

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Heritage Place of Decatur		STREET ADDRESS, CITY, STATE, ZIP CODE 605 W Mulberry 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen and failed to ensure food, subject to spoilage and removed from its original container, was kept sealed, labeled, and dated for food service safety in the facility's only kitchen. 1. The facility failed to ensure the deep fryer was cleaned in accordance with professional standards. 2. The facility failed to ensure food items was properly labeled, dated, and thawed in accordance with professional standards. 3. The facility failed to ensure food items stored in the freezer were properly discarded. These failures could place residents at risk from food contamination and food-borne illness. Findings included: Observation on 09/28/25 at 9:08 AM, revealed the deep fryers was layered in grease with food spills and food particles. Observation on 09/28/25 at 9:11 AM, of the refrigerators revealed the following: - a plastic container with pineapple slices, with no label or date; - three packages of cheese in sealed plastic bags with no label or date; - ham in a sealed plastic bag with no label or date; - a clear bag of lettuce that was unsealed and did not have a label or date; and - facility's refrigerator revealed an unopened ham lying in the opened case of petite tomatoes. Observation on 09/28/25 at 9:19 AM, of the facility's freezer revealed the following: -Cookie dough that had been thawed and refrozen because it had freezer shelf lines. The cookie dough was in a clear plastic bag and was not sealed properly, and the bag was not labeled or dated. - A sealed plastic bag with frozen chicken was unlabeled and undated in the freezer as well. - A large plastic bucket with a red frozen substance and a large knife sticking out of it was also in the freezer with no label or date. Observation on 09/28/25 at 9:21 AM, of the facility's kitchen area revealed a case of unopened defrosted breaded cauliflower on the floor. Interview on 09/28/25 at 9:25 AM, [NAME] A revealed he had been employed at the facility about two months as the weekend cook. [NAME] A stated the facility policy was that he should be wearing a beard guard. [NAME] A said he forgot to put his beard guard on that morning. He stated not wearing a beard guard could cause hair to get into the residents' food. [NAME] A stated beard nets was available for the staff. He stated the case of unfrozen cauliflower had been taken out of the freezer during a morning shift on another day and then had been left lying in the floor and had defrosted. He revealed he forgot to throw it out. [NAME] A stated all foods placed in refrigerators and freezers should be labeled, dated, and sealed in plastic bags or containers. He also said serving unlabeled and undated food to residents was dangerous because it could be spoiled and could cause residents to get sick. He stated he was unsure of the contents of the red substance in the freezer with knife in it or who or when it was placed in the freezer. He revealed the ham lying in the case of cherry tomatoes could have led to cross contamination. [NAME] A said he was unsure when the deep fryer had last been cleaned. He stated foods in refrigerators should be on the correct shelving when thawing, and it was the Cook's responsibility to ensure that it was done correctly to prevent cross contamination. He revealed all staff in the kitchen should be wearing hair nets as well as beard guards if they have facial hair. He also said that the deep fryer should be cleaned by the cook. [NAME] A revealed all these items should have been reported to the Dietary Manager when he arrived to work. He stated he (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675513 If continuation sheet Page 1 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Heritage Place of Decatur		STREET ADDRESS, CITY, STATE, ZIP CODE 605 W Mulberry 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	could not recall his last in-service. Interview on 09/29/25 at 9:21 AM, the Dietary Manager revealed he had been employed at the facility for about four months. The Dietary Manager stated he was scheduled to start the Certified Dietary Manager class on 10/10/25. The Dietary Manager said that staff should all be wearing hair nets and beard guards if they had facial hair to prevent cross contamination of food. The Dietary Manager revealed he last opened and reviewed the contents of the refrigerators and freezers on 09/25/25. The Dietary Manager revealed the policy on opened items was they should have the date they were opened, the name of the item, the date it expired, and the person's initials who put it in the container or sealed plastic bag. The Dietary Manager said that all items must be in sealed containers or sealed plastic bags. The Dietary Manager also revealed that who is responsible for labeling the items correctly would be the individual who pulled the item out of the refrigerator or freezer. The Dietary Manager said the red substance in the