with 3 wipes and went between his legs, there was no bowel movement present. Then CNA B and CNA A still wearing the same gloves used during incontinent care, repositioned Resident #2, stuffed a 3-sided body pillow all around Resident #2, used the draw pad under him to pull Resident #2 up in bed, pulled his gown down and then removed their gloves. Neither CNA A nor CNA B wore a gown during Resident #2's incontinent care. Resident #2 had a blue name tag outside his door, an EBP sign posted on the wall just inside his door along with a PPE cart with EBP supplies. During an interview on 7/14/25 at 1:50 PM, CNA A said she had worked at the facility since 2019 and normally worked the 6 AM to 2 PM shift. CNA A said staff should change gloves during incontinent care more times than she did on Resident #2. CNA A said she should have changed her gloves after cleaning Resident #2's front perineal (private) area and before touching multiple surfaces in his room. CNA A said it was a hygiene thing and cross-contamination and could give Resident #2 an infection. CNA A said it was an infection control issue and could cause skin irritation too. CNA A said she would know someone was on EBP if there was a bucket and a sign outside the resident's door. CNA A said staff had to suit up with gown, gloves, and mask if a resident was on EBP. CNA A said residents on EBP were the residents with something in their urine or bowel. CNA A said Resident #2 probably should be on EBP because he had a feeding tube. CNA A said she did not see the EBP sign or the bucket just inside Resident #2's room and did not know what EBP was. CNA A said she did not know why Resident #2 had a EBP sign and cart, because they did not use it. CNA A said she had been on Resident #2's hall since April 2025 and had not ever used a gown during Resident #2's care. During an interview on 7/14/25 at 1:56 PM, CNA B said she had worked at the facility since May of 2025 and normally worked the 2</p>		