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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>675513  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                             | (X3) DATE SURVEY COMPLETED<br><br>08/08/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Place of Decatur  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>605 W Mulberry<br>Decatur, TX 76234 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>48236</p> <p>Based on observation, interview, and record review the facility failed to provide a private meeting space for the residents' monthly group meeting for 12 of 12 confidential residents reviewed for resident council.</p> <p>The facility failed to provide a private space for resident group meetings.</p> <p>This failure could place residents, who attended resident group meetings, at risk of not being able to voice concerns due to a lack of privacy.</p> <p>Findings included:</p> <p>Observation and interview on 08/07/24 beginning at 10:05 AM, during a confidential resident group meeting with 12 residents, revealed the meeting was held in the front lobby of the facility near the front door and the Administrator's office door. During this meeting, there were two signs posted. However, multiple staff walked through the space as well as people from the community. One resident stated she did not feel comfortable talking about issues due to staff and administration interrupting the meeting as well as when they have their monthly meetings.</p> <p>Interview on 08/08/24 at 03:54 PM, the Activity Director revealed she became the AD on 08/05/24. She stated she was responsible for organizing the resident council meetings. She stated the resident council meeting should be held in a private area. She said she asked the residents where they would like to hold the meeting on 08/07/24. She stated the Resident Council President told her a vote was taken, and the residents voted to have the meeting in the lobby which was near the front door and the Administrator's door. The Activity Director stated before the meeting began on 08/07/24, she posted two signs that read, Resident Council Meeting in Process and This is Where They Chose to Have It. The Activity Director stated she posted the signs in spots near the residents' group meeting. The Activity Director said the next resident council meeting would be held in an area that allowed for the residents' privacy. The Activity Director revealed the risk to the residents was that the residents were not comfortable or able to voice their concerns in an open area where staff could hear them.</p> <p>Interview on 08/08/24 at 6:19 PM, the Administrator revealed the resident council meeting was supposed to be held in a place of privacy. The Administrator stated it was the Activity Director's responsibility to ensure the meeting was held in a private area. The Administrator said that she had not received complaints about the meeting not being held in a private location. The Administrator stated she would ensure the residents had a private area for next month's resident council meeting.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE     | (X6) DATE                             |
| FORM CMS-2567 (02/99)<br>Previous Versions Obsolete                   | Event ID: | Facility ID:<br>675513                |
|   |           | If continuation sheet<br>Page 1 of 11 |

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| <p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Record review of the resident council minutes revealed no requests for a private area.</p> <p>Record review of Resident Council policy dated 12/13/16 revealed: The facility will provide the resident council with private space .</p> |

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| <p>F 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide doctor's orders for the resident's immediate care at the time the resident was admitted.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48236</p> <p>Based on observation, interview, and record review, the facility failed to ensure at the time each resident was admitted the facility had a physician order for the resident's immediate care for 1 of 1 resident (Resident #43) reviewed for residents receiving care and services upon admission.</p> <p>The facility failed to ensure Resident #43 had a current physician's order for use of an indwelling catheter as well as its treatment and maintenance after readmission to the facility.</p> <p>The failure could place residents at risk for not receiving the necessary care and services.</p> <p>Findings included:</p> <p>Review of Resident #43's admission record dated 08/08/24 reflected the resident was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses that included unspecified fracture of left femur, unspecified fracture of right wrist and hand, vascular dementia, and retention of urine.</p> <p>Review of Resident #43's admission MDS assessment, dated 07/17/24, reflected a BIMS score was 00 indicating severely impaired cognition. Her functional status indicated she was dependent on staff for toileting. The MDS assessment indicated Resident #43 admitted with an indwelling catheter.</p> <p>Review of Resident #43's care plan, dated 08/08/24, reflected the resident was incontinent. The care plan reflected: Resident has bladder incontinence. Goals: Resident will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions: Incontinent: care at least q2h and apply moisture barrier after each episode. Monitor/document for s/sx UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever chills, altered mental status, change in behavior, change eating patterns. Monitor/document report to MD PRN possible medical causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects. and report signs of urinary tract infection to physician.</p> <p>Review of Resident #43's undated physician orders reflected no physician orders for a urinary catheter.</p> <p>Observation and interview on 08/07/24 at 2:08 PM, Resident #43 was in her room in her bed resting. Resident #43 had a catheter line with clear yellow fluid draining into her foley drain bag which was covered by the privacy cover. Resident stated that she had no urinary pain.</p> <p>(continued on next page)</p> |

