

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 09/10/2025
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)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a therapeutic diet was offered when there were nutritional problems and the therapeutic diet was recommended for 1 of 2 residents reviewed for nutrition. The facility failed to put interventions in place when Resident # 1 had poor intake related to swallowing food, inability to consume meals as result of physical decline. Resident #1 had a wound and did not receive a dietician consult as needed. Resident #1 did not have updated care plan interventions related to her change in condition . This failure could cause residents to lose weight and not have interventions in place that could lead to significant weight loss. Record review of Resident #1's face sheet indicated she was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of abnormal weight loss. Record review of Resident #1's annual MDS dated [DATE] indicated Resident was cognitively stable with a BIMS score of 13. Resident #1's functional abilities with eating was setup or clean up assistance. The MDS indicated the resident did not have any nutritional issues. Record review of Resident #1's care plan that was in the system on 9/9/25 indicated the last care plan interventions for weight loss was dated 2/6/25 with interventions to monitor and assist as needed. There were no current problems identified with weight loss, pressure wounds, or swallowing issues. During a record review and interview on 9/9/25 at 12:48 p.m. the ADON said there were no revisions regarding Resident #1's weight loss, swallowing or wounds since 2/6/25. There was a care plan intervention dated 8/14/25 that indicated Resident #1 was non-compliant with removing her boot from her leg. During an interview on 9/10/25 at 1:43 p.m. with the RNC and DON, they said some revisions to Resident #1's care plan and added some interventions. They said Resident #1's weight would not have triggered in their system because it did not go in until the 7th of the month. Record review of Resident #1's care plan on 9/10/25 with the RNC indicated additional interventions that were not present on 9/9/25 to include a problem with a initiation date of 7/5/25 of a fracture of Resident #1's left out ankle, with interventions of reporting abnormalities to the physician. A care plan problem dated 8/7/25 indicated impaired skin integrity. The resident had a wound to her left leg. Some of the interventions were a referral to wound care for weekly skin assessments, maintain adequate nutrition and hydration, and staff were to report any skin changes. A problem dated 9/5/25 indicated the staff reported the resident required medications to be crushed. This varied from nurse to nurse because she would swallow well for certain nurses. The interventions were she was referred to speech therapy, and the physician was to be notified of significant changes. Record review of Resident #1's computerized physician orders indicated an order dated 6/13/25 for a regular diet consistency, with thin liquids and no added salt. Record review of Resident #1's Nutritional Therapy assessment dated [DATE] indicated a regular diet with boost two times daily (order discontinued 4/6/25). She was to be monitored for significant weight changes, labs, skin issues, monitor oral intake of food and fluid. Record review of Resident #1's nursing note dated 4/6/25 indicated the house shake order was discontinued, the residents weighed monthly, and the dietician will reassess if needed according to policy. The Resident has a good appetite, eats in the dining room and often obtains multiple snacks between meals and has bedtime snacks form the snack cart. Record review of Resident #1's weight log indicated on 7/4/25 Resident #1 weighed 212.60 pounds. Record review of Resident #1's pre albumin (measures nutritional status, specifically protein and calorie intake) dated 7/10/25 indicated a prealbumin of 15 which was low with a normal range of (20-40.) Record review of Resident #1's physician orders indicated on 7/17/25 she was placed on weekly weights. Record review of Resident #1's weight log indicated on 7/20/25 she weighed 198.40 pounds. Record review of Resident #1 wound care note from the wound care doctor dated 8/7/25 indicated she had a no pressure wound on left leg identified when cast was removed. The wound was 4.1 x 3.6 x 0.3 cm. The note indicated a plan to discuss the patient's abnormal body mass index (32.95) with the current dietitian. If the patient does not currently have a dietitian following, recommend dietary consult. Record review of Resident #1's per albumin lab completed on 8/13/25 revealed the prealbumin was 9 -low with a normal range of (20-40.) Record review of Resident #1's wound care note dated 8/15/25 indicated the wound care doctor recommended a dietician consult for protein optimization. Record review of Resident #1's weight log indicated on 8/29/25 she weighed 193.40. Record review of Resident #1's nursing note dated 9/1/25 at 6:44 p.m. Resident having increased difficulty swallow suggested the resident took 1 pill at a time. The resident was having difficulty eating, the writer brought resident food today. She consumed only the soft notions during dinner the resident tried mechanical soft with purred vegetables with no change with the</p>		