

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675561	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Heritage Plaza Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 W 52nd St Texarkana, TX 75501	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128</p> <p>Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 2 of 4 residents reviewed for resident rights. (Resident #1 and Resident #4)</p> <ol style="list-style-type: none"> The facility failed to treat Resident #1 with dignity and respect by denying his request to be repositioned in bed. The facility failed to treat Resident #4 with dignity and respect when the previous Administrator told him he looked like a child molester on 03/25/24. <p>These failures could place residents at risk for decreased quality of life, decreased self-esteem and increase anxiety.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Record review of an undated face sheet indicated Resident #1 was an [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), major depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), anemia (low iron in the blood), and congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should). He discharged [DATE]. <p>Record review of the quarterly MDS assessment dated [DATE] revealed Resident #1 had a BIMS score of 11, which indicated mild cognitive deficit. Resident #1 required moderate assistance for ADLs such as bed mobility, transfer, and toileting.</p> <p>Record review of a care plan dated 04/03/2024 titled ADL assistance indicated Resident #1 had an ADL self-deficit. The intervention for Resident #1 revealed the staff was to assist resident as needed with ADLs.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/29/2024 at 2:00 p.m., Resident #1's family member stated there was a camera in Resident #1's room while he was a resident at the facility. She stated that on more than one occasion the staff treated Resident #1 poorly by the way they talked to him. Resident #1's family member provided the video evidence of the staff being disrespectful. Video evidence reviewed on 09/03/2024 at 8:00 a.m. revealed the following:</p> <p>04/09/2024 at 8:23 p.m.- Resident #1 was lying in bed with the head elevated causing his body to be positioned toward the foot of the bed. Resident #1's call light was answered by CNA A. CNA A entered the room and asked what he needed because his light was on. Resident #1 stated he needed the CPAP (a machine that is used for treatment for sleep apnea (when one stops breathing during sleep). It keeps the airways open during sleep). CNA replied, She is down the hall passing meds, you will have to wait. I don't know when she will make it back down here. Resident #1 then asked CNA A to do him a favor. CNA A replied, what? Resident #1 indicated he was uncomfortable in the bed and asked if she would pull him up in the bed. CNA replied, no I'm not pulling on you. Resident #1 said, so you won't help me. CNA A replied, nope I'm not going to do it. I'm not going to hurt my shoulder pulling on you. CNA A stated all right then and exited the room without having provided any assistance to Resident #1.</p> <p>During a phone interview on 09/03/2024 at 10:20 a.m., CNA A stated she had declined to help Resident #1 that night. She stated she had a bad shoulder, and she could not pull on him by herself because she would injure herself. CNA A stated everyone was busy and she could not stop them from doing their work to come help her with hers. CNA A stated normally if there was someone that was not busy, she would ask them to help. CNA A stated after the fact she felt like she should have gone and got help to pull him up and it was not respectful to tell a resident no she would not help them. CNA A stated the residents were entitled to be treated with dignity and respect and not left in uncomfortable situations. She stated in hindsight, it may have made him upset to be told no when he could not help himself. CNA A stated she was terminated from the facility related to her disrespect and poor attitude with Resident #1 that day.</p> <p>During an interview on 09/04/2024 at 10:00 a.m., the ADON stated she was made aware of the disrespect of CNA A to Resident #1 by Resident #1's family member on 04/09/2024. She stated she brought it to the attention of the DON and Administrator the next week and after suspension for her behavior and attitude CNA A was terminated. The ADON stated it was against Resident #1's rights to be mistreated and disrespected by being brushed off by the staff like he was not important.</p> <p>During an interview on 09/04/2024 at 3:00 p.m., the DON stated it was brought to her attention on 04/17/2024 that CNA A was being disrespectful to Resident #1, and it had been recorded by Resident #1's family member. The DON stated as soon as she was told about the incident, she called CNA A to let her know she would be suspended until it was determined what happened and she would be given education on resident rights before being able to come back to work. The DON stated after reviewing the video it was determined CNA A's services would no longer be needed at the facility. She stated the facility did not allow mistreatment of their residents in anyway. The DON stated CNA A was terminated on 04/17/2024.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/04/2024 at 3:30 p.m., the ADM stated CNA A was terminated from the facility specifically related to her treatment of Resident #1. She stated it was against their resident rights policy to speak to a resident in the manner she spoke to Resident #1 and to deny him care that she could have gotten assistance in providing. The ADM stated the treatment of Resident #1 could have resulted in Resident #1 having a feeling of decreased self-worth.</p> <p>2. Record review of a face sheet dated 08/29/24 indicated Resident #4 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses including dementia, chronic obstructive pulmonary disease (chronic lung disease) and repeated falls.</p> <p>Record review of the annual MDS assessment dated [DATE] revealed Resident #4 had a BIMS score of 12, which indicated mild cognitive deficit. Resident #4 was independent to requiring set up assistance with ADLs.</p> <p>Record review of a care plan dated 07/11/24 indicated Resident #4 was prescribed an antidepressant. There was an intervention to monitor closely for worsening of depression.</p> <p>Record review of a Provider Investigation Report dated 04/02/24 indicated on 03/25/24 at 6:50 p.m., CNA A had reported hearing the previous Administrator tell Resident #4 he looked like a child molester following a shave and not having his teeth in place. She reportedly followed this statement with just kidding. The report indicated the social worker had assessed the resident and he had no emotional distress regarding the incident. The report indicated the previous Administrator was immediately suspended and she admitted to making the statement but denied it being abusive stating they were joking around.</p> <p>Record review of a General Interview Statement dated 03/26/24 at 2:00 p.m., indicated the ADON interviewed Resident #4. The statement indicated on 03/25/24, The administrator made a comment after I shaved my beard. It made me feel kind of funny/different for a minute then we laughed it off. I don't keep up with time anymore, but it was yesterday. Everyone else said it looked good, and that I looked younger.</p> <p>Record review of a General Interview Statement dated 03/26/24 at 2:00 p.m., indicated the ADON interviewed CNA A. The statement indicated on 03/25/24, I heard (the previous Administrator), say to (Resident #4) Oh, you look like a child molester. (Resident #4) had just gotten his face shaved moments before. This occurred yesterday (03/25/24) around 6:51 pm. I took the residents out to smoke at 7:00 pm, other staff members and residents were complimenting him, and he was in good spirits shortly after.