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 03/04/2025
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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on observations, interviews, 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 1 of 17 residents (Resident #4) reviewed for resident rights. The facility failed to ensure Resident #4 had a dignified existence by allowing her to be covered in feces on 2/27/25. These failures could place residents at risk of humiliation, diminished quality of life, loss of dignity and loss of self-worth. Findings included: Record review of Resident #4's face sheet dated 3/03/25 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #4 had diagnoses which included diverticulitis (occurs when an infected pouch becomes filled with pus) of large intestine with perforation (rupture) and abscess (pocket of pus), hypertension (high blood pressure), and depression (persistent sadness that can interfere with daily life). Record review of Resident #4's MDS assessment indicated it had not been completed prior to exiting the facility. Record review of Resident #4's care plan dated of 3/03/25 indicated she was taking an antidepressant (medication to treat depression); she had impaired physical mobility with an intervention to provide appropriate level of assistance to promote safety of resident; she had a self-care deficit with an intervention to provide assistance with self-care as needed; she was at risk for problems with elimination; and she had a colostomy/ileostomy (surgical procedure that created an opening in the abdominal wall through which waste products from the small intestine could exit the body). Record review of Resident #4's Progress Note dated 2/25/25 indicated Resident #4 had an ileostomy due to a perforated (ruptured) diverticulitis and a large midline surgical incision with staples and dehisced area (open/separation of wound edges) to the end of the incision near the ileostomy and it was being packed with saline soaked gauze. NP F documented the ileostomy bag had dark liquid stool in it. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Nurse Note dated 2/28/25 at 6:45 AM indicated LVN A had come on duty on 2/27/25 at about 1910 (7:10 PM) and was informed by LVN C, Resident #4's family was there and was upset that Resident #4 had bowel all over her and her wound from her leaking colostomy bag. LVN A documented Resident #4's clothing and brief were soiled with bowel from her leaking colostomy bag, as well as the dressing covering the wound. LVN A documented Resident #4's family member stated Resident #4 had been sitting in poop for four hours. During an observation and interview on 3/03/25 at 11:50 AM, Resident #4 was lying in bed visiting with two family members in her room. Resident #4 said since her FM #1 fussed at the facility on 2/27/25, things had been much better and they now checked on her hourly and emptied her colostomy bag, but the first three days at the facility were awful. Resident #4 said the staff did not empty her colostomy bag and it burst the first night she was at the facility and covered her in poop and it frequently leaked. Resident #4 said she laid in her own poop and had poop in her wound that was by her colostomy frequently for the first three days, but the worst time was on 2/27/25. Resident #4 said they had issues on 2/27/25 four times during the day with her colostomy bag leaking and the nurse had changed it a couple times earlier in the day, but it would be back to leaking shortly after it was changed. Resident #4 said she laid in her own poop for about four hours until FM #3 came to see her. FM #2, who was visiting with Resident #4, said she had called Resident #4 at 3:00 PM and Resident #4 said her colostomy bag was leaking and no one had come to answer her call light and she was lying in her own poop. FM #2 said she called the facility about 3:30 PM and no one answered the phone. Resident #4 said she knew she had been lying in her own poop for about four hours based off the time of the phone calls with FM #2. Resident #4 said by the time FM #3 arrived in her room a little after 7:00 PM, she was covered in her own poop. Resident #4 said when FM #3 entered the room, he said, what is that smell and Resident #4 said she was crying and threw back the covers and she told FM #3 it was her because no one had fixed her leaking colostomy and she was covered in her own poop. Resident #4 said she laid in her own poop until her FM #3 arrived at the facility, and he went to try to get someone to clean her up and was told by staff that it was not their jobs and would have to get the nurse. Resident #4 said it was about 8:00 PM before they finally started cleaning her up. Resident #4 said it was embarrassing to be covered in her own poop and the smell was awful. Resident #4 said they were not answering her call light timely which led to her colostomy bag getting too full and it pulled away from the skin from the weight and then it would start leaking. Resident #4 said at times the CNA would come by and would tell her it was not their job to empty it, and she would have to get the nurse, but no one came. Resident #4 said a CNA did offer to change her gown on 2/27/25 but what good would that have done when everything was covered in poop and her leaking colostomy was continuously producing more liquid poop. Resident #4 said she had been told the nurse would be coming to change the colostomy bag, but she did not come. During an interview on 3/4/25 at 10:37 AM, FM #3 said he arrived at the facility at 7:00 PM per his life 360 application on his phone. FM #3 said he walked into Resident #4's room and opened her door and said, what is that smell and Resident #4 pulled her covers back and she had poop from her chest to her knees and she was crying. FM #3 said he went down the hall and saw someone on her phone and asked her, who was going to clean Resident #4 up. He said she said it was not her job and she would go get someone. FM #3 said Resident #4 said she had been sitting in poop for almost for four hours. FM #3 said he then saw a nurse he knew coming in the front door and asked her to come down to Resident #4's room. FM #3 said when the nurse walked into the room she said, O my and said she would get Resident #4 taken care of. FM #3 said the nurse cleaned on Resident #4 for almost two hours. FM #3 said there was no excuse for the state Resident #4 was in. FM #3 said someone should have tended to her colostomy bag long before it got to the point it did with covering Resident #4 in her own poop. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/4/25 at 10:58 AM, LVN A said she was late coming in for her shift (6 PM-6 AM) on 2/27/25 and arrived around 7:10 PM. LVN A said the day shift nurse (LVN C) was in a tizzy and said she (LVN A) would have to go deal with Resident #4's family because they were cussing at LVN C. LVN A said she went into Resident #4's room and she had poop everywhere, in the wound, in her brief, in the bed and linens, and covering her gown from her chest to below her knees. LVN A said she went and gathered all the supplies she would need to clean Resident #4 up, change the colostomy bag, and clean and redress her wound, and then went back to Resident #4's room. LVN A said it took her about two hours to clean Resident #4 up, change the colostomy, and clean and redress her wound. LVN A said, let's just say if that was my mother, I would have flipped my you know what, if I had found her like that. LVN A said some of the feces was dried with brown ring edges on the bedding and some was still liquid. LVN A said the dried feces with brown ring edges indicated it had been there for a while, but she was not sure how long it would have taken it to dry. LVN A said she was sure it embarrassed Resident #4 and made her feel awful and it was probably irritating to her skin. LVN A said the entire ordeal was embarrassing for Resident #4. During an interview on 3/4/24 at 11:20 AM, CNA B said she had gone into Resident #4's room a little while before her family arrived and she asked Resident #4 about changing her gown due to her colostomy bag was leaking. CNA B said she placed a towel under Resident #4 and over her gown because Resident #4 said she wanted to wait until after the nurse changed the colostomy bag. CNA B said the colostomy bag was leaking and it would be the nurse that would have to change it. CNA B said she had come in to work the 2 PM to 10 PM shift. CNA B said she had not emptied the colostomy bag during her shift. CNA B said she did not know she could empty the colostomy bag. CNA B said they had been having issues with the colostomy bag leaking that day. CNA B said the nurse would have been responsible for ensuring the colostomy bag was not leaking and for emptying it because she was unaware, she could empty the bag. CNA B said Resident #4 probably felt disgusted and dirty lying in her own feces. During an interview on 3/4/25 at 12:19 PM, LVN C said she had worked at the facility for about a month on the 6 AM-6 PM shift. LVN C said the CNAs were going into Resident #4's room regularly on 2/27/25. LVN C said she emptied the colostomy bag three times herself and changed the bag twice during her shift and was not sure why the family was saying that she had been lying in feces for four hours. LVN C said no one had told her that Resident #4's bag was leaking, and she was confused when FM #1 was yelling at her that it had leaked, she did not know there was an issue with it leaking. LVN C said FM #3 had asked her when they were going to clean her up and then FM #1 showed up and started yelling at her. LVN C said she was going to give another resident pain medication and then come back and take care of Resident #4. LVN C said she was not told that the resident was covered in feces on 2/27/25. LVN C said she did not witness what the Resident #4 looked like prior to her family arriving. LVN C said it would be embarrassing to Resident #4 and it could cause an infection to be covered in her own feces. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/4/25 at 3:30 PM, the DON said she had gotten a phone call about a family member being at the facility and was yelling and screaming and a couple of the CNAs felt threatened by the family member's body language toward them on 2/27/25. The family member was making allegations that Resident #4 had not been cared for and left covered in feces. The DON said she then called the ADM, and the ADM came to the facility. The DON said there was an issue with getting the colostomy bag to seal, due to the placement of the ileostomy and her open wound, and it would leak. The DON said she would have been responsible to ensure that staff were knowledgeable of caring for the colostomy and care was being provided timely. The DON said she was not sure how long it would take for stool to dry, maybe a couple of hours. The DON said if there were dried brown circles it would be indicative that the stool had been there for a while. The DON said Resident #4 could have skin issues and there was the dignity issue of having feces on her. The DON said the aide did offer to clean her up, but the resident declined because she wanted to wait until the nurse came to change her colostomy. During an interview on 3/4/25 at 4:00 PM, the ADM said Resident #4 had only been in the facility for three days and she had not gotten any complaints from Resident #4 until her FM #1 was at the facility cussing staff and saying Resident #4 had not been cared for. The ADM said Resident #4 had not told her about having