freezer with a knife in it was frozen gelatin, and he did not know who or why a knife was placed in it in the freezer. The Dietary Manager revealed he was responsible for ensuring the facility's policies was followed correctly. The Dietary Manager stated he was informed about the case of cauliflower on Saturday. He stated he was unsure about when it was taken out of the freezer and left out. He said he instructed staff to throw it away on Saturday morning. He stated the cookie dough should not have been refrozen after thawing. He stated unlabeled, undated, unsealed items, no beard guards, foods left out of the freezer, and refrozen items could all lead to food poisoning and other food borne illnesses which could make residents sick. The Dietary Manager said it was everyone's responsibility to properly label, date, and store items correctly as well as wear the appropriate hair nets and beard guards. The Dietary Manager also revealed after every meal the deep fryer and other equipment should be wiped down after every meal as part of the cleaning process. The Dietary Manager said he did have access to the facility's dietary policies. The Dietary Manager revealed it was his responsibility to ensure all dietary policies were properly in place and followed. The Dietary Manager stated he last provided an in-service training to his staff about a month ago. A copy of the in-service was requested; however, the in-service record was not provided to the survey team. Interview on 09/29/25 at 1:19 PM, [NAME] B revealed she had been employed at the facility for eight years and worked Monday through Thursday. She stated the facility policy was to throw away all fried foods into the trash after they are cooked as well as all frozen foods that was left out and defrosted. She stated the facility policy was when something was defrosted, it could not be refrozen. She stated she was unaware of the frozen red substance in the freezer with the knife in it and said she had not seen it in the freezer when she worked her last shift. [NAME] B then said that baked foods and other types of items that are stored in the refrigerator and the freezer should be labeled and dated for seven days from the date they are placed in the refrigerator or freezer and in a sealed container or sealed plastic bag. She revealed the facility policy was to clean all equipment after each meal served. She stated meat should never be stored on top of vegetables because it could contaminate the vegetables. She stated meat should be put in a pan and defrosted in a pan alone. She revealed all hair should be covered or shaved so no hair would get into the food and that it was everyone's responsibility. She stated all these policies were to prevent residents from getting sick. She stated if she saw these items, she would report them to the Dietary Manager. Interview on 09/29/25 at 1:32 PM, the Corporate Traveling CDM revealed she had trained the Dietary Manager twice for four days each time. The Corporate Traveling CDM stated foods should be placed in a food grade sealed container and labeled with its name, date opened and use by date when placing the items in refrigerators. The Corporate Traveling CDM also stated food should not be refrozen after it was defrosted. The Corporate Traveling CDM said that the ham should not have been placed on the cherry tomatoes due to cross contamination risk. The Corporate Traveling CDM explained that there is signage in the kitchen that shows what shelf everything should be on in refrigerators to prevent food borne illnesses. The Corporate Traveling CDM stated frozen breaded cauliflower should stay in the freezer until time to be fried or baked. The Corporate Traveling CDM continued by stating that the [NAME] should be wiped down after every shift. Finally, The Corporate (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Heritage Place of Decatur		STREET ADDRESS, CITY, STATE, ZIP CODE 605 W Mulberry 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Traveling CDM stated staff should be wearing hair nets and beard coverings, if they have facial hair, in the kitchen. Record review of undated facility policy, Food Storage and Supplies, reflected: All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin, and insects.4. Open packages of food are stored in closed containers with covers or in sealed bags and dated as to when opened. 10. Frozen items that should be thawed before preparation should be stored under refrigeration until thawed and should be dated with the date removed from the freezer and used within 7 days. Some items that are nearing expiration may be frozen prior to expiration to preserve food safety and should be dated when removed from freezer to maintain proper time frame for food safety.If a frozen food does not have an expiration date or a dated shipping label it will be dated when received or is removed from original packaging. Record review of the facility's Dietary Service Policy and Procedure Manual, revised 04/09/25, reflected: Policy: We will ensure that all employees practice infection control in the Food and Nutrition Services Department, and maintain sanitary food preparation. Procedure:5. All kitchenware and food contact used in the preparation and/or serving of food are cleaned and sanitized before use and cleaned after each meal preparation. Record review of the Federal Drug Administration Food Code, dated 2017, section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils reflected the following: .