</p> <p>Record review of a General Interview Statement dated 03/26/24 at 3:35 p.m. indicated the ADON interviewed LVN J. The statement indicated on 03/25/24, (Resident #4) was seated on the couch in the front lobby .Around 7:00 pm, as (the previous Administrator) was walking out the front door, she said to the resident, Do you have your teeth in? You look like a child molester. I didn't hear the rest of the conversation because I was headed down the hall to give evening meds.</p> <p>Record review of a Community Personnel Action Form with an effective date of 03/27/24 indicated the previous Administrator had been terminated and was not eligible for rehire.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/29/24 at 1:46 p.m., Resident #4 said on 03/25/24 he was sitting at the front of the facility. He said there were two staff members in the lobby with him. He said he had been clean shaven. He said as the previous Administrator was leaving she told him that since he had been shaved he looked like a child molester. He said he thought she was just playing and goofing off. He said it embarrassed him, but he just let it go. He said he was not going to say anything else about it but the two staff members reported it.</p> <p>During an interview on 09/03/2024 at 11:03 a.m., the previous Administrator said earlier in the day of 03/25/2024, she had a conversation with Resident #4. She said Resident #4 told her he was having all of the hair cut off of his face that day and he wondered what he was going to look like. He said to her that he hoped he did not look like he came from jail or was a pedophile. She said later that evening they were sitting on the couch talking to each other. She said they were laughing. She said she did repeat what he had said earlier in the day and told him he did not look that way. She said during the conversation they were laughing and joking. She said she was not trying to be disrespectful. She said she may have said he did not look like a pedophile. She said there was not an intent to be disrespectful. She said she was terminated the next day. She said she was never even asked what happened. She said she loved her residents. She said she felt like they used it to just get rid of her. She said she was not even suspended for 3 days. She said the resident was crying when she left and said he never meant for this to happen.</p> <p>During an interview on 09/03/2024 at 12:42 p.m., Resident #4 said what the previous Administrator said was not true. He said he had not said anything about being shaved earlier in the day because he did not even know he was going to be clean shaven until it was done. He said he did not feel like he was abused. He said he was embarrassed.</p> <p>During an interview on 09/03/2024 at 12:48 p.m., LVN J said on 03/25/24 she was busy at the desk. She said she heard the previous Administrator say, You shaved. You don't have your teeth in. You look like a child molester. She said she could not hear what Resident #4 was saying. She said he did not seem upset. She said she tried to talk to him about it later and he did not want to talk about it. She said CNA A heard more of the conversation.</p> <p>During an interview on 09/03/2024 at 1:10 p.m., CNA A said the previous Administrator did say to Resident #4 that he looked like a child molester. She said later Resident #4 told her, Baby, she didn't know any better. She said he did shave occasionally but that day they had cut his hair too. She said she did feel like afterwards he did not want talk to her about the incident. She said she reported the incident to the DON.</p> <p>During an interview on 09/04/2024 at 1:18 p.m., the Social Worker said she had not witnessed the previous Administrator call Resident #4 a child molester. She said she was one of the staff members that interviewed him. She said that Resident #4 said the previous Administrator had said he looked like a child molester. She said he seemed like he was embarrassed and that he really did not want to talk about it. She said she could not remember his exact words, but he voiced not wanting to get anyone in trouble. She said there have been no lasting effects from the incident.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/04/2024 at 1:58 p.m., the ADON said she had not witnessed the previous Administrator saying Resident #4 looked like a child molester. She said there was a CNA and a nurse that each said that when she was leaving for the day said told him that he looked different, and he looked like a child molester. She said he had been shaved. She said she did interview him the next day. She said he did not want to tell them what she had said and seemed to be just brushing it under the rug.</p> <p>During an interview on 09/04/2024 at 3:05 p.m., the DON said the incident was reported to her. She said she felt it was inappropriate. She said she was told the previous Administrator walked out of the office and said to Resident #4, where are your teeth, you look like a child molester. She said she felt like it was a dignity issue. She said she did not interview Resident #4. She said he has not seemed upset. She said he told the Social Worker that it was weird when she said it and he just brushed it off. The aide and the nurse that witnessed the incident said he was laughing when the previous Administrator said what she did.</p> <p>Review of a Resident Rights facility policy dated 08/14/2022 indicated, .Employees shall treat all resident with kindness, respect, and dignity .Federal and state laws guarantee certain basic right to all resident in this facility. These rights include the resident's right to .a dignified existence .be treated with respect, kindness, and dignity .</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062</p> <p>Based on interview and record review the facility failed to ensure residents were free from abuse for 2 of 14 residents (Resident #1 and Resident #2) reviewed for resident abuse.</p> <p>1.The facility failed to ensure Resident # 1, was free from physical abuse when CNA A roughly placed his legs into the bed when he asked for assistance into bed.</p> <p>2.The facility failed to ensure Resident #2 was free from abuse when CNA E verbally abused him on 4/09/24.</p> <p>These failures could place residents at risk of physical harm, mental anguish, and/or emotional distress.</p> <p>The findings included:</p> <p>1.Record review of an undated face sheet indicated Resident #1 was an [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), major depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), anemia (low iron in the blood), and congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should). He discharged on [DATE].</p> <p>Record review of the quarterly MDS assessment dated [DATE] revealed Resident #1 had a BIMS score of 11, which indicated mild cognitive deficit. Resident #1 required moderate assistance for ADLs such as bed mobility, transfer, and toileting.</p> <p>Record review of a care plan dated 4/03/2024 titled ADL assistance indicated Resident #1 had an ADL self-deficit. The intervention for Resident #1 revealed the staff was to assist resident as needed with ADLs.</p> <p>During an interview on 8/29/2024 at 2:00 PM, Resident #1's family member stated that on more than one occasion the staff treated Resident #1 poorly by the way they talked to him. Resident #1's family member provided the video evidence of the staff being caring for him on 4/09/2024. Video evidence reviewed on 9/03/2024 at 8:00 AM revealed the following:</p> <p>Video footage dated 4/09/2024 5:29 PM, began with Resident #1 sitting on the side of the bed in his room with his feet dangling above the floor holding on to the edge of the mattress. CNA A was standing behind the left side of the resident's bed about 3 feet. CNA B was standing in the front of the resident's bed about 6 feet.