frequent leaking from her colostomy bag. The ADM said when the colostomy bag would get to a certain level Resident #4 wanted it emptied. The ADM said Resident #4 told her that staff would come in and say that they were coming back and did not come back quickly. The ADM said FM #1 told her Resident #4 had feces all over her on 2/27/25. The ADM said she came to the facility on [DATE] during the incident with Resident #4's family, but the nurse had already been cleaning up the resident and the ADM said she did not see any of the issue. The ADM said being covered in feces could make the resident feel like she was not being cared for. The ADM said the resident had told her the aide had offered to change her and the resident declined because she was waiting for the nurse to return and change the colostomy bag. Record review of the facility's Training In-service Form dated 2/28/24, titled Customer Service, Rounding, Call lights, Abuse/Neglect, and Providing Care in a timely manner, indicated . CNA Inservice . routine rounds were important . not only for incontinent care . residents depend on us to notice when something was right . the earlier we notice a change, the better the outcome . call lights should be answered timely . if the resident's need is out of your scope of practice, ensure the resident that you will locate the appropriate staff, then do so . emptying, and cleaning ostomy bags and the skin around them IS within your scope of practice and you are expected to perform this duty . if the ostomy bag itself has become dislodged, clean the area, place a towel for comfort, and inform the resident's nurse immediately . provide care to residents in a timely manner . if you cannot attend to the resident's request immediately, give them a time frame in which you will return and then make sure you adhere to that time frame . this alleviates some of the anxiety they feel when waiting for care . Review of the facility's policy titled Resident Rights dated revised August 14, 2022, indicated . the staff would abide by and protect resident rights in accordance with state and federal guidelines .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observations, interviews, and record review, the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 2 of 17 (Resident #1 and Resident #2) residents reviewed for call lights. The facility failed to ensure call lights were within reach while Resident #1 and Resident #2 were in bed. This failure could place residents at risk for a delay in assistance and decreased quality of life, self-worth, and dignity. Findings included: 1. Record review of Resident #1's face sheet dated 03/03/25 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #1 had diagnoses which included dementia, amputation at knee level of right lower leg, and impulse disorder (a group of behavioral conditions that make it hard to control reactions or actions). Record review of Resident #1's annual MDS assessment dated [DATE], indicated he had a BIMs score of 10, which indicated she had moderate cognitive impairment. Resident #1 required maximal assistance or was totally dependent on staff for most ADLs. The MDS indicated Resident #1 was totally dependent for chair to bed transfers. The MDS indicated Resident #1 was always incontinent of bowel and bladder. Record review of Resident #1's Care Plan last reviewed on 01/16/25 reflected Resident #1 was a fall risk. There was an intervention to keep the call light and most frequently used personal items within reach. During an observation and interview on 03/02/25 at 8:57 a.m., Resident #1 said a lot of the time his call light was out of his reach, and he had to holler for help. Resident #1's call light was hanging on the privacy curtain at the foot of his bed. He said he could not reach it if he needed it. Resident #1 said this happened all of the time. 2. Record review of Resident #2's face sheet dated 03/03/25 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #2 had diagnoses which included overactive bladder, left femur (thigh bone) fracture, and major depressive disorder (a common mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's latest MDS assessment dated [DATE], indicated he had a BIMs score of 8, which indicated he had moderate cognitive impairment. Resident #2 required moderate assistance or was totally dependent on staff for most ADLs. The MDS indicated Resident #18 was always incontinent of bladder and bowel. The MDS indicated Resident #2 had fallen in the last month. The MDS indicated Resident #2 had fallen 2 times with no injury and 2 times with injury since admission to the facility. Record review of Resident #2's Care Plan last updated 02/10/25 reflected Resident #2 was at risk for falls. There was an intervention to keep the call light and most frequently used personal items within reach. During an observation and interview on 03/04/25 at 11:25 a.m., Resident #2's call light was under the head of his bed on the floor. Resident #2 was watching television in bed. He said he did not know where his call light was. He said he would have to yell for help if he needed help. He said he only used his call light about once a week. During an observation on 03/04/25 at 2:13 p.m., Resident #2's call light was under the head of his bed on the floor. Resident #2 was watching television in bed. During an interview on 03/04/25 at 2:15 p.m., LVN C said it was the nurse's and CNA's responsibility to make sure residents had their call light. She said residents that could not reach their call lights might fall trying to get the call lights or not be able to call for help. She said Resident 1's call light should not have been attached to his curtain and should have been within his reach. She said Resident #1 did not use the call light. She said all