STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675561	A. Building B. Wing	11/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Plaza Nursing Center	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)
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** 46062 Based on interviews and record review the facility failed to develop, and implement a comprehensive care plan to meet the medical, nursing, mental and psychosocial needs for 1 of 5 residents (Resident #1) reviewed for care plans. The facility failed to implement a comprehensive person-centered care plan for Resident #1's refusal of care, refusal to be repositioned, and refusal to take medications. This failure could place residents in the facility at an increased risk of a decline in physical or functional well-being, of not receiving necessary care or services, and having personalized plans developed to address their needs. Findings included: Record review of Resident #1's face sheet dated 11/01/24 revealed he was [AGE] years old and admitted to the facility on [DATE] and discharged on [DATE]. Resident #1 had diagnoses of acute respiratory failure with hypoxia (lack of adequate oxygen in the body's tissues to sustain function), cardiomyopathy (disease of the heart muscle which makes it hard for the heart to deliver blood to the body and could lead to heart failure), atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on the artery walls), anxiety (feeling of fear, dread, and uneasiness), and atrial fibrillation (irregular, often rapid heart rate that causes poor blood flow). Record review of Resident #1's admission MDS assessment dated [DATE] revealed he was rarely understood and sometimes understood others. Resident #1 was unable to complete the BIMS, indicating severe cognitive impairment. The MDS indicated Resident #1 had continuous inattention and disorganized thinking. The MDS indicated Resident #1 rejected care one to 3 days in the look back timeframe. The MDS indicated Resident #1 required total to maximum assistance for most ADLs. The MDS indicated Resident #1 was always incontinent of bowel and bladder. Record review of Resident #1's care plan printed 11/01/24 revealed he had a self-care deficit, but it did not indicate he refused care. The care plan indicated Resident #1 was at risk for/actual skin breakdown, but it did not indicate he refused repositioning or care. Resident #1's care plan did not indicate he refused medications. The care plan indicated Resident #1 had a urinary catheter, but it did not indicate he had a history of pulling out his urinary catheter. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nurses' notes indicated he refused a skin assessment on 9/6/24 due to pain. Resident #1 refused incontinent care on 9/7/24. Resident #1 refused incontinent care on 9/8/24 and took off his brief and threw it and an entire plate of food and beverage onto the floor and told staff Don't fuck with me. Resident #1 refused medications on 9/17/24. Resident #1 was non-compliant with repositioning, incontinent care, refused medications, and all care from staff on 9/18/24. Resident #1 pulled his urinary catheter out on 9/20/24. Resident #1 removed his pain patch on 9/23/24. Resident #1 refused to be repositioned on 10/03/24 and stated, do not move me. Resident #1 pulled out his urinary catheter on 10/6/24. During an interview on 11/02/24 at 11:13 AM, LVN A said she had worked at the facility for approximately two months and normally worked the 6 AM to 6 PM shift. LVN A said they had one resident that refused most care, Resident #1. LVN A said Resident #1 would refuse pretty much everything. LVN A said Resident #1 did not want medications, did not want to be touched due to his pain, and every time they would try to reposition off his right side, he would try to hit them. LVN A said the care plan described what care the resident needed to meet their needs. LVN A said Resident #1 needed comfort care and their goal was to keep him comfortable. LVN A said this was her first nursing facility she had worked in, and she was not completely sure of all the right answers related to the care plans. During an interview on 11/02/24 at 11:49 AM, LVN B said she had worked at the facility since August 2024 and normally worked the 6 PM to 6 AM shift. LVN B said the nurses should chart if the resident refused care and she thought the care plans were updated by the ADON or the DON. LVN B said if the resident continued to refuse, the care plan should indicate it and if there was a decline related to their refusals. LVN B said Resident #1 was non-compliant with turning, they would try to reposition him, and he would refuse or turn himself back over to what was most comfortable to him. LVN B said Resident #1 was just very non-compliant with his care . During an interview on 11/02/24 beginning at 2:20 PM, the ADON said Resident #1 would refuse care due to severe pain and he did not want to be touched. The ADON said Resident #1's left hip hurt, and he would lay on his right side and would move himself back onto his right side even when he would let them reposition him. The ADON said the MDS Coordinator, or any nurse or RN could update or revise the care plans. The ADON said if the care plan was not updated, it placed the resident at risk of not receiving the most up to date care to meet their needs. During an interview on 11/02/24 at 1:18 PM, RN C said she had worked at the facility since August 2024 and normally worked on 6 AM to 6 PM. RN C said the nurses were responsible for updating the care plans. RN C said the purpose of the care plan was to identify problems and figure out the interventions for the resident and then evaluate if they were effective. RN C said if the care plan was not updated, then the new problems could not get acknowledged, taken care of, or monitored for effectiveness. During an interview on 11/02/24 at 1:45 PM, CNA D said she had worked at the facility for five years and normally worked on the day shift. CNA D said Resident #1 had severe pain, did not want you to touch him, and he would tell you to get out of his room. CNA D said the MDS coordinator and DON/ADON were responsible for updating the care plans. CNA D said the care plan let staff know how to care for the resident, such as how much assistance they needed and if they were able to transfer safely. CNA D said if the care plans were not updated, staff would just be doing the best they could to figure out what the resident was capable of and needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/02/24 beginning at 2:40 PM, the DON said any refusal of care should have been care planned. The DON said the IDT was responsible for revising the care plans, which consisted of the DON, the ADON, the MDS coordinator, the ADM, the SW, nursing, CNAs, hospice, and anyone involved in the resident's care. The DON said the care plan not being revised had the potential of the resident not receiving the care that they needed. The DON said the purpose of the care plan was to guide the resident's care and any refusal of care should have been care planned. During an interview on 11/02/24 at 5:02 PM, the MDS Coordinator said she had worked at the facility for over [AGE] years. The MDS Coordinator said the nurses were responsible for making updates and changes to the care plan and she was responsible for developing the comprehensive care plans. The MDS Coordinator said any refusals of care would be documented in the care plan, if she was aware, and there was supporting documentation. The MDS Coordinator did not know why Resident #1 did not have rejection of care on his care plan when he was marked as rejecting care on the MDS. The MDS Coordinator said the purpose of the care plan was to paint a picture of what was going on with the resident and let staff know what was happening and what care needs were to be provided to the resident. The MDS Coordinator said acute changes were a collective attempt of herself, the nurses, and ADON/DON to keep the care plan updated. The MDS Coordinator said the CNAs have an ADL care plan that told what care the resident needed, and direct care staff knew what care the resident needed, therefore she did not feel there would be a negative effect on the resident. During an interview on 11/02/24 at 5:20 PM, the ADM said Resident #1 had severe pain and refused care often and refused repositioning. The ADM said she would expect staff to follow the facility's policies related to care plans. The ADM said Resident #1's refusal of care should have been care planned. The ADM said the IDT team was responsible for developing and updating the care plans . Record review of the facility's policy titled Care Plan- Process dated revised February 12, 2020, revealed . the interdisciplinary team (IDT) would coordinate with the resident and their legal representative an appropriate care plan for the resident's needs or wishes based on the assessment and reassessment process within the required timeframes . the IDT meets and reviews the care plan as follows . seven days after the closure on the date of the admission MDS . with any change in condition . the team directs care planning toward attaining and maintaining the highest optimal physical, psychosocial, functional status including Advanced Directives, and signs the approved Plan of Care . the Plan of Care identifies the Date, Problem, Goals- measurable and realistic, time frames for achievement, Interventions, discipline specific services, and frequency, Resolution/Goal analysis, Discharge option .