</p> <p>Resident #1: Where are we going? This isn't working. I'm going to fall.</p> <p>CNA A: Then put your feet in the bed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1: I'm gonna fall, please help.</p> <p>CNA A: {Resident #1's first name}, put your feet in the bed.</p> <p>Resident #1: I can't put my feet in the bed.</p> <p>CNA A: Put your feet in the bed {Resident #1's first name}!</p> <p>Resident #1: I'm falling! I'm about to fall!</p> <p>CNA A moved around the bed in front of Resident #1. She grabbed his ankles and quickly lifted them and shoved them onto the mattress. CNA B was in the same position 6 feet from the bed and had not moved to assist.</p> <p>Resident #1: Ow, God, do you have to be so rough?</p> <p>CNA A: You are a big man, and I am not hurting myself messing with you.</p> <p>Resident #1: You don't have to be so rough with me.</p> <p>CNA A: I told you; you are a big man and I have a bad shoulder. I am not hurting myself trying to help you.</p> <p>Resident #1: You do not have to be rough with me. Just please don't be rough with me.</p> <p>CNA A: You are right I don't have to do it because I don't even have to be here. You are the one that needs help. You can't be telling people how to help you.</p> <p>CNA A to CNA B: Come over here and roll him because he is not going to do anything for himself.</p> <p>CNA B walks towards Resident #1 to assist with perineal care.</p> <p>End of video clip</p> <p>During a phone interview on 9/03/2024 at 10:20 AM, CNA A stated she was frustrated on 04/09/2024 with Resident #1 because just a short time before he was able to do everything for himself and he was not even trying to do for himself. She stated she placed his feet into the bed when he stated he was going to fall but she did not feel she had done it roughly. She stated that was just the amount of power it took to move his legs with one good shoulder. CNA A stated she should have asked CNA B who was also in the room to assist in moving his legs. CNA A stated she told Resident #1 that she was not rough with him and explained to him that he was a larger man it took force to move that much weight. She stated she was not attempting to be rough. CNA A stated she was terminated on 4/17/2024 related to the incident with Resident #1 that occurred on 4/09/2024. CNA A stated she felt it was not right to have been terminated over something that was not abuse. CNA A stated she was in serviced on abuse when she hired and several times throughout the year and she understood what abuse was and how to report it.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 9/03/2024 at 11:00 AM, CNA B stated she was terminated on 4/17/2024 following the incident with Resident #1. She stated she felt that CNA A was rough with Resident #1 when she put his legs in the bed, but she did not feel Resident #1 had been abused. CNA B stated she was in serviced on abuse and neglect up on hire and at least 3 times since she had been working at the facility. CNA B stated the facility wrote her up and fired her for not reporting the behavior of CNA A toward Resident #1 and not stopping CNA A from continuing care with Resident #1 after the abuse occurred. She stated she understood it was important to report the abuse so the abuser could be suspended, and no other residents would potentially be abused.</p> <p>During an interview on 9/04/2024 at 10:00 AM, the ADON stated she was made aware of the actions of CNA A to Resident #1 by Resident #1's family member on 4/09/2024 around 1:00 p.m. She stated she viewed the video, and it was apparent to her CNA A was being mean to Resident #1, but she was not sure it would have been considered abuse by the abuse coordinator. She stated she brought it to the attention of the DON and Administrator the next week because they were both on vacation at the time, and after suspension for her behavior and attitude CNA A was terminated. The ADON stated it was against Resident #1's rights to be mistreated and disrespected by being roughly handled by the staff.</p> <p>During an interview on 9/04/2024 at 3:00 PM, the DON stated it was brought to her attention by the ADON on 4/17/2024 that CNA A was being abusive to Resident #1, and it had been recorded by Resident #1's family member. The DON stated as soon as she was told about the incident, she called CNA A to let her know she would be suspended until it was determined what happened and she would be given education on abuse before being able to come back to work. The DON stated after reviewing the video it was determined CNA A's services were no longer needed at the facility. She stated the facility did not allow mistreatment of their residents in any way. The DON stated CNA A and CNA B was terminated on 4/17/2024.</p> <p>During an interview on 9/04/2024 at 3:30 PM, the ADM stated CNA A was terminated from the facility specifically related to her treatment of Resident #1. She stated it was against their abuse policy to treat residents in the manner she treated Resident #1. The ADM stated the treatment of Resident #1 could have resulted in Resident #1 having a feeling of decreased self-worth, skin tear, or other injuries. She stated abuse and neglect training was done immediately and the reporting process was included in that training.</p> <p>2. Record review of Resident #2's face sheet, printed 8/29/24, revealed he was [AGE] years old and admitted to the facility on [DATE]. Resident #2 had diagnoses of dementia (forgetfulness), heart failure, weakness, and lack of coordination.</p> <p>Record review of Resident #2's quarterly MDS assessment, dated 4/12/24, indicated he was usually understood and usually understood others. The MDS indicated Resident #2 had a BIMS score of 12, which indicated he had moderate cognitive impairment. The MDS indicated Resident #2 had continuous disorganized thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject). The MDS indicated Resident #2 did not have physical or verbal behavioral symptoms directed at others. The MDS indicated Resident #2 had limited range of motion to both lower extremities. The MDS indicated Resident #2 used a wheelchair for mobility. The MDS indicated Resident #2 was dependent on staff for transfers from chair to bed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's comprehensive care plan printed 8/29/24, indicated Resident #2 had impaired physical mobility related to decrease range of motion to both lower extremities due to amputations. The care plan indicated Resident #2 preferred to not be cussed at by others and preferred to bedtime was 2100 (9:00 PM). The care plan indicated Resident #2 was socially inappropriate related staff reported resident would become fixated on certain staff members at times, would make complaints against staff he did not agree with or had disagreements with, and had been heard telling others he would get them fired. The care plan indicated Resident #2 was verbally aggressive with interventions for all caregivers educated about triggers, what de-escalates, what signals onset of aggression; analyze key times, places, circumstances, triggers, and what de-escalates behavior; if patient becomes aggressive, caretaker to walk calmly away, approach patient later; intervene before patient agitation escalates.