(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris Section 3-305.11 Food Storage. (A) Except as specified in (B) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (B) FOOD in packages and working containers may be stored less than 15 cm (6 inches) above the floor on case lot handling EQUIPMENT as specified under S 4-204.122. 3-305.14 Food Preparation. During preparation, UNPACKAGED FOOD shall be protected from environmental sources of contamination. 3-307.11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306. 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. 92 3-501.13 revealed Thawing: TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be thawed: (A) Under refrigeration that maintains the FOOD temperature at .(41 [degrees] F) or less; or (B) Completely submerged under running water: (1) At a water temperature of . (70 [degrees] F) or below, (2) With sufficient water velocity to agitate and float off loose particles in an overflow. The facility was asked to provide its policy regarding the defrosting of food; however, the policy was not provided to the team prior to exit.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Heritage Place of Decatur		STREET ADDRESS, CITY, STATE, ZIP CODE 605 W Mulberry 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement its advance directives policy regarding obtaining and placing advanced directives in the clinical record for 1 of 4 residents (Resident #9), reviewed for do not resuscitate status. The facility failed to upload Resident #9's OOH DNR to her clinical record to ensure all staff were aware of her elected resuscitation status. This failure could place residents at risk of not having their end-of-life wishes honored. Findings included: Record review of Resident #9's quarterly MDS dated [DATE] reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. The residents' diagnoses included respiratory failure, and she had severe cognitive impairment with a BIMS score (mental assessment) of 5. Record review of Resident #9's care plan initiated on [DATE] and revised on [DATE] reflected the resident was a full code status. The care plan interventions included initiating BLS CPR if the resident was without a heartbeat or not breathing. Record review of Resident #9's [DATE] physician orders reflected there was an order for a OOHDNR with a start date of [DATE]. Interview on [DATE] at 2:34 PM, the Social Worker revealed she worked at the facility two days a week and she and the nurses was responsible for ensuring each resident's clinical record had the appropriate advanced directives in place. The Social Worker said Resident #9's family was undecided if they wanted the resident to be a DNR, so the resident was to remain a full code. The Social Worker further stated no one had communicated to her that the resident had become a DNR. Interview on [DATE] at 11:17 AM, the ADON revealed they had asked Resident #9's family about the resident's code status, and initially the family did not want the resident to be a DNR status. After the resident had a hospital stay, Resident #9's family elected for the resident to have a DNR status. The ADON stated Resident #9's family member told the facility staff they had given the OOHDNR to a nurse. The family member could not tell them which nurse, so they asked the family member to bring them another copy of the DNR. She stated she was not aware the OOHDNR had not been uploaded to the resident's clinical record. Interview on [DATE] at 1:34 PM, the DON revealed Resident #9's family was initially undecided whether they wanted the resident to be a DNR. She stated that after the resident came back to the facility following a hospital stay, the family decided the resident would be a DNR status. The order for the DNR was put in the system on [DATE], and the resident's family emailed her a copy on [DATE]. The DON stated she forgot to upload the OOHDNR to Resident #9's clinical record. She stated it was important to have the document in the clinical record to ensure they did right by the resident's wishes. Record review of the facility's current, undated Self Determination End of Life Measures policy reflected the following: .Policy.3. If the resident has already executed advanced directive, the facility will obtain a copy and place it on the clinical record.