

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 03/06/2024
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 0561</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 and the facility must promote and facilitate resident self-determination through support of resident choice.</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 promote resident self-determination through support of resident choice for 2 of 12 residents reviewed for resident rights. (Resident #32, Resident #35)</p> <ol style="list-style-type: none"> The facility did not assist Resident #32 out of bed as often as she preferred. The facility failed to shower Resident #35 instead of a bed bath per his request. <p>These failures could place dependent residents at risk for feelings of depression, lack self-determination and decreased quality of life.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Record review of the face sheet dated 03/05/24 indicated Resident #32 was [AGE] years old and admitted on [DATE] with diagnoses including heart disease, diabetes, and anxiety disorder. <p>Record review of a quarterly MDS assessment dated [DATE] indicated Resident #32 was usually understood and usually understood others. The MDS indicated a BIMS score of 14 which indicated Resident #32 was cognitively intact. The MDS indicated Resident #32 was dependent on staff for chair/bed-to-chair transfers.</p> <p>Record review of a care plan revised on 02/13/24 indicated Resident #32 had impaired physical mobility. There was an intervention to assist as needed with wheelchair mobility. The care plan indicated Resident #32 had a history of depression. The care plan indicated Resident #32 wanted to be involved in care decisions. There was a goal indicating resident's wishes will be respected, and autonomy will be maintained.</p> <p>Record review of nurse's notes from 02/10/24 to 03/05/24 did not indicate Resident #32 had refused to be gotten out of bed.</p> <p>During an observation on 03/04/24 at 2:00 p.m., Resident #32 was in bed. A wheelchair was present in her room.</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
---	-------	-----------

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 03/06/2024
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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 03/05/24 at 8:23 a.m., Resident #32 was in bed. A wheelchair was present in her room.</p> <p>During an observation and interview on 03/05/24 at 9:42 a.m., Resident #32 was lying in bed. She said staff did not always get her up out of bed when she wanted to get out of bed. She said she did not want to get up every single day, but she would like to be gotten out of bed some.</p> <p>During an observation on 03/05/24 at 3:03 p.m., Resident #32 sleeping in bed.</p> <p>During an observation and interview on 03/06/24 at 8:21 a.m., Resident #32 was in bed. She said she would like to be gotten out of bed once or twice a week. She said there were entire weeks that she was not gotten out of bed at all. She said there were days she had said no to getting up but there were also days she wanted to get up and was not gotten up. She said she felt ignored. She said she felt annoyed by the whole situation. She said staff will probably say they come down here and I am asleep. She said, That is my answer to the whole thing. Just go to sleep. She said she liked to get out of her room to socialize and visit with other people.</p> <p>During an interview on 03/06/24 at 9:02 a.m., CNA G said she only knew Resident #32 to have been gotten out of bed once or twice since she had been working at the facility. She said she had been an employee for maybe a year. She said Resident #32 had never requested to be gotten up. She said every day she was working she had offered to get Resident #32 up out of bed.</p> <p>During an interview on 03/06/24 at 9:25 a.m., the MDS Nurse said Resident #32 did get up out of bed occasionally, but not routinely. She said there being weeks that she was not gotten out of bed was not inaccurate.</p> <p>During an interview on 03/06/24 at 10:00 a.m., LVN H said she had seen Resident #32 up out of bed maybe twice. She said that it had been a long time since she had seen her up. She said a resident not being gotten up can affect their will to live, depression, general attitude and to quit eating.</p> <p>During an interview on 03/06/24 at 10:21 a.m., the DON said Resident #32 was asked every day if she wanted to get up and the resident had refused. She said the resident did not want to get up. She said she had seen her up a few times and she did not stay up long. She said any refusals should be documented. She said a resident not getting up or attending activities could cause them to feel isolated and cause depression.</p> <p>During an interview on 03/06/24 at 10:48 a.m., the Administrator said if a resident wanted to get out of bed they should have been gotten out of bed. She said Resident #32 had been up over the last few days so that her bed could be replaced. She said the resident became upset because she was up for maybe 30 minutes to an hour. She said if Resident #32 was asked in the morning to get up she would tell you no. She said she would expect any refusals to be documented and ask her again later. She said she had been down to Resident #32's room and had talked to her. She said because she refused 90 percent of the time it could be the reason staff were not asking her to get up.</p> <p>(continued on next page)</p>		