residents should have their call lights within reach. She said she was not sure if Resident #2 used his call light or not. During an interview on 03/04/25 at 2:21 p.m., CNA E said everyone was responsible for making sure the residents could reach their call lights. She said anyone entering the room could see that call lights were not in reach. She said residents not having a call light could cause them to not get the help they needed in a timely manner. CNA E said it also increased the resident's risk for a fall if they got up to get something themselves. She said every resident should have their call light within reach. During an interview on 03/04/25 at 2:58 p.m., the DON said it was her expectation that residents have their call lights. She said anybody in the room was responsible for making sure the residents had their call lights. She said she would have expected for Resident #1 to have had his call light and it not be hanging on the curtain. She said she would have expected Resident #2 to have had his call light. She said she was not sure he would use it if he had it. She said a resident not being able to reach their call light could cause a fall or cause staff to miss a change in their condition. During an interview on 03/04/25 at 3:05 p.m., the Administrator said her expectations were for call lights to be within reach of the residents. She said if the resident was in need, staff would not know because they would not be able to call. Record review of a Call Lights Answer facility policy, last revised on 02/12/20 indicated, .The staff will provide an environment that helps meet the resident's needs by answering call lights appropriately .when leaving the room, be sure the call light is placed within the resident's reach .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on interviews and record review, the facility failed to ensure the right to be free from abuse was provided for 1 of 18 reviewed for abuse. (Resident #3) The facility failed to ensure Resident #3 was free from abuse when CNA D told him, all you do is lie and that's why people don't want to deal with you. This failure could place residents at risk for abuse. Findings included: Record review of a face sheet dated 03/03/25 revealed Resident #3 was [AGE] years old and was admitted on [DATE] with diagnoses including dementia, Parkinson's disease (a progressive neurological disorder that affects movement, balance, and coordination), and insomnia (a common sleep disorder characterized by difficulty falling or staying asleep, resulting in poor sleep quality and daytime fatigue). Record review of the MDS dated [DATE] revealed Resident #3 had a BIMS score of 7, indicating severe cognitive impairment. The MDS indicated Resident #3 required moderate to maximal assistance with most ADLs. Record review of a care plan last reviewed on 02/27/25 revealed Resident #3 had a self-care deficit with an intervention for staff to provide assistance with self-care. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Provider Investigation Report dated 10/29/24 revealed that on 10/23/24 at approximately 7:00 a.m. the Resident #3 was being assisted in the shower by CNA D. Resident #3 stated that he was finishing up with his shower and was drying off and that he was having difficulty getting up and would sit back down. Resident #3 stated that CNA D acted like she was going to try to get him up by his neck. The Administrator stated that Resident #3 did not appear to be fearful or in any distress when giving the statement. The previous DON's statement revealed, When walking down the hall, I overheard someone saying, Don't lie, we aren't going to do that. Don't lie and then the resident saying, I am not lying. The other person then stated, Yes you are, all you do is lie and that's why people don't want to deal with you. I stepped to the door of the shower room to intervene. (CNA D) had finished giving the resident a shower and was in process of drying and dressing resident at this time. I asked CNA to step to the door and tell me what was going on. She stated that the resident had a towel draped around his shoulders holding both ends, drying his back and stated to her loudly while she was at the sink, not touching the resident to, not choke him. She said that she was attempting to redirect the resident because he was making false statements that could get her in trouble. While speaking with (CNA D), the resident continued to holler at her to come back and help him finish getting dressed. I allowed her to continue care while I witnessed the interaction. The resident continued to yell at (CNA D) to get him various items or help him stand at inappropriate times then yell at her that he cannot stand at all. (CNA D) completed required care without further incident and took the resident to the dining room for breakfast as requested. The resident did not seem to be in any distress . The Provider Investigation Report indicated a statement from CNA D, I got resident up into the shower early this morning thinking maybe it would make him have a good day, just trying to figure out what I needed to do to get him on the right routine. While in there he kept yelling at me to do different things. I would ask him to remain seated and he would try to stand up but then yell at me that he couldn't stand up on his own and that I needed to help him stand. I would redirect him, and he would yell at me more. When we got done with the shower, I had him sitting in the shower chair, trying to get him dried off and get his clothes on him. He kept trying to stand or move the chair around. I stepped to the sink to get something he wanted, and he had the towel around his shoulders drying his upper back and started yelling, Don't choke me, don't choke me. I told him I was not choking him, and I was not even touching him. I told him not to lie like that because that could get me in trouble. That was when (previous DON) came to the door and asked me what was going on. She stood as a witness while I finished his care because he was yelling at me to hurry up . The report indicated a skin assessment, and a Trauma Assessment were completed and revealed no concerns. The report indicated safe surveys were completed. One survey dated 10/23/24 indicated, .