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Heritage Place of Decatur		STREET ADDRESS, CITY, STATE, ZIP CODE 605 W Mulberry 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, the facility failed to provide comfortable and safe temperature levels between 71 to 81 degrees Fahrenheit for 3 of 8 residents (Residents #11, #15, and #38) reviewed for environment. The facility failed to maintain comfortable temperature levels in Residents #11, #15, and #38's rooms. The failure placed residents at risk of a decreased quality of life. Findings included: Observations on 09/28/25 from 10:00 AM-10:30 AM revealed Resident #38 was sitting in his wheelchair in his room with a blanket wrapped around him. Observation on 9/28/25 at 10:10 AM, Resident #15 was sitting in her recliner in her room with a thick jacket on with a heavy blanket covering her. Observation on 9/28/25 at 10:30 AM, Resident #11 in bed with multiple blankets covering her. Observation on 9/28/25 at 10:20 AM of the thermostat in Hall A revealed it was set to 72 degrees F and Cooling. Observation of temperatures, using an ambient thermometer On 9/28/25 room temperatures were as follows: At 10:35 AM Resident #38's room temperature was 70 degrees F. At 10:40 AM Resident #15's room temperature was 69 degrees F. At 10:47 AM Resident #11's room temperature was 70 degrees F. Interview on 09/28/25 at 10:00 AM, Resident #38 revealed at night his hands got so cold he could not stand to touch himself anywhere. Interview on 09/28/25 at 10:23 AM, Resident #15 revealed she had to wear her down jacket all the time because her room was always too cold. She stated she also slept with a heavy comforter on her bed at night because of the cold. Interview on 09/28/25 at 10:30 AM, Resident #11 revealed the facility got very cold at night, and she had to keep asking the staff to get her another blanket. She stated sometimes she had 3-4 blankets on her by morning. When she asked staff to turn up the heat, they told her they were not allowed to. Interview on 09/28/25 at 12:48 PM, the Maintenance Director revealed staff was complaining the facility was too warm in the morning, so he turned the thermostat down to 72 degrees from 74 degrees. He stated he tried to keep the temperatures between 70 and 75 degrees. He stated the standard was to keep the temperature between 71 and 81 degrees. He stated the residents needed a comfortable environment to promote well-being. He stated residents having to use extra blankets or winter coats to keep warm was not acceptable. The Maintenance Director stated he would adjust the thermostat. Interview on 09/28/25 at 2:15 PM, CNA C revealed some residents was cold and some was hot. She stated for residents, who was cold, she would cover them up and try to keep their door shut to keep warm air in. She stated she had told Maintenance about it, and they had been told not to touch the thermostats because they must stay in a certain range. She stated Residents #15 and #38 was always complaining of it being cold. Interview on 09/29/25 at 2:00 PM, the DON revealed staff was busy running around, and they sometimes did not notice that residents who was not so active could be cold. She stated it was important to make sure the residents was comfortable as the facility was their home. Interview on 09/30/25 at 3:15 PM, the Regional Nurse Consultant revealed the facility addressed room temperatures and followed the federal regulations, but they did not have a policy about room temperatures or homelike environment.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Heritage Place of Decatur		STREET ADDRESS, CITY, STATE, ZIP CODE 605 W Mulberry 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to coordinate assessments with the PASRR program under Medicaid in subpart C of this part to the maximum extent practicable for 2 of 5 residents (Residents #6 and #29) reviewed for PASRR Level 1 screenings. The facility did not correctly identify Resident #6 and #29 as having a mental illness and did not complete a new PASRR Level 1 Screening. These failures could place residents at risk of not being evaluated for PASRR services. Findings included: Record review of Resident #6's Quarterly MDS Assessment, dated 09/01/25, reflected the resident was a [AGE] year-old female initially admitted on [DATE] and re-admitted on [DATE]. Her diagnoses included: schizophrenia (disruptions in thought processes, perceptions emotional responsiveness, and social interactions), bipolar disorder (is a mental illness that causes clear shifts in a person's mood, energy activity levels, and concentrations), anxiety disorder (a condition that occurs when there is dread, worry, or fear that is out of proportion to the situation), and major depressive disorder (a mood disorder causes a persistent feeling of sadness and loss of interest for at least two weeks). Record review of Resident #6's care plan, dated 09/29/25, reflected the resident's diagnoses included schizophrenia, bipolar, and depression for which she was currently taking medications. Record review of Resident #6's PASARR Level 1 Screening, dated 12/09/21, reflected she did not have mental illness. Interview on 09/29/25 at 10:25 AM, the MDS Coordinator revealed she had been employed at the facility for about three years. The MDS Coordinator stated Resident #6 was admitted to the facility