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| <p>F 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Interview on 08/07/24 at 02:50 PM, LVN A revealed Resident #43 entered the facility with a catheter. LVN A stated that she did not remember checking to see if there was an order for the catheter, and assumed there was an order. LVN A revealed that there should be an order for all catheters including the gauge of the catheter as well as an order to change it. LVN A also said that it was the admitting nurse's responsibility to input the order for the catheter when a resident comes to the facility with the catheter in place. LVN A revealed it was all oncoming nurses' responsibility to verify that there were orders for Resident #29's catheter. LVN A also stated that without orders to document input/output of urine, there is a risk that the nurse will not know if the catheter is flowing properly. LVN A revealed there is a risk of infection if the resident's catheter is not changed.</p> <p>Interview on 08/07/24 at 03:08 PM, the ADON revealed that Resident #43 did not have physician's orders for a catheter. The ADON stated that all residents who have catheters should have orders. The ADON also stated that it is the admitting nurses' responsibility to input the order for the catheter if the resident comes to facility with the catheter. The ADON said that it is the ADON and the DONs responsibility to ensure the order is input correctly in the EHR. The ADON revealed the oncoming nurses should have a continuum of care and make sure orders are in the chart. The ADON stated if there is no order for the resident's catheter, the risk to the resident is infection and/or injury to the resident. The ADON concluded by stating that nurses are in-serviced on infection prevention and catheter care 1-2 times per month.</p> <p>Interview on 08/07/2024 at 3:45 PM, the DON revealed Resident #43 did not have an order for a catheter. The DON stated the resident entered the facility with a catheter. The DON said it was the admitting nurses' responsibility to input the order and then the oncoming nurses' responsibility to [NAME] the orders are correct. The DON revealed it is the ADON and DONs responsibility to ensure the orders are correct. The DON said that if there are no physician's orders for catheters, that the resident can risk infections, sepsis, and other possible health risks. The DON concluded by stating that she in-services her staff at least one time per month on infection prevention, peri-care, and catheter care.</p> <p>Interview on 08/08/24 at 9:31 AM with corporate nurse revealed the facility did not have a policy addressing the topic of inputting and following physician's order.</p> |  |  |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48236</p> <p>Based on interview and record review, the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 8 residents (Residents #29), reviewed for care plans.</p> <p>The facility failed to revise and update Resident #29's comprehensive care plan with new diet orders.</p> <p>These failures could affect residents of the facility by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome.</p> <p>Findings included:</p> <p>Record review of the Admission Record dated 8/8/24 revealed Resident #29 was a [AGE] year-old male initially admitted on [DATE] and readmitted on [DATE] with diagnoses including end stage renal disease, diabetes mellitus, acquired absence of right leg below the knee, congestive heart failure, unspecified protein-calorie malnutrition, and morbid obesity.</p> <p>Record review of the quarterly MDS dated [DATE] revealed Resident #29 had a BIMS of 15 meaning, Resident #29 was cognitively intact. MDS Section K0520 revealed that Resident #29 did not receive a therapeutic diet.</p> <p>Record review of Resident #29's undated care plan revealed Resident #29 has a diet order other than Regular and is at risk for unplanned weight loss or gain. Resident #29's care plan goal revealed Resident will maintain ideal weight and receive proper nutrition daily x 90 days. Resident #29's Intervention revealed The resident has a low concentrated sweets diet. The resident's low concentrated sweets diet was discontinued on 8/11/21 and the care plan did not reflect the current diet order.</p> <p>Record review of the undated physician's diet orders indicated Resident #29's diet order was a regular diet, mechanical soft texture, regular consistency with a start date of 7/10/24 and revision date of 7/20/24.</p> <p>Interview on 08/08/24 at 5:12 PM, the MDS Coordinator revealed care plans should be reviewed quarterly and updated. MDS Coordinator also stated that she does the standard care plans, but she does not do the acute clinical care plan. MDS Coordinator said diets should be updated quarterly. MDS also revealed that it is her responsibility to ensure care plans are accurate. MDS coordinator stated that she was last in-serviced on care plans about a month ago.</p> <p>Interview on 08/08/24 at 5:20 PM with DON revealed care plans should be updated when there is a diet change or order change. DON stated when dietary and speech do evaluations, she has asked that the results be given to her as well as the MDS coordinator to ensure that care plans be updated. DON said that it is her responsibility to make sure the care plans reflect current orders. DON also revealed that she last in-serviced the staff about a month ago on the importance of accurate care plans.</p> <p>(continued on next page)</p> |  |  |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few                            | Record review of undated policy and procedure titled, Care Planning Policy revealed .The resident's care will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions . |  |  |