(CNA D) is disrespectful to me. Record review of a Trauma Informed Observation Dated 10/23/24 revealed Resident #3 denied having ever experience, witnessed, or learned about a physical assault. During the observation the resident did not mention the incident with CNA D. The observation was signed by the Social Worker at 1:16 p.m. Record review of a Skin Data report dated 10/23/24 did not indicate any redness to the resident's neck. The report indicated the resident had no bruising or injuries. The report was signed by the previous DON at 11:01 a.m. Record review of a Nurse Noted dated 10/23/24 at 11:10 a.m. revealed, .Resident without evidence of adverse psychosocial effects. The note was signed by the previous DON. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Notice of Warning dated 10/23/24 indicated CNA D was placed on an Investigatory Suspension due to Rudeness to Residents. An Explanation of Offense indicated, Verbal abuse allegation. The notice was signed by CNA D and the previous DON. Record review of CNA D's employee file revealed a typed note that stated, DON and Administrator attempted to contact (CNA D) on 10/31/24. (CNA D) did not answer the phone but later text the DON's personal phone after working hours. DON did not respond to message and (CNA D) was contacted again on 11/01/24 for notice of termination. During an interview on 03/03/25 at 10:55 a.m., Resident #3 said CNA D was helping him in the shower on 10/23/24. Resident #3 said CNA D became upset with him and grabbed him by the throat. He said she then called him a liar and denied grabbing him by the throat. He said he was not injured. He said he let the whole incident go pretty quick. He said she left the facility that day and had not been back. He said he did feel safe at the facility. During an interview on 03/03/25 at 10:58 a.m., a family member of Resident #3 said they were unsure of the date but there was another incident before the shower incident. They said Resident #3 had called them to tell them that he had not been put to bed. They said they called the facility and told staff that he needed to be assisted to bed. The family member said CNA D then wheeled Resident #3 to his room. The family member said CNA D did not realize they were still on the phone with the resident, and they could hear CNA D tell Resident #3, I don't have time for this. I'm not putting you in that bed. The family member said the DON called them after the incident concerning the shower and told them that she had heard a commotion and heard CNA D tell the resident he was a liar. During an interview on 03/03/25 at 2:15 p.m., the previous DON said CNA D had Resident #3 in the shower the morning of 10/23/25. The previous DON said she was walking down the hall when she heard CNA D say that Resident #3 was lying. The previous DON said she did hear CNA D say, Don't lie, we aren't going to do that. Don't lie and then the resident saying, I am not lying. She said CNA D then said, Yes you are, all you do is lie and that's why people don't want to deal with you. She said when she got to the door CNA D was standing by the sink and was not near Resident #3. She said she called CNA D to the door and asked her what happened. She said CNA D told her that Resident #3 had asked for something, and she had stepped away from him. She said he was trying to put on his shirt, and he accused her of choking him. She said CNA D told her that he was saying something untrue, and it could be something that could get her in trouble. The previous DON said she did hear the exact things that were quoted in the Provider Investigation Report. She said she did feel like what CNA D had said was abusive. She said CNA D was immediately removed from the floor and was suspended pending the results of the investigation. She said CNA D did not come back to work. She said she was later terminated. She said on 10/31/24, she had attempted to contact CNA D to terminate her. The previous DON said before the incident on 10/23/24 she had received multiple customer service complaints on her because her tone was not the best. During an interview on 03/03/25 at 4:09 p.m. CNA D said she was assisting Resident #3 with a shower on 10/23/24. She said the resident was drying off. She said the only thing she did wrong was she was talking on her cell phone. She said she was talking to her son, and he had said that he had repaid her money that he had not repaid. She said she called her son a liar. She said Resident #3 was behind her drying off. She said the previous DON stood in the doorway and saw her on her phone. She said at no time did Resident #3 ever accuse her of choking him. She said she thought she had a good relationship with Resident #3, and he would always ask for her. (continued on next page)