with a negative Level I PASARR screening and a diagnosis of schizophrenia. The MDS Coordinator stated a new Level I should have been completed due to the resident's mental illness diagnoses. The MDS Coordinator said not having an accurate Level I prevented Resident #6 from possibly receiving PASARR special services. The MDS Coordinator said it was her responsibility to ensure PASARR screenings was completed and accurate. The MDS Coordinator stated they did not review residents' charts to ensure PASARR documents was updated and accurate. The MDS Coordinator stated she should report any issues to her corporate manager. The MDS Coordinator said she was in-serviced about 3-4 months ago on PASARR. Interview on 09/29/25 at 10:45 AM, the DON revealed Resident #6 should have a positive PASARR based on her mental illness diagnoses. The DON stated it was the MDS Coordinator's responsibility to complete an accurate PASARR and any additional forms such as Form 1012. The DON continued by stating that inaccurate PASARRs affected residents by possibly preventing them from receiving PASARR services. The DON stated the DON and the MDS Coordinator reviewed diagnoses in their daily stand-up meetings so they knew what needed to be completed and what services could be offered. The DON could not recall the last time the MDS Coordinator was in-serviced on PASARR. Record review of Resident #29's quarterly MDS assessment reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included anxiety disorder, depression, and bipolar disorder. Resident #29's cognition was intact with a BIMS score of 15. Record review of Resident #29's care plan initiated on 11/25/25 reflected she had a mood problem related to the disease process of bipolar major depressive disorder. Interventions included to monitor/record/ report to MD mood patterns of signs and symptoms of depression, anxiety, said mood, as per facility behavior monitoring protocols. Record review of Resident #29's PASARR Level 1 Screening dated 11/07/22 reflected NO had been answered on question C0100 where it asked if there was evidence or an indicator that this was an individual that had a mental illness. Interview on 09/30/25 at 11:15 AM, the MDS Nurse revealed she was working at the facility at the time Resident #29 transferred from another facility. The MDS Nurse said she was responsible for completing and reviewing the PASRR Level 1 Screenings and she did not realize the screening had been marked NO on the question that asked if the resident had a mental illness. The MDS Nurse stated Resident #29 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Heritage Place of Decatur		STREET ADDRESS, CITY, STATE, ZIP CODE 605 W Mulberry 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have had another PASARR Level 1 Screening had she noticed the mental illness questions was answered wrong, so the resident could have had a PASARR Level II evaluation. The MDS Nurse further stated it was important to make sure the PASARR screenings were correct to ensure all the residents had access to PASRR services. Record review of the facility's PASARR Level 1 Screen Policy and Procedure, revised 03/6/19, reflected: Policy: It is the policy of Creative Solutions in Healthcare facility to obtain a PL1 screening form from the RE (referring entity) prior to admission to the NF. The PL1 will be submitted via [PASRR system] timely per PASRR Regulator timeframes. PASRR is a federally mandated program requiring all states to prescreen all individuals seeking admission to a Medicaid-certified nursing facility, regardless of payor source or age. The PASRR Program is important because it provides options for individuals to choose where they live, who they live with and the training and therapy they need to live as independently as possible. PASRR Program has 3 Goals:1. To Identify individuals with MI, ID, or DD/RC (this includes adults and children);2. To ensure appropriate placement, whether in a community or in a NF;3. To ensure individuals receive the required services for their MI, ID, or DD.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Heritage Place of Decatur		STREET ADDRESS, CITY, STATE, ZIP CODE 605 W Mulberry 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet the resident's medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment for 1 of 8 residents (Resident #11) reviewed for comprehensive care plans. The facility failed to ensure Resident #11's psychosocial needs was identified in her care plan. This failure could place residents at risk of not receiving the care they need. Findings included:1.Record review of Resident #11's admission MDS, dated [DATE], reflected the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included anxiety disorder, depression, psychotic disorder, and schizophrenia. The resident's cognition was intact with a BIMS score of 15. Record review of Resident #11's care plan, dated 08/16/25, reflected it addressed the resident's use of anti-psychotic medications related to schizophrenia but did not specifically address her diagnosis of schizophrenia, which would include goals and interventions. Interview on 09/30/25 at 12:34 PM, the MDS Coordinator revealed she was responsible for ensuring care plans were complete and up to date. She learns of new issues that need to be added to a resident's care plan during the facility's Standards of Care meetings. She stated it was important to have accurate care plans, so the residents have all their needs met. Interview on 09/30/25 at 2:34 PM, the DON revealed accurate care plans were necessary to ensure each resident received the appropriate care, and their needs were being met. Record review of the facility's current, undated Comprehensive Care Planning policy reflected: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Heritage Place of Decatur		STREET ADDRESS, CITY, STATE, ZIP CODE 605 W Mulberry 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, 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 1 of 2 residents (Resident #9) observed for wound care. RN D failed to sanitize his hands between glove changes when providing wound care for Resident #9. The failure placed residents at risk for infection. Findings included: Record review of Resident #9's quarterly MDS dated [DATE] reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. The residents' diagnosis included respiratory failure. Resident #9 had a BIMS of 5 which indicated the resident had severe cognitive impairment. The MDS further reflected Resident #9 was at risk of developing pressure ulcers/injuries. Record review of Resident #9's care plan revised on 09/22/25 reflected that she had a pressure ulcer to her left heel. Interventions included to clean left heel with wound cleanser, pat dry, apply thin layer Iodosorb to gauze, place on open wound and cover with dry dressing daily and as needed. Record review of Resident #9's September 2025 physician orders reflected the following: Woundcare: left heel: Clean left heel with wound cleanser, pat dry, apply thin layer of Iodosorb to gauze, place on open wound. Cover with dry dressing. Change daily and prn. every day shift for woundcare. Observation on 09/29/25 at 9:37 PM, revealed RN D had all the wound care supplies set up on Resident #9's bedside table to treat the wound on Resident #9's left heel. The supplies included hand sanitizer. CNA E was assisting RN D, and she held up Resident #9's left foot. Both RN D and CNA E was wearing a gown and gloves. CNA E took the resident's sock off, while RN D took the old bandage off the resident's left heel and threw it in the trash bag. RN D then took off his dirty gloves and applied new ones without sanitizing his hands. RN D next cleansed the wound with wound cleanser. Afterwards, RN D removed his dirty gloves and applied new gloves, without sanitizing his hands. RN D then got a new bandage and applied a thin layer of Iodosorb (an antimicrobial gel) to the bandage and placed the bandage on the resident's left heel. Next, RN D put Resident #9's sock back on her left foot, removed his gloves, and applied hand sanitizer to his hands. Interview on 09/29/25 at 3:13 PM, RN D revealed hand hygiene should be done before starting wound care, any time gloves were removed, before new gloves was put on, and when wound care was complete. When asked about Resident #9's wound care procedure, he said he thought he had used hand sanitizer in between his glove changes. RN D said it was important to sanitize his hands during wound care to keep from spreading bacteria and cross contamination. Interview on 09/30/25 at 11:12 AM, the ADON revealed hand hygiene should be performed before starting wound care, after removing dirty gloves and before applying new gloves and when the treatment is done. The ADON said it was important to perform hand hygiene during wound care to prevent germs and infection to the wound. Interview on 09/30/25 at 1:34 PM, the DON revealed hand hygiene should be performed before the wound care procedure, each time gloves were changed, and after the treatment was completed. The DON said hand hygiene was important to prevent infections and cross contamination. Record review of the facility's Pressure Injury: Prevention, Assessment and Treatment policy, revised 05/05/25, reflected the following: Procedure 1. Nursing personnel will continually aim to maintain the skin integrity, tone, turgor and circulation to prevent breakdown, injury and infection. Record review of the facility's undated Dressing Change Checklist the nurses are to follow reflected the following: .Preparation for Dressing Change Washes hands. Dressing Removal Washes hands prior to applying gloves, when changing gloves and upon removal of gloves throughout the dressing procedure. Changes gloves and wash/sanitize hands after removal of dressing. Cleansing Wound (Clean Technique) .Applies new gloves and cleanses wound per orders and facility policy Changes gloves and wash/sanitize hands Dressing Application (Clean Technique) Open dressings and then applies new gloves. When completed reposition patient remove gloves and wash hands.		