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 03/06/2024
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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #35's face sheet dated 3/04/24 indicated Resident #35 was a [AGE] year-old male, who admitted to the facility on [DATE]. Resident #35 had diagnoses including traumatic amputation (loss of body part as the result of an accident/injury) at knee level of right leg, weakness, lack of coordination, severe kidney disease, diabetes (high blood sugar), heart disease, and heart failure.</p> <p>Record review of Resident #35's quarterly MDS assessment dated [DATE] indicated Resident #35 was usually understood and usually understood others. The MDS indicated Resident #35 had a BIMS score of 10 which indicated he had moderate cognitive impairment. The MDS indicated Resident #35 did not reject care. The MDS indicated Resident #35 had impairment of both lower extremities and used a wheelchair for mobility. The MDS indicated Resident #35 required moderate to maximal assistance with most ADLs. The MDS indicated Resident #35 was occasionally incontinent of urine and was always incontinent of bowel. The MDS indicated Resident #35 had a diagnosis of depression (persistent sadness) and took and antidepressant (medication to treat depression).</p> <p>Record review of Resident #35's care plan dated 3/04/24 indicated Resident #35 had impaired physical mobility and he had a self-care deficit with an intervention to provide assistance with self-care as needed.</p> <p>During an observation and interview on 3/04/24 at 3:35 PM, Resident #35 was sitting in his room in his wheelchair. Resident #35 said it was hard to get a shower and he had only received 6 showers since he admitted to the facility, and he said he needed a shave. Resident #35 said he had asked to be shaved and was told they did not have time. Resident #35 said he liked to be clean shaved, and he never had facial hair, because his mother always taught him a man should be clean shaved. Resident #35 was observed with continued full beard of facial hair approximately 1/2 inch to 3/4 inch long.</p> <p>During an observation and interview on 3/05/24 at 8:48 AM, Resident #35 was sitting up in his room in his wheelchair. Resident #35 continued to have a full beard of facial hair approximately 1/2 inch to 3/4 inch long. Resident #35 said he had to asked staff to be bathed but had only had 6 showers since he had been at the facility, and he had not been shaved.</p> <p>During an observation and interview on 3/05/24 at 2:50 PM, Resident #35 was observed in his room sitting in his wheelchair with a continued full beard of facial hair approximately 1/2 inch to 3/4 inch long. Resident #35 said he did not know what days he was supposed to receive his baths/showers. Resident #35 said he would take a bath/shower every day because he liked to be clean, and he said his skin gets dry. Resident #35 said he preferred a shower. Resident #35 said he saw himself in the mirror today (3/05/24) and just could not believe how long his facial hair had gotten and he hardly recognized himself. Resident #35 stated he would shave himself if he was able to. Resident #35 stated again that he had only received 6 showers since he came to the facility.</p> <p>During an observation and interview on 3/06/24 at 9:02 AM, Resident #35 was sitting in his wheelchair in his room. Resident #35 said he still had not been showered in about 3 weeks. Resident #35 said they usually just clean his lower parts up when he had an incontinent episode. Resident #35 said he preferred to be showered and liked the water running over him to feel clean.</p> <p>(continued on next page)</p>		