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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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/04/25 at 8:30 a.m., Resident #3 said at no time was CNA D on her cell phone during the incident on 10/23/24. Resident #3 said, she was too concentrated on me. During an interview on 03/05/25 at 2:25 p.m., the previous DON said at no time during the incident on 10/23/24 was CNA D on her cellphone. The previous DON said, that is just flat ass not true. Her story has changed 5 times. The previous DON said CNA D even admitted she said Resident #3 was lying, but she was trying to redirect him from saying things that were untrue. During an interview on 03/04/25 at 3:05 p.m., the Administrator said during the investigation of the incident on 10/23/24, she was going off what Resident #3 told her. She said he told her that CNA D was rude and was not affected by her being rude. She said concerning the comments the previous DON overheard, I would not want anyone to say those things to me. She said a staff member calling a resident a liar could make them feel like they were not being respected and burdensome to the staff member or to anyone. Record review of an Abuse, Neglect, and Exploitation and Misappropriation of Resident Property facility policy last reviewed on 02/12/20 indicated, .The purpose of this policy is to ensure that all healthcare facilities comply with federal and state regulations regarding (i) protecting facility patients and residents from abuse . Verbal abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, inability to comprehend, or disability .

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on observations, interviews, and record review, the facility failed to ensure residents who required colostomy, urostomy, or ileostomy services, received such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 1 resident (Resident #4) reviewed for ostomy care. The facility failed to provide Resident #4 with appropriate colostomy care resulting in her colostomy leaking and covering her in feces. This failure could place the resident at risk of skin irritation and breakdown from exposure to fecal matter. Findings included: Record review of Resident #4's face sheet dated 3/03/25 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #4 had diagnoses which included diverticulitis (occurs when an infected pouch becomes filled with pus) of large intestine with perforation (rupture) and abscess (pocket of pus), hypertension (high blood pressure), and depression (persistent sadness that can interfere with daily life). Record review of Resident #4's MDS assessment indicated it had not been completed prior to exiting the facility. Record review of Resident #4's care plan dated of 3/03/25 indicated she was taking an antidepressant (medication to treat depression); she had impaired physical mobility with an intervention to provide appropriate level of assistance to promote safety of resident; she had a self-care deficit with an intervention to provide assistance with self-care as needed; she was at risk for problems with elimination; and she had a colostomy/ileostomy (surgical procedure that created an opening in the abdominal wall through which waste products from the small intestine could exit the body). Record review of Resident #4's Consolidated Orders dated 3/06/25 indicated an order for ileostomy care every am shift (10 PM- 6 AM- 2 PM) with a start date of 2/25/25. Record review of Resident #4's eTAR dated 2/01/25-2/28/25 indicated on order for ileostomy care every am noc shift (10 PM- 6 AM- 2 PM) with start date of 2/25/25 with documentation of completed on day shift and night shift 2/25/25-2/28/25. Record review of Resident #4's Progress Note dated 2/25/25 indicated Resident #4 had an ileostomy due to a perforated (ruptured) diverticulitis and a large midline surgical incision with staples and dehisced area (open/separation of wound edges) to the end of the incision near the ileostomy and it was being packed with saline soaked gauze. NP F documented the ileostomy bag had dark liquid stool in it. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Nurse Note dated 2/28/25 at 6:45 AM indicated LVN A had come on duty on 2/27/25 at about 1910 (7:10 PM) and was informed by LVN C, Resident #4's family was there and was upset that Resident #4 had bowel all over her and her wound from her leaking colostomy bag. LVN A documented Resident #4's clothing and brief were soiled with bowel from her leaking colostomy bag, as well as the dressing covering the wound. LVN A documented Resident #4's family member stated Resident #4 had been sitting in poop for four hours. During an observation and interview on 3/03/25 at 11:50 AM, Resident #4 was lying in bed visiting with two family members in her room. Resident #4 said since her FM #1 fussed at the facility on 2/27/25, things had been much better and they now checked on her hourly and emptied her colostomy bag, but the first three days at the facility were awful. Resident #4 said the staff did not empty her colostomy bag and it burst the first night she was at the facility and covered her in poop and it frequently leaked. Resident #4 said she laid in her own poop and had poop in her wound that was by her colostomy frequently for the first three days, but the worst time was on 2/27/25. Resident #4 said they had issues on 2/27/25 four times during the day with her colostomy bag leaking and the nurse had changed it a couple times earlier in the day, but it would be back to leaking shortly after it was changed. Resident #4 said she laid in her own poop for about four hours until FM #3 came to see her. FM #2, who was visiting with Resident #4, said she had called Resident #4 at 3:00 PM and Resident #4 said her colostomy bag was leaking and no one had come to answer her call light and she was lying in her own poop. FM #2 said she called the facility about 3:30 PM and no one answered the phone. Resident #4 said she knew she had been lying in her own poop for about four hours based off the time of the phone calls with FM #2. Resident #4 said by the time FM #3 arrived in her room a little after 7:00 PM, she was covered in her own poop. Resident #4 said when FM #3 entered the room, he said, what is that smell and Resident #4 said she was crying and threw