</p> <p>Record review of the facility's PIR dated 4/12/24 with an incident category of abuse indicated Resident #2 reported on 4/11/24 that on 4/09/24 CNA E cussed at him saying all kinds of cuss words but could not recall what cuss words were said other than the word ass. The PIR indicated CNA E was suspended pending investigation. The PIR indicated Resident #2 was assessed for adverse psychological effects and he was at his normal baseline with no signs of distress noted on assessment. The PIR indicated CNA E would be in-serviced on customer service prior to returning to work and CNA E would no longer be providing care to Resident #2. The PIR indicated Resident #2 told CNA E he was going to call his family member because they put him to bed late and CNA E responded with Okay, I will whoop her ass too, after accusing the resident of cussing her first.</p> <p>Record review of grievances from February 2024 to September 2024 did not reveal any abuse concerns related to CNA E.</p> <p>During an observation and interview on 9/3/24 at 2:00 PM, Resident #2 was sitting in his power chair in his room and said CNA E came in one night with another aide (CNA L) and CNA E said if you were like Resident #9, you would be in bed now. Resident #2 said he told CNA E he was not going to bed that early and CNA E started cussing at him. Resident #2 said he retaliated and said he was going to call his family member but did not cuss at CNA E. Resident #2 said he told the ADON and CNA E was no longer allowed back in his room. Resident #2 said he was fine with that resolution.</p> <p>During an interview on 9/3/24 at 3:28 PM, CNA L said she had worked at the facility since January of 2024 and normally worked the 10 PM-6 AM shift. CNA L said on 4/09/24, Resident #2 was upset that he was being put to bed late because Resident #2 had refused for the previous shift to put him to bed. CNA L said CNA E told Resident #2, if he would have agreed to be put to bed on the other shift, he would not have been put to bed late. CNA L said Resident #2 said he would do whatever he wanted. CNA L said CNA E helped transfer Resident #2 from his power chair to his bed with the mechanical lift, because it took 2 people. CNA L said Resident #2 continued to call CNA E ugly, and Resident #2 said he would have his family member come up there and whoop her (CNA E) ass. CNA L said CNA E told Resident #2 to tell her (family member) to bring her ass up there. CNA L said she told CNA E to leave the room, and she would finish Resident #2. CNA L said then CNA E went and stood in his doorway and said, I don't have time for this shit. CNA L said Resident #2 said he would come over there and slap CNA E. CNA L said CNA E told him to walk over there and slap her; knowing Resident #2 did not have any legs. CNA L said CNA E kept going back and forth with Resident #2 and it was not helping the situation. CNA L said she finished providing Resident #2's care. CNA L said she reported the situation to the nurse immediately following because Resident #2 said he was going to call his family member and his family member had come to the facility before and caused trouble.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Heritage Plaza Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 W 52nd St Texarkana, TX 75501	
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/4/24 at 5:00 AM, CNA E said she had worked at the facility for about a year and normally worked the 2PM-10PM or 10PM-6AM shifts. CNA E said the night of Resident #2 being mad about being put to bed late, just happened to be on a night when she was having transportation issues and CNA L came and picked her up for work. CNA E said they both were late getting to work. CNA E said Resident #2 was CNA L's resident, but he was a mechanical lift, and it took two people. CNA E said they went in to put Resident #2 to bed and he was already mad because it was late. CNA E said Resident #2 preferred to be put to bed by 9 PM and it was well after 10 PM when they went to put him to bed. CNA E said she tried to explain to Resident #2 that if he had let the other shift put him to bed then he would not have had to wait until then to be put to bed. CNA E said she let him get under her skin and she did say a cuss word and she probably should not have said some things. CNA E said she told Resident #2 to tell his family member to bring her ass up there because he was threatening to call his family member to whoop her ass while she was standing in the doorway. CNA E said he also said he was going to slap her. CNA E said she stood at the doorway to be a witness while CNA L completed his care. CNA E said she should have left and went and got the nurse. CNA E said she had received training on abuse, but she had not had training about deescalating a situation. CNA E said she should have walked away instead of engaging with Resident #2, but CNA L needed help. CNA E said she was not trying to escalate the situation. CNA E said it was abuse with her engaging back and forth with Resident #2 and saying a cuss word.</p> <p>During an interview on 9/04/24 beginning at 1:57 PM, the ADON said Resident #2 told her the next day after the incident with CNA E in April 2024 that he did not want CNA E back in his room. The ADON said Resident #2 and CNA E have had a personality conflict in the past and they had offered to remove CNA E from caring for him and he declined at that time. The ADON said she did some customer service education with CNA E, and CNA E has not been back in Resident #2's room. The ADON said CNA E should have deescalated the situation and stepped out of the room and told nurse. The ADON said she reported the incident to the ADM, who was the Abuse Coordinator. The ADON said CNA E should have not re-acted and stepped out and went and got the nurse.</p> <p>During an interview on 9/04/24 beginning at 2:33 PM, the DON said Resident #2 was mad about the 10 PM-6 AM shift having to put him to bed. The DON said Resident #2 told CNA E he was going to have his family member whoop her ass and CNA E stood in the doorway. The DON said CNA E should have not exchanged words with Resident #2, but CNA E felt she needed to defend herself. The DON said Resident #2 would say sexually inappropriate things and they keep a witness when providing his care. The DON said CNA E should not have continued to exchange words with Resident #2 and should have walked away and gotten the nurse.</p> <p>During an interview on 9/04/24 beginning at 3:10 PM, the ADM said Resident #2 was upset with CNA E for being put to bed late. The ADM said Resident #2 was moody and picky at times. The ADM said CNA E should not have continued to verbally interact with Resident #2 and should have left the situation and had someone else come to assist CNA L. The ADM said there had been no other resident complaints or incidents related to CNA E. The ADM said she would expect staff to follow the facility's policies and procedures.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy titled, Abuse and Neglect, with effective date of October 2022 read in part, . It is the policy of the facility to administer care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment, .VII. Reporting/Response (483.13(c)(1)(iii), 483.1 (c)(2) and 483.13 (c)(4)): Have procedures to: All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee. All allegations of abuse will be reported to HHSC immediately after the initial allegation is received .</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596</p> <p>Based on interview and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, exploitation, or mistreatment of residents for 1 of 14 residents (Resident #1) reviewed for abuse and neglect in that:</p> <p>The facility failed to suspend an alleged perpetrator immediately following CNA A roughly handling Resident #1 during ADL care. The facility allowed CNA A to work 7 more shifts before suspension while investigation the abuse allegations, and the facility failed to report the abuse within 24 hours to the state agency. The ADON and CNA B failed to report the abuse to the abuse coordinator immediately.</p> <p>The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 04/09/2024 and ended on 04/17/2024. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk for continued abuse and neglect due to inappropriate interventions and failure to report the allegations of abuse timely.</p> <p>Findings included:</p> <p>Record review of the facility's policy and procedure, titled Reporting Abuse and Neglect Policy, revision date March 2018, . 'With an allegation of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, the employee will immediately be suspended pending an investigation' . 'The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 .a. If the allegations involve abuse or result in serious bodily injury, the report is made within 2 hours of the allegation. If the allegations do not result in serious bodily injury, the report is made within 24 hours of the allegation.</p> <p>Record review of an undated face sheet indicated Resident #1 was an [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), major depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), anemia (low iron in the blood), and congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should). He discharged [DATE].</p> <p>Record review of the quarterly MDS assessment dated [DATE] revealed Resident #1 had a BIMS score of 11, which indicated mild cognitive deficit. Resident #1 required moderate assistance for ADLs such as bed mobility, transfer, and toileting.</p> <p>Record review of a care plan dated 04/03/2024 titled ADL assistance indicated Resident #1 had an ADL self-deficit. The intervention for Resident #1 revealed the staff was to assist resident as needed with ADLs.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/29/2024 at 2:00 p.m., Resident #1's family member stated there was a camera in Resident #1's room while he was a resident at the facility. She stated that on more than one occasion the staff treated Resident #1 poorly by the way they handled him. Resident #1's family member provided video evidence of the staff mistreating him on 04/09/2024. She stated Resident #1 was upset about the mistreatment and more upset they allowed CNA A to continue to work with him after she had been so rough with him during his care. She reported to the ADON on 04/09/2024 that the video showed her Resident #1 being handled in an abusive manner.</p> <p>Record review of video evidence on 09/03/2024 at 8:00 a.m. revealed the following:</p> <p>Video footage dated 04/09/2024 5:29 p.m., began with Resident #1 sitting on the side of the bed in his room with his feet dangling above the floor holding on to the edge of the mattress. CNA A was standing behind the left side of the resident's bed about 3 feet. CNA B was standing in the front of the resident's bed about 6 feet.</p> <p>Resident #1: Where are we going? This isn't working. I'm going to fall.</p> <p>CNA A: Then put your feet in the bed.</p> <p>Resident #1: I'm gonna fall, please help.</p> <p>CNA A: {Resident #1's first name}, put your feet in the bed.</p> <p>Resident #1: I can't put my feet in the bed.</p> <p>CNA A: Put your feet in the bed {Resident #1's first name}!</p> <p>Resident #1: I'm falling! I'm about to fall!</p> <p>CNA A moved around the bed in front of Resident #1. She grabbed his ankles and quickly lifted them and shoved them onto the mattress. CNA B was in the same position 6 feet from the bed and had not moved to assist.</p> <p>Resident #1: Ow, God, do you have to be so rough?</p> <p>CNA A: You are a big man, and I am not hurting myself messing with you.</p> <p>Resident #1: You don't have to be so rough with me.</p> <p>CNA A: I told you; you are a big man and I have a bad shoulder. I am not hurting myself trying to help you.</p> <p>Resident #1: You do not have to be rough with me. Just please don't be rough with me.</p> <p>CNA A: You are right I don't have to do it because I don't even have to be here. You are the one that needs help. You can't be telling people how to help you.</p> <p>CNA A to CNA B: Come over here and roll him because he is not going to do anything for himself.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>CNA B walks towards Resident #1 to assist with perineal care.</p> <p>End of video clip</p> <p>During an interview on 9/04/2024 at 10:00 AM, the ADON stated she was made aware of the actions of CNA A to Resident #1 by Resident #1's family member on 4/09/2024 around 1:00 p.m. She stated she viewed the video, and it was apparent to her CNA A was being mean to Resident #1, but she was not sure it would have been considered abuse by the abuse coordinator. She stated she brought it to the attention of the DON and Administrator the next week because they were both on vacation at the time, and after suspension for her behavior and attitude CNA A was terminated. The ADON stated it was against Resident #1's rights to be mistreated and disrespected by being roughly handled by the staff.</p> <p>During an interview on 09/04/2024 at 3:00 p.m., the DON stated it was brought to her attention by the ADON on 04/17/2024 that CNA A was being abusive to Resident #1, and it had been recorded by Resident #1's family member. The DON stated as soon as she was told about the incident, she called CNA A to let her know she was suspended until it was determined what happened and she was required to complete education on abuse before being able to come back to work. The DON stated after reviewing the video it was determined CNA A's services were no longer needed at the facility because abusive behavior was confirmed. She stated mistreatment of the residents was not allowed. The DON stated CNA A and CNA B was terminated on 04/17/2024. The DON stated the ADON was written up and received immediate one on one abuse and neglect training that included reporting protocol and timelines.</p> <p>During an interview on 09/04/2024 at 3:30 p.m., the ADM stated CNA A was terminated from the facility specifically related to her treatment of Resident #1. She stated the ADON was counseled on the abuse policy of the facility and was educated on reporting abuse to the abuse coordinator immediately and that the abuse coordinator had only 2 hours to report to HHS once abuse was suspected or confirmed. The ADM stated by not reporting the abuse immediately CNA A was allowed to work 7 more shifts with the same resident and other residents that she potentially could have abused. The ADM stated safe surveys were completed and the entire staff was inserviced on types of abuse, who the abuse coordinator was, and reporting time frames.</p> <p>The facility had corrected the noncompliance on 04/17/2024 by the following:</p> <ul style="list-style-type: none"> - Termination of CNA A who was responsible for the abuse - Termination of CNA B who was responsible for not reporting the abuse to the Abuse Coordinator - Written counseling of the ADON with education on the reporting process - Safe surveys of all the residents in the facility - 100% staff in-service on abuse and neglect and reporting - Backup plan established, and staff educated for the absence of the abuse coordinator (ADM) and the DON. Staff to notify corporate [NAME] President of Operations. <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of a Quality Assurance (QA) Meeting Sign-in Sheet dated 04/18/2024 indicated the facility had an QA meeting addressing abuse reporting. The QA Meeting Sign-in Sheet indicated the ADON, DON, ADM, NP, dietary manger, housekeeping supervisor, floor nurses, and CNAs attended the meeting.</p> <p>Record review of the sampled residents (Resident #6, Resident #7, and Resident 38) revealed abuse allegations were reported timely to the abuse coordinator and HHS.</p> <p>All staff interviewed (CNA E, LVN G, ADON, CNA H, and LVN K) on 09/03/2024 verbalized any allegation of abuse should be reported to the administrator immediately. They verbalized understanding of the types of abuse and the facility's obligation to report abuse to HHS within 2 hours.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 04/09/2024 and ended on 04/17/2024. The facility had corrected the noncompliance before the survey began.</p>		

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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>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596</p> <p>Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) for 1 of 14 residents (Resident #1) reviewed for abuse.</p> <p>The facility failed to report an allegation of physical abuse within 2 hours of the allegation being reported to the ADON on 04/09/2024. The ADM (abuse coordinator) reported the abuse to HHS on 04/17/2024 within 1 hours of being notified of the allegation of abuse by the ADON.</p> <p>These failures could place residents at risk of physical harm, mental anguish, and/or emotional distress.</p> <p>The findings included:</p> <p>1. Record review of an undated face sheet indicated Resident #1 was an [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), major depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), anemia (low iron in the blood), and congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should). He discharged on [DATE].</p> <p>Record review of the quarterly MDS assessment dated [DATE] revealed Resident #1 had a BIMS score of 11, which indicated mild cognitive deficit. Resident #1 required moderate assistance for ADLs such as bed mobility, transfer, and toileting.</p> <p>Record review of a care plan dated 4/03/2024 titled ADL assistance indicated Resident #1 had an ADL self-deficit. The intervention for Resident #1 revealed the staff was to assist resident as needed with ADLs.</p> <p>During an interview on 8/29/2024 at 2:00 PM, Resident #1's family member stated that on more than one occasion the staff treated Resident #1 poorly by the way they talked to him. Resident #1's family member provided the video evidence of the staff caring for him on 4/09/2024 being abusive. Video evidence reviewed on 9/03/2024 at 8:00 AM revealed the following:</p> <p>Video footage dated 4/09/2024 5:29 PM, began with Resident #1 sitting on the side of the bed in his room with his feet dangling above the floor holding on to the edge of the mattress. CNA A was standing behind the left side of the resident's bed about 3 feet. CNA B was standing in the front of the resident's bed about 6 feet.</p> <p>(continued on next page)</p>		

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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>Resident #1: Where are we going? This isn't working. I'm going to fall.</p> <p>CNA A: Then put your feet in the bed.</p> <p>Resident #1: I'm gonna fall, please help.</p> <p>CNA A: {Resident #1's first name}, put your feet in the bed.</p> <p>Resident #1: I can't put my feet in the bed.</p> <p>CNA A: Put your feet in the bed {Resident #1's first name}!</p> <p>Resident #1: I'm falling! I'm about to fall!</p> <p>CNA A moved around the bed in front of Resident #1. She grabbed his ankles and quickly lifted them and shoved them onto the mattress. CNA B was in the same position 6 feet from the bed and had not moved to assist.</p> <p>Resident #1: Ow, God, do you have to be so rough?</p> <p>CNA A: You are a big man, and I am not hurting myself messing with you.</p> <p>Resident #1: You don't have to be so rough with me.</p> <p>CNA A: I told you; you are a big man and I have a bad shoulder. I am not hurting myself trying to help you.</p> <p>Resident #1: You do not have to be rough with me. Just please don't be rough with me.</p> <p>CNA A: You are right I don't have to do it because I don't even have to be here. You are the one that needs help. You can't be telling people how to help you.</p> <p>CNA A to CNA B: Come over here and roll him because he is not going to do anything for himself.</p> <p>CNA B walks towards Resident #1 to assist with perineal care.</p> <p>End of video clip</p> <p>During an interview on 9/04/2024 at 10:00 AM, the ADON stated she was made aware of the actions of CNA A to Resident #1 by Resident #1's family member on 4/09/2024 around 1:00 p.m. She stated she viewed the video, and it was apparent to her CNA A was being mean to Resident #1, but she was not sure if it would have been considered abuse by the abuse coordinator. She stated she brought it to the attention of the DON and Administrator the next week because they were both on vacation at the time, and after suspension for her behavior and attitude CNA A was terminated. The ADON stated she was unaware of the 2 hour reporting window for abuse until after she reported it to the ADM on 04/17/2024.</p> <p>(continued on next page)</p>		

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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>During an interview on 9/04/2024 at 3:00 PM, the DON stated it was brought to her attention by the ADON on 4/17/2024 that CNA A was being abusive to Resident #1, and it had been recorded by Resident #1's family member. The DON stated as soon as she was told about the incident, she called CNA A to let her know she would be suspended until it was determined what happened and she would be given education on abuse before being able to come back to work. The DON stated after reviewing the video it was determined CNA A's services were no longer needed at the facility. She stated the facility did not allow mistreatment of their residents in any way. The DON stated CNA A and CNA B was terminated on 4/17/2024.</p> <p>During an interview on 9/04/2024 at 3:30 PM, the ADM stated she called the allegation of abuse in within 1 hour of being notified of the abuse allegation. The ADM stated CNA A was terminated from the facility specifically related to her treatment of Resident #1 immediately. She stated it was the facility's policy to report any abuse allegation within 2 hours of notification and she reported it within one hour of notification. The ADM stated not reporting the abuse allegation timely could delay the survey team longer than usual investigate the allegations of abuse. The ADM stated she reported the allegation in April of 2024, and it was September 2024 before the state agency reviewed her investigation.</p> <p>Record review of the facility's policy titled, Abuse and Neglect, with effective date of October 2022 read in part, . It is the policy of the facility to administer care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment, .VII. Reporting/Response (483.13(c)(1)(iii), 483.1 (c)(2) and 483.13 (c)(4)): Have procedures to: All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee. All allegations of abuse will be reported to HHSC immediately after the initial allegation is received .</p>		

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NAME OF PROVIDER OR SUPPLIER Heritage Plaza Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 W 52nd St Texarkana, TX 75501	
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062</p> <p>Based on observation, interview, and record review, the facility has failed to ensure that the resident environment remains as free of accident hazards as possible and provide supervision to prevent avoidable accidents for 2 of 8 residents reviewed for accidents. (Resident #3 and Resident #5)</p> <p>1. The facility failed to ensure CNA D performed safe repositioning with two staff members during incontinent care for Resident #3 on 3/26/24, which resulted in Resident #3 falling off the bed and required stitches to the inside of her lip.</p> <p>2. The facility failed to transfer Resident #5 with the required 2 people for a safe mechanical lift transfer from his bed to his chair.</p> <p>These failures could place residents at risk of injury from accident and hazards.</p> <p>Findings included:</p> <p>1. Record review of Resident #3's face sheet dated 8/29/24 indicated she was [AGE] years old and admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebral infarction (disruption of blood flow to the brain, resulting in parts of the brain dying), abnormalities of gait and mobility, lack of coordination, and diabetes (high blood sugar).</p> <p>Record review of Resident #3's quarterly MDS assessment dated [DATE] indicated she was rarely/never understood and sometimes understood others. The MDS indicated a Resident #3 had a BIMS score of 00, which indicated she had severe cognitive impairment. The MDS indicated Resident #3 had inattention continuously (easily distracted) and disorganized thinking continuously (rambling or irrelevant conversation). The MDS indicated Resident #3 required extensive assistance of two persons for bed mobility, toileting, and personal hygiene. The MDS indicated Resident #3 was totally dependent on 2 persons assistance during bathing. The MDS indicated Resident #3 was always incontinent of bowel and bladder. The MDS indicated she had diagnoses of cerebral infarction, aphasia (difficulty speaking), and hemiplegia or hemiparesis (unable to move or weakness on one side of the body).</p> <p>Record review of Resident #3's quarterly MDS assessment dated [DATE] indicated she was rarely/never understood and rarely/never understood others. The MDS indicated a Resident #3 was rarely/never understood and unable to complete BIMS, which indicated she had severe cognitive impairment. The MDS indicated Resident #3 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident #3 had inattention continuously (easily distracted) and disorganized thinking continuously (rambling or irrelevant conversation). The MDS indicated Resident #3 had limited range of motion to both upper and lower extremities on one side of the body. The MDS indicated Resident #3 was dependent on staff for toileting hygiene and rolling left and right in bed. The MDS indicated she was always incontinent of bowel and bladder.</p> <p>Record review of Resident #3's Fall Risk assessment dated [DATE] indicated she scored 15, a score of 7-18 indicated she was high risks for falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #3's care plan printed on 8/29/24 indicated Resident #3 had impaired physical mobility with an onset of 3/03/23 and an intervention to provide appropriate level of assistance to promote safety of resident. The care plan indicated Resident #3 had impaired physical mobility with a reviewed date of 3/04/23 as evidenced by right upper and lower extremity weakness; interventions included provide appropriate level of assistance to promote safety of resident, required assistance of one staff, required assistance of two staff, required extensive assistance, and required limited assistance. The care plan indicated Resident #3 was a high fall risk with an onset of 3/04/23 as evidenced by right upper and lower extremity weakness.</p> <p>Record review of Resident #3's Vital Sign report printed on 9/04/24 indicated she weighed 237 pounds on 3/06/24.</p> <p>Record review of Resident #3's Nurses Note documented on 3/26/24 at 2:46 AM by LVN C indicated the CNA notified her of Resident #3 had rolled out of the bed and was on the floor. LVN C arrived and observed Resident #3 lying face down and had small amount of bright red blood to head area. Resident #3 was assessed and found to have appeared to have bitten the inside of her lip with blood to mouth and her left eye slightly swollen with discoloration noted, and Resident #3 complained of right shoulder pain. Resident #3 was sent to the emergency room . LVN C documented on 3/26/24 at 3:49 AM, Resident #3 received three stitches to right upper inner lip and her head scans were clear.</p> <p>Record review of the facility's PIR dated 3/26/24, indicated Resident #3 was observed lying face down at bedside by LVN C after rolling off the bed attempting to reach something on her bedside table during ADL care. CNA D stated she turned Resident #3 to her right side and Resident #3 reached for something and rolled off the bed. Resident #3 had a small laceration to the inside of her upper lip and small abrasion to head and bruising to left and right eyes. Resident #3 was transferred to the hospital and received three stitches to inside of her lip.</p> <p>Attempted to call Resident #3's responsible party on 8/29/24 at 1:47 PM and on 9/3/24 at 1:08 PM, but there was no answer, a voice mail was left requesting a return call. Resident #3's responsible party did not return call prior to exiting the facility.</p> <p>During an observation and interview on 9/4/24 at 8:36 AM, Resident #3 was sitting up in bed with her breakfast tray in front of her with most of the food gone. Resident #3 said she was doing good and had a good breakfast. Resident #3 said she did not remember rolling out of bed and busting her lip. Resident #3 said no one had been mean to her and they took good care of her.</p> <p>Attempted to call CNA D on 9/3/24 at 3:19 PM and 9/04/24 at 11:45 AM, but there was no answer, a voice mail was left requesting a return call. CNA D did not return call prior to exiting the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/4/24 at 10:17 AM, LVN C said she remembered the incident in March 2024, and Resident #3 reached over to get snacks off her bedside table while CNA D was rolling her over during incontinent care. LVN C said Resident #3 was a very heavy-set lady. LVN C said CNA D was performing Resident #3's incontinent care by herself. LVN C said Resident #3 should have been a two person assist for safety, but CNA D was doing it by herself. LVN C said she did not know CNA D was even down there and CNA D did not ask her for help. LVN C said CNA D should have asked for help to ensure Resident #3's safety. LVN C said CNA D said she tried to catch Resident #3 but could not catch her in time. LVN D said CNA D was rolling her away from her and Resident #3 was a large resident and Resident #3 just kept going and rolled off the bed and into the floor. LVN C said she sent Resident #3 to the emergency room and Resident #3 received stitches to the inside of her mouth. LVN C said she asked CNA D why she did Resident #3's incontinent care by herself, and CNA D told her she thought she could do it.</p> <p>During an interview on 9/4/24 at 1:22 PM, CNA H said Resident #3 took two to three staff for incontinent care. CNA H said Resident #3 was a big lady. CNA H said it was not safe for one person to perform Resident #3's incontinent care because Resident #3 could roll out of the bed.</p> <p>During an interview on 9/4/24 beginning at 1:57 PM, the ADON said, unfortunately, CNA D was not following Resident #3's care plan. The ADON said Resident #3 required two people for incontinent care and CNA D was performing incontinent care by herself. The ADON said she would not change Resident #3 by herself because of Resident #3's size and Resident #3 was flaccid (unable to move) on her right side. The ADON said unfortunately there happens to be one aide more often than she would like, but there were always two nurses, and the nurses were instructed to assist the aides.</p> <p>During an interview on 9/4/24 beginning at 2:33 PM, the DON said Resident #3 was impulsive and she believed Resident #3 was a one person assist in March of 2024. The DON said as part of their updated interventions following Resident #3's fall, she was a two person assist now. The DON said she did not know if she could look back and see if Resident #3 was a one or two person assist in March of 2024. The DON said CNA D had rolled resident onto her right side and Resident #3 reached for something on her bedside table. The DON said CNA D tried to catch Resident #3 but could not and Resident #3 rolled onto the floor. The DON said Resident #3 was assessed and sent to the emergency room , where she received stitches to her lip.</p> <p>During an interview on 9/4/24 beginning at 3:10 PM, the ADM said she became the ADM in April of 2024 after the incident with Resident #3 on 3/26/24. The ADM said she was not the ADM when Resident #3 fell out of the bed during incontinent care, but she would expect staff to follow the proper procedures for providing care safely.</p> <p>Record review of the facility's form titled Certified Nurse Aide Orientation Packet with a start date of 1/10/24 indicated CNA D completed her Returned Demonstrated Clinical Skills on 1/22/24 with a pass rate on all skills including incontinent care, resident transfers/safe handling, and fall prevention.</p> <p>2. Record review of an undated face sheet indicated Resident #5 was a [AGE] year-old male that admitted to the facility on [DATE] and discharged [DATE] with the diagnoses of schizoaffective disorder (mental health condition including schizophrenia and mood disorder symptoms), hemiplegia (paralysis of one side of the body), and BPH (Age-associated prostate gland enlargement that can cause urination difficulty).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #5's quarterly MDS assessment dated [DATE] indicated he had a BIMS score of 00 which indicated severe cognitive impairment. The MDS also indicated Resident #5 was dependent for ADLs such as toileting, hygiene, bathing, bed mobility, transfer, dressing and personal hygiene.</p> <p>Record review of Resident #5's care plan dated 1/30/2024 titled 'Self Care' revealed Resident #5's goal was to be transferred by 2 staff members with the mechanical lift to maintain safety.</p> <p>Record review of incident and accidents from 01/01/2024 to 09/04/2024 showed no accidents related to mechanical lift transfers.</p> <p>During an interview and record review on 8/29/2024 at 10:00 AM, Resident #5's family member stated she had video of Resident #5 being transferred with just one CNA on multiple occasions. She stated she reported it to the ADM each time it occurred and nothing changed. Review of the video dated 5/19/2024 at 11:10 AM, revealed CNA F transferring Resident #5 from his bed to his chair using a mechanical lift by herself.</p> <p>During an interview on 9/03/2024 at 1:20 PM, CNA F stated there had been times in the past that she had no choice but to transfer residents with one person using a mechanical lift. She stated you cannot stop others from doing their work to come help you with every single transfer. She stated she now primarily worked the 300 hall and there were not too many residents requiring mechanical lifts for transfer, so she had not run into the issue of having to transfer someone by herself. She stated she now will ask therapy to help her when she does a mechanical lift transfer. CNA F stated she did not recall transferring Resident #5 on that day without help, but it was possible that she had. She had no recollection of any specific in service training on mechanical lift transfers.</p> <p>During an interview on 9/04/2024 at 1:30 PM, CNA H stated she transferred people alone with a mechanical lift every day. She stated there were 9 residents on hall 100 that required a mechanical lift to be used for transfer. CNA H stated there was no way one could get a CNA from another hall to stop what they were doing and come spot you 9 times to get them up and 9 times to put them back down. CNA H stated sometimes therapy had not minded helping, but she was told no by most of the nurses when she asked for assistance. She stated she has told the DON, ADM, and ADON numerous time and they told her to do the best she could. CNA H stated she understood that 2 people should be present with mechanical lift transfers for the safety of the resident and incase anything malfunctioned.</p> <p>During an interview on 9/04/2024 at 2:00 PM, LVN G stated she was aware there were times CNAs were left with no choice but to transfer residents by mechanical lift on their own. LVN G stated she and all the staff were aware it was a requirement for safety to have 2 people when using a mechanical lift. She stated anytime anyone of the CNAs asked her for help she helped, but there were times when she had to tell them she could help in an hour but not immediately. She stated the nurses had responsibilities that limited the amount of time they were able to do extra care for the residents. LVN G stated during the night shift everyone had to help everyone out to get all their jobs accomplished and keep the residents cared for. LVN G stated she felt they worked well as a team and were able to get all their duties done and the residents were cared for.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/04/2024 at 2:30 PM, the DON stated it was the policy of the facility to have 2 staff members present during a mechanical lift transfer for safety. The DON stated it had not been brought to her attention that the CNAs were unable to get help or help one another when performing a mechanical lift transfer. She stated she was unaware that Resident #5 had been transferred with only one staff member. The DON stated day shift has the most staff and there was no excuse for Resident #5 to have been transferred unsafely. The DON stated she was responsible for training and monitoring safe transfers. She stated she educated at least annually and as needed on safety of transfer.</p> <p>During an interview on 9/04/2024 at 3:30 PM, the ADM stated the facility was staffed for the acuity of the residents and the number of residents. She stated during the day there were department heads that included the DON, ADON, and MDS Nurse that could be asked to assist with mechanical lift transfers. The ADM stated therapy was always willing to help with these transfers, as well. The ADM stated Resident #5's family was very active in his care while he was there and had not mentioned a concern about him being transferred with one staff member. The ADM stated if Resident #5 was care planned to be a 2-person transfer and the staff was using a mechanical lift to transfer him, then it was unacceptable to transfer him alone. The ADM stated bruising, skin tears, and even more serious injuries like falling and fractures could occur from an improper transfer.</p> <p>On 9/4/24 at 3:40 PM, requested a policy on accidents and hazards or repositioning residents during incontinent care from the ADM.</p> <p>On 9/4/24 at 4:30 PM, the ADM said they did not have a policy on accidents and hazards or repositioning residents during incontinent care. The ADM provided a policy on Perineal care that did not address the positioning of the resident during the care.</p> <p>Review of FDA 'Guidelines to Hoyer Transfer', retrieved 6/10/2024 at 3:45 PM, https://www.fda.gov/files/medical%20devices/published/Patient-Lifts-Safety-Guide.pdf, indicated, . the safest practice for Hoyer transfers was to use 2 people. One person was required to operate the machine and the other assists and guarded the patient against injury. In instances of negligent operation, the machine may tip over with the resident in it or a loop on the sling may dislodge from the machine causing the resident to fall to the floor. The second person is there to prevent serious injury to the resident. Residents sometimes become agitated, and a second person should be there to help stabilize the sling. The battery may also lose power during a transfer. A second person could go get another battery while the first person stays with the resident .</p> <p>Review of an undated facility policy titled Hydraulic Lift revealed . the goals of using a hydraulic lift are . 1. The resident will achieve safe transfer to bed or chair via a mechanical lift device. 2. The caregiver will demonstrate and correct transfer of the resident to the bed or chair via the hydraulic lift. 3. The resident will verbalize a decrease in anxiety following explanation of the procedure .</p>		