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| <p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>48236</p> <p>Based on interview and record review, the facility failed to designate a person to serve as the director of food and nutrition services who met at a minimum one of the following qualifications: a certified dietary manager or certified food service manager, or had a similar national certification for food service management and safety from a national certifying body, or had an associate's or higher degree in food service management or in hospitality, or had 2 or more years of experience in the position of food and nutrition services in a nursing facility and had completed a course of study in food safety management for one of one Dietary Manager reviewed for qualifications.</p> <p>The Dietary Manager did not have the appropriate certification, education, or qualifications to serve as the Director of Food and Nutrition Services.</p> <p>This failure could place residents who consumed food prepared by staff in the kitchen at increased risk of food borne illness and not receiving adequate nutrition.</p> <p>Findings included:</p> <p>Record review of the staff roster provided by the facility, undated, reflected the hire date for the Dietary Manager was 04/22/24.</p> <p>Record review of the Dietary Manager's records reflected she had completed a Food Handler Essentials Course. There was no evidence the Dietary Manager met any of the requirements for a Dietary Manager, which were: a certified dietary manager or certified food service manager, or had a similar national certification for food service management and safety from a national certifying body, or had an associate's or higher degree in food service management or in hospitality, or had 2 or more years of experience in the position of food and nutrition services in a nursing facility and had completed a course of study in food safety management</p> <p>Record review of facility employee files revealed the facility's Registered Dietitian worked eight full time hours during the month of July 2024.</p> <p>During an interview on 08/06/24 at 8:55 AM with the Dietary Manager, it was revealed she had been employed at the facility for approximately three months. She stated she had not started taking any dietary manger classes because she was short-staffed and had to work as a cook on shifts that she was short a cook. She stated she did not have a certificate evidencing she had completed the Certified Food Protection Manager. The Dietary Manager confirmed there was no personnel working in the kitchen that was a trained and certified Food Protection Manager.</p> <p>(continued on next page)</p> |

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| <p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&amp;HS, revealed 2-102.12 Certified Food Protection Manager. (A) The PERSON IN CHARGE shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM. 2-102.20 Food Protection Manager Certification. (B) A FOOD ESTABLISHMENT that has a PERSON IN CHARGE that is certified by a FOOD protection manager certification program that is evaluated and listed by a Conference for FOOD Protection-recognized accrediting agency as conforming to the Conference for FOOD Protection Standard for Accreditation of FOOD Protection Manager Certification Programs is deemed to comply with S2-102.12.</p> |  |  |

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| <p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>48236</p> <p>Based on observation, interview, and record review, the facility failed to ensure that menus were followed for 1 of 5 meals (breakfast [08/07/24]) reviewed for meal accuracy.</p> <p>The facility failed to follow the menu for breakfast on 08/07/24.</p> <p>This failure could place residents at risk for poor intake and weight loss.</p> <p>Findings included:</p> <p>Record review for breakfast menu for 08/07/24 reflected the following: Choice of juice, hot or cold cereal, fresh pasteurized eggs, bacon or sausage, breakfast bread, margarine/jelly, milk, coffee.</p> <p>Interview on 08/07/24 beginning at 10:05 AM, during a confidential resident group meeting with 12 residents, revealed residents were told they could not have eggs for breakfast on 08/07/24 because the kitchen was out of eggs.</p> <p>Observation of the kitchen on 08/07/24 at 11:29 AM revealed the kitchen had no eggs to serve for breakfast on 08/07/24. However, further observation revealed the foodservice company did deliver the eggs on 08/07/24 at 11:45 AM.</p> <p>Interview on 08/07/24 at 11:35 AM with the Dietary Manager revealed she had been employed for three months at the facility. She stated it was her responsibility for ordering food. She stated the kitchen had run out of eggs the previous day and could not provide residents with eggs for breakfast on 08/07/24.</p> <p>Interview on 08/08/24 at 6:23 PM with Administrator revealed that based on the facility's census, the dietary manager knew how much of each item to order per recipe to ensure that enough food is cooked for the residents.</p> <p>Record review of undated dietary services policy and procedure manual 2012 titled, Preparation Of Foods revealed . We will establish safe and nutritional preparation of food. Food is to be prepared in such a manner as to maximize flavor, appearance, and nutritional value.</p> |

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| <p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Keep all essential equipment working safely.</p> <p>43791</p> <p>Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 washing machine (Washer A) of 2 reviewed for essential equipment.</p> <p>The facility failed to maintain a laundry washing machine (Washer A) in operating condition.</p> <p>This failure could place residents at risk of not having clean linen for their beds.</p> <p>Findings included:</p> <p>Interview on 08/08/24 at 9:40 AM, Resident #39 stated the facility seemed to have a problem keeping up with linen. He stated a week prior he had to sleep on six bath towels after he had soiled his linen and staff said there were no clean sheets available. Resident #39 stated as President of the Resident Counsel he talked with all the residents, several of whom reported delays in getting their clothing back from laundry and a shortage of linen, especially on the weekends.</p> <p>Interview on 08/08/24 at 10:00 AM. the Laundry Aide stated one washing machine (Washer A) was out of service for a part on order, leaving her with one functioning washer. She stated the washer had been out of service for two months at least. The Laundry Aide stated linen took priority over resident clothing. She stated she has had to take clothes to the laundry mat sometimes in order to keep up.</p> <p>Interview on 08/08/24 at 10:30 AM, the Maintenance Specialist stated the washing machine had been out of service since April 2024. He stated the two inlet valves were coming from overseas and had not been delivered yet. He stated he kept checking in with the supplier for updates. He supplied an email chain detailing his conversations with the supplier.</p> <p>Record review of email chain provided by the Maintenance Specialist reflected:</p> <p>04/25/24 - Area Maintenance Specialist inquired about the part, requested two parts.</p> <p>04/26/24 - Supplier acknowledge the order</p> <p>04/30/24 - Maintenance Specialist asks for update on order. Supplier did not know, part comes from Spain.</p> <p>05/21/24 - Maintenance Specialist asks for another update. Supplier had no answer, still waiting for manufacturer.</p> <p>06/10/24 - Maintenance Specialist asks for another update.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Interview on 08/08/24 at 5:00 PM, the Administrator stated she was aware of the washing machine being out of service. She stated when the laundry staff get behind, she supplies them with money to go to the local laundry mat to wash resident clothes. The Administrator stated laundry staff seemed to be able to keep up with the linen as she had not had any complaints of being short on linen. She had not spoken to Corporate about possibly replacing the machine due to delays in getting replacement parts.</p> |  |  |