back the covers and she told FM #3 it was her because no one had fixed her leaking colostomy and she was covered in her own poop. Resident #4 said she laid in her own poop until her FM #3 arrived at the facility, and he went to try to get someone to clean her up and was told by staff that it was not their jobs and would have to get the nurse. Resident #4 said it was about 8:00 PM before they finally started cleaning her up. Resident #4 said it was embarrassing to be covered in her own poop and the smell was awful. Resident #4 said they were not answering her call light timely which led to her colostomy bag getting too full and it pulled away from the skin from the weight and then it would start leaking. Resident #4 said at times the CNA would come by and would tell her it was not their job to empty it, and she would have to get the nurse, but no one came. Resident #4 said a CNA did offer to change her gown on 2/27/25 but what good would that have done when everything was covered in poop and her leaking colostomy was continuously producing more liquid poop. Resident #4 said she had been told the nurse would be coming to change the colostomy bag, but she did not come. During an interview on 3/4/25 at 10:37 AM, FM #3 said he arrived at the facility at 7:00 PM per his life 360 application on his phone. FM #3 said he walked into Resident #4's room and opened her door and said, what is that smell and Resident #4 pulled her covers back and she had poop from her chest to her knees and she was crying. FM #3 said he went down the hall and saw someone on her phone and asked her, who was going to clean Resident #4 up. He said she said it was not her job and she would go get someone. FM #3 said Resident #4 said she had been sitting in poop for almost for four hours. FM #3 said he then saw a nurse he knew coming in the front door and asked her to come down to Resident #4's room. FM #3 said when the nurse walked into the room she said, O my and said she would get Resident #4 taken care of. FM #3 said the nurse cleaned on Resident #4 for almost two hours. FM #3 said there was no excuse for the state Resident #4 was in. FM #3 said someone should have tended to her colostomy bag long before it got to the point it did with covering Resident #4 in her own poop. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/4/25 at 10:58 AM, LVN A said she was late coming in for her shift (6 PM-6 AM) on 2/27/25 and arrived around 7:10 PM. LVN A said the day shift nurse (LVN C) was in a tizzy and said she (LVN A) would have to go deal with Resident #4's family because they were cussing at LVN C. LVN A said she went into Resident #4's room and she had poop everywhere, in the wound, in her brief, in the bed and linens, and covering her gown from her chest to below her knees. LVN A said she went and gathered all the supplies she would need to clean Resident #4 up, change the colostomy bag, and clean and redress her wound, and then went back to Resident #4's room. LVN A said it took her about two hours to clean Resident #4 up, change the colostomy, and clean and redress her wound. LVN A said she went back in a few hours later to check on Resident #4 and the colostomy bag was leaking again, and Resident #4 said the aide had pulled on it while emptying it and got it to leaking again. LVN A said she changed the colostomy bag again. LVN A said there was not much room from where the colostomy bag was and the open wound was which made it challenging to get a good seal around the colostomy bag. LVN A said she had to cut the sticky part of the colostomy bag and had to turn the bag to her opposite side, and it worked better, and she changed the type of bag. LVN A said, let's just say if that was my mother, I would have flipped my you know what, if I had found her like that. LVN A said some of the feces was dried with brown ring edges on the bedding and some was still liquid. LVN A said the dried feces with brown ring edges indicated it had been there for a while, but she was not sure how long it would have taken it to dry. LVN A said the seal of the colostomy bag was broken and it was not stuck to Resident #4 when she arrived in her room. LVN A said she was sure it embarrassed Resident #4 and made her feel awful and it was probably irritating to her skin to have feces on her. LVN A said staff were giving Resident #4 the run around about not being able to do anything with the colostomy. LVN A said it was pretty much the 2 PM -10 PM aides that told Resident #4 they could not change or take care of the colostomy. LVN A said the entire ordeal was embarrassing for Resident #4. During an interview on 3/4/24 at 11:20 AM, CNA B said she had gone into Resident #4's room a little while before her family arrived and she asked Resident #4 about changing her gown due to her colostomy bag was leaking. CNA B said she placed a towel under Resident #4 and over her gown because Resident #4 said she wanted to wait until after the nurse changed the colostomy bag. CNA B said the colostomy bag was leaking and it would be the nurse that would have to change it. CNA B said she had come in to work the 2 PM to 10 PM shift. CNA B said she had not emptied the colostomy bag during her shift. CNA B said she did not know she could empty the colostomy bag. CNA B said they had been having issues with it leaking that day. CNA B said the nurse would have been responsible for ensuring the colostomy bag was not leaking and for emptying it because she was unaware, she could empty the bag. CNA B said she was taught in CNA training school not to touch the colostomy bags. CNA B said she learned on 2/28/25 after the 2/27/25 incident during an in-service that she could empty the bag. CNA B said she was assigned to Resident #4's hall after someone had called in on 2/27/25. CNA B said Resident #4 probably felt disgusted and dirty lying in her own feces. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/4/25 at 12:19 PM, LVN C said she had worked at the facility for about a month on the 6 AM-6 PM shift. LVN C said the CNAs were going into Resident #4's room regularly on 2/27/25. LVN C said she had emptied the colostomy bag three times herself and changed the bag twice during her shift on 2/27/25 and was not sure why the family was saying that she had been lying in feces for four hours. LVN C said she had training in nursing school in caring for colostomy bags about 6 years ago, but she had just recently started working as a nurse. LVN C said she had her co-worker do a demonstration with her on how to change the colostomy bag and she had watched U-tube videos to educate herself. LVN C said herself and another aide were responsible for emptying Resident #4's colostomy bag. LVN C said the aides were checking on Resident #4 every 2 hours. LVN C said no one had told her that Resident #4's bag was leaking, and she was confused when FM #1 was yelling at her that it had leaked, she did not know it was leaking. LVN C said she remembered answering Resident #4's call light a few times and she wanted the bag emptied. LVN C said FM #3 had asked her when they were going to clean her up and then FM #1 showed up and started yelling at her. LVN C said she was going to give another resident pain medication and then come back and take care of Resident #4. LVN C said she thought the contents of the colostomy might take about 30 minutes to dry on bedding, but she was not sure. LVN C said she did not witness what the resident looked like prior to her family arriving. LVN C said it would be embarrassing to the resident and it could cause an infection to be covered in her own feces. During an interview on 3/4/25 at 3:30 PM, the DON said she had gotten a phone call about a family member being at the facility and was yelling and screaming and a couple of the CNAs felt threatened by the family member's body language toward them on 2/27/25. The family member was making allegations that Resident #4 had not been cared for and left covered in feces. The DON said she then called the ADM, and the ADM came to the facility. The DON said the next day she did some in-services with staff and started every 1-hour checks on Resident #4 to ensure she was getting her colostomy emptied or changed as needed. The DON said she had talked to a few CNAs and two nurses about caring for a colostomy bag upon Resident #4's admittance to the facility. The DON said she did not do any in-services with staff prior to or upon admittance of Resident #4 coming to the facility to ensure all direct care staff were knowledgeable of caring for a colostomy bag. The DON said the CNAs and nurses should have known how to care for a colostomy bag with their training from their schools. The DON said she would have been responsible to ensure that staff were knowledgeable of caring for the colostomy and care was being provided timely. The DON said she did have conversations with some staff, about emptying the bag and cleaning around it, and if it was leaking or off then to notify the nurse. The DON said there was an issue with getting the colostomy bag to seal due to the placement of the ileostomy and her open wound and it would leak. The DON said the colostomy bag had to be changed a few times on 2/27/28. The DON said the wound care physician had been there 2/27/25 and they discussed things to possibly help with the issue of the colostomy bag leaking. The DON said the colostomy bag was changed while the wound care was done with the wound care physician. The DON said she knew LVN C had changed the colostomy bag at least once that day also. The DON said they would not know if what they tried worked until they tried it and seen if it would stay. The DON said she was not sure how long it would take for stool to dry, maybe a couple of hours. The DON said if there were dried brown circles it would be indicative that the stool had been there for a while. The DON said Resident #4 could have skin issues and there was the dignity issue of having feces on her. The DON said the aide did offer to clean her up, but the resident declined because she wanted to wait until the nurse came to change her colostomy. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/4/25 at 4:00 PM, the ADM said Resident #4 had only been in the facility for three days and she had not gotten any complaints from Resident #4 until her FM #1 was at the facility cussing staff and saying Resident #4 had not been cared for. The ADM said Resident #4 had not told her about having frequent leaking from her colostomy bag. The ADM said when the colostomy bag would get to a certain level Resident #4 wanted it emptied. The ADM said Resident #4 told her that staff would come in and say that they were coming back and did not come back quickly. The ADM said FM #1 told her Resident #4 had feces all over her on 2/27/25. The ADM said she came to the facility on [DATE] during the incident with Resident #4's family, but the nurse had already been cleaning up the resident and the ADM said she did not see any of the issue. The ADM said being covered in feces could make the resident feel like she was not being cared for. The ADM said the resident had told her the aide had offered to change her and the resident declined because she was waiting for the nurse to return and change the colostomy bag. Review of the facility's policy titled Pouching a Colostomy or an ileostomy dated revised January 12, 2020, indicated . Staff would use appropriate methods to pouch a colostomy or an ileostomy in accordance with standard practice guidelines . report abnormal findings to the nurse in charge or health care provider .