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 03/06/2024
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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/05/24 at 3:08 PM, RN F said she had worked at the facility for approximately 8 months on the 6 AM-6 PM shift. RN F said as the nurse, she was responsible for ensuring the CNAs were bathing residents and the CNAs were responsible for bathing the residents. RN F said Resident #35 had not told her he had not been bathed/showered or shaved. RN F said if a resident was not being bathed/showered or shaved per their request, it could affect how they felt about themselves, it could be a dignity issue, and it could make them feel bad about their self.</p> <p>During an interview on 3/06/24 at 10:39 AM, CNA M said she usually worked the evening shift from 2 PM-10 PM. CNA M said they really needed more staff on evening shift because it was hard to get the bathing in and baths were not always done. CNA M said sometimes there were 6-7 baths/showers on a hall, and it was hard to get everything done. CNA M said she knew she missed Resident #35's bath/shower one day last week because she did not have time due to, she was caught up in another resident's room for over an hour. CNA M said Resident #35 had asked her for showers, but often she would do a bed bath because she was running behind schedule. CNA M said Resident #35 had not asked her to be shaved. CNA M said Resident #35 was alert and oriented and knew what was going on. CNA M said the CNAs were responsible for ensuring the residents were bathed, shaved, and they would tell the charge nurse if the resident refused. CNA M said if the resident was not receiving their scheduled baths/showers or not being shaved per their requests, the resident would feel like they were not getting the proper care when they asked for it.</p> <p>During an interview on 3/06/24 at 2:22 PM, the DON said she had not been informed of Resident #35 stating he had only been receiving bed baths on his lower half of his body with incontinent care, had not received a shower in months, or had not been shaved. The DON said she would expect residents to be showered per their shower schedule, as needed, and per their request. The DON said bathing of only the lower half of the resident's body during incontinent care, would not be considered a scheduled bath/shower. The DON said the resident could have adverse psychological effects from not being bathed/showered or shaved.</p> <p>During an interview on 3/06/24 at 2:45 PM, the ADM said she would expect the residents' wishes to be honored. The ADM said she expected residents to be showered/shaved on their scheduled shower days, as needed, and per their request. The ADM said Resident #35 had told her about not liking the bed baths, but he did not mention he was only receiving bathing to his lower half during incontinent care and not being shaved. The ADM said the resident should have a shower or shave anytime they wanted one. The ADM said the resident should have a full bath at least three times weekly on their scheduled bath/shower days and be offered a shave. The ADM said she had ordered a special shower chair for Resident #35 because when he first came to the facility, he did not want to sit on the same chair as other residents. The ADM said the special shower chair was on backorder and had not delivered to the facility. The ADM said there was other things they could do if the resident still had an issue with sitting on the same shower chair as other residents. The ADM said it was unacceptable to not shower or shave Resident #35 on his scheduled bath/shower days and per his request.</p> <p>Review of a Resident Rights facility policy last revised on August 14, 2022 indicated, .The staff will abide by and protect resident rights in accordance with state and federal guidelines .Staff will abide by resident rights as outlined within CMS State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities .</p> <p>(continued on next page)</p>		

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 03/06/2024
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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities dated 10/21/22 indicated, .The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility .</p> <p>46062</p>		

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 03/06/2024
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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>45643</p> <p>Based on interview and record review, the facility failed to allow for private Resident Council meetings and without facility staff present for 5 of 5 Residents reviewed for resident rights.</p> <p>The facility failed to provide a private space for Resident Council meetings.</p> <p>The facility failed to inform members of the Resident Council they could have their meetings in private and staff could only attend if invited.</p> <p>This failure placed residents at risk of not having the right to voice their concerns without staff being present or overhearing their concerns and to conduct resident council meetings without interference.</p> <p>Findings include:</p> <p>During a confidential resident group interview on 3/5/2024 at 10:00 a.m., the residents in attendance stated that the Resident Council meetings were always held in the dining room. All residents in the confidential group interview were upset and unhappy that staff continuously interrupted the resident council meeting. All residents agreed they would feel more willing to express their views without a staff person being able to overhear the meeting.</p> <p>During the confidential resident group interview on 3/5/2024 and at 10:45 a.m., two staff entered the back door of the dining room that led to the parking lot. The two staff went in and out of the dining room while the meeting was in progress. Surveyor said to staff that they were having a private resident council meeting and to please leave. Facility staff left temporarily but came back into the dining room and again interrupted the resident council meeting.</p> <p>During an interview on 3/5/2024 at 10:52 a.m., Dietary Aide K said she did not know there was a resident council meeting in progress when she entered the dining room. She said there was no sign at the back door and if there was, she would have gone through the front door of the facility. She said she did know that resident council meetings were private. She said she had to go clock in to work and the clock in device was located in the hallway, but she went in the back door because that was where she parked.</p> <p>During an interview on 3/5/2024 at 10:49 a.m., Dietary Aide L said she did not know a resident council meeting was ongoing when she entered the building. She said she saw that there was a meeting on going but she had to go clock in and then reenter the kitchen. She said the clock in machine was in the hallway. She said she always entered the building in that way.</p> <p>During an observation on 3/05/2024 at 10:58 a.m., surveyor observed the dining room exit that led to the parking lot. There was no sign in place indicating that a resident council meeting was in progress.</p> <p>(continued on next page)</p>		

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 03/06/2024
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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an anonymous resident interview on 03/05/2024 at 3:42 p.m., anonymous resident said that staff was not supposed to enter the dining room when the resident council meeting is in progress. Anonymous resident said the staff will listen to what they were saying during the resident council meetings, and he did not appreciate that they were listening. Anonymous resident said they wanted to have a private resident council meeting.</p> <p>During an interview on 03/06/2024 at 9:09 a.m., the Activity Director said they had resident council once a month. She said the meetings were supposed to be private. She said in the past, the dietary staff have interrupted their meetings. She said staff ignored the signs that there was a resident council meeting in progress. She said the point of the private meeting was so that residents can be comfortable speaking their mind truthfully without other staff listening to them. She said she would like for the resident council meetings to be private.</p> <p>During an interview on 03/06/2024 at 11:05 a.m., the Ombudsman said that in the past when she attended resident council meetings, kitchen staff would continuously interrupt their meetings. She said they were disrespectful to and upset the activity director. She said the activity director told the staff to stop coming in while a meeting was in progress, they ignored her, and went on to do what they wanted to do anyway. She said staff got ugly with her and the activity director as well. She said the Administrator previously said that they could find a new room to use as a meeting place. She said she thought she heard the staff in the kitchen talking about what the residents said during the meetings as well. She said she once saw the kitchen staff prop the door open to the kitchen and when the activity director closed the door the kitchen staff opened it right back up.</p> <p>During an interview on 03/06/24 at 11:15 a.m., with the Administrator she said the resident council meeting should have been private for residents. She said if the kitchen staff heard and disrupt the meeting then the meeting itself is not private. She said kitchen staff were inappropriate when they ignored the fact that a resident council meeting was in progress. She said staff could have entered the front door to get to the time clock and could enter the kitchen from the hallway avoiding the dining room all together.</p> <p>Review of an undated facility Policy, titled Resident Council indicated, To aide in the facility's sense of community, quality of life for the residents and meet the requirements of F565, the wellness department will assist, as required, to oversee the facility's Resident Council as assigned .The council may request the presence of any administrative staff by invitation at any time .Visitors to the meeting, which may include: Department Heads, family members, Ombudsman, etc, may be in attendance with no objections from any council member present.</p>		

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 03/06/2024
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 0584</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 safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</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 provide a safe, functional, sanitary, and comfortable environment for 1 of 12 residents reviewed for resident rights. (Resident #9)</p> <p>The facility failed to repair the wall behind the bed of Resident #9.</p> <p>This failure placed residents at risk of an unsafe or uncomfortable environment and a decrease in quality of life and self-worth.</p> <p>Findings included:</p> <p>Record review of a face sheet 03/05/24 indicated Resident #9 was [AGE] years old and was admitted on [DATE] with diagnoses including stroke, major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and diabetes.</p> <p>Record review of the MDS assessment dated [DATE] indicated Resident #9 was rarely/never understood and sometimes understood others. The MDS indicated a BIMS score of 0 indicating severe cognitive impairment.</p> <p>Record review of a care plan revised on 01/11/24 indicated Resident #9 had a history of depression. There was an intervention to adjust room temperature, reduce noise, and dim lights.</p> <p>Record review of Maintenance Work order binder kept at the nurse's station did not indicate a work order request for Resident #9.</p> <p>During an observation on 03/04/24 at 10:34 a.m., Resident #9 was not in her room. There were multiple areas of peeled paint on the wall behind the bed. To the left of the bed, approximately 2 - 3 feet from the floor was a vertical area of damaged sheetrock approximately 1 inch in width and 12 inches in length. There were 6 smaller damaged areas scattered on the bottom portion of the wall. There was an area of what appeared to be a cutout area of the sheet rock approximately 10 - 12 inches x 3 feet. In this area was old wallpaper. The rest of the wall was painted.</p> <p>During an observation and interview on 03/04/24 at 11:40 a.m., Resident #9 was sitting in the dining room. The resident did make eye contact but did not answer any questions.</p> <p>During an interview on 03/06/24 at 9:02 a.m., CNA G said a hospice aide had torn some of the places on the wall in Resident #9's room. She said the vertical areas were caused while raising and lowering the bed. She said the family had a poster hanging on the wall that pulled the paint off. She said the wall had looked like this for months. She said she had reported it to the Maintenance Supervisor a long time ago. She said the Maintenance Supervisor told her he was aware of the issue. She said she would not want her home to look like that. She said Resident #9 did talk a little but was more of an observer. She said if she did not know someone, she might just stare and not say anything. She said she felt the wall should have been fixed.</p> <p>(continued on next page)</p>

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 03/06/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/06/24 at 9:31 a.m., the Maintenance Supervisor said he was mostly made aware of issues by word of mouth. He said there was a work order log kept at the nurse's station. He said he had been aware of the wall in Resident 9's room. He said he had mentioned it in the stand-up meeting two weeks ago. He said just had not gotten to it. He said they were preparing another room for Resident #9, so he could do the sheet rock repair. He said it was his fault it had not been done yet. He said they had been remodeling rooms but had not gotten to Resident #9's yet.</p> <p>During an interview on 03/06/24 at 10:00 a.m., LVN H said the wall in Resident 9's room was partly because of family sticking posters on the wall. She said she would not want a wall in her home to look like that wall did. She said she would have expected the wall to have not taken months to be fixed.</p> <p>During an interview on 03/06/24 at 10:21 a.m., the DON said she would have expected the wall to have been fixed as soon as possible after the Maintenance Supervisor became aware of the damage. She said she would not want her home to look like that. She said Resident #9 would talk to you if she knew you. She said the wall not being repaired could cause Resident #9 to feel like her home was not pretty.</p> <p>During an interview on 03/06/24 at 10:48 a.m., the Administrator said there was a hole in the wall behind Resident #9's bed. She said they asked the resident's family to move the resident's camera to another room so they could then move the resident. She said the family would have to move her cameras and have not done that. She said for the wall to be fixed, the resident would need to be moved out of the room. She said they asked the family for months and family has been non-compliant. She said the wall could not be repaired while the resident was out of the room for the day because the camera would have to be unplugged and the family did not want the camera unplugged. She said there might be documentation of the facility requesting family move the cameras. This documentation was not provided prior to exit.</p> <p>Review of an undated Homelike Environment policy indicated, .It is the policy of the facility to ensure that the environment provided by the facility is safe, sanitary, functional and comfortable .Resident rooms and common areas will be kept in a clean, orderly and comfortable manner .All room contents to include clothes, furniture, devices, linens, bedspreads, privacy curtains, window covering, wall hangings, wall paper and floors should be clean and in good repair .</p>

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 03/06/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living, received the necessary services to maintain good grooming and personal hygiene for 2 of 12 residents reviewed for quality of life (Resident #21 and Resident #35).</p> <ol style="list-style-type: none"> The facility failed to provide scheduled bath/showers for Resident #21. The facility failed to provide scheduled bath/showers and shave Resident #35. <p>These failures could place residents who required assistance from staff for ADLs at risk of poor care, risk for skin breakdown, feelings of poor self-esteem, lack of dignity and health.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of Resident #21's face sheet dated 3/04/2024 revealed that she was a [AGE] year-old and admitted on [DATE] with diagnoses including unspecified dementia without behavioral disturbance, and cerebral infarction. <p>Record review of quarterly MDS assessment dated [DATE] revealed a BIMS with a score of 1, which indicated Resident #21 had severely impaired cognition. The MDS also revealed, Resident #21, required maximal assistance with showering and bathing.</p> <p>Record review of Resident #21's care plan dated 1/9/2024, Resident #21 had Self Care deficits care planned to maintain and improve self-care areas of dressing, grooming and hygiene over the next 90 days with intervention for staff to encourage resident to complete as much self-care as possible independently or with minimal assistance.</p> <p>Record review of ADL plan of care provided from 2/3/2024 to 3/4/2024 indicated Resident # 21 had 6 baths documented as completed. Documented and completed baths indicated on 2/6/2024 (Tuesday), 2/10/2024 (Saturday), 2/15/2024 (Thursday), 2/22/2024 (Thursday), 2/24/2024 (Saturday), 2/29/2024 (Thursday).</p> <p>Record Review of shower schedule updated 2/14/2024 indicated Residents who reside in odd room numbers receive shower on Monday, Wednesday, and Friday at 6 AM-2PM for residents in A beds and residents in B beds receive showers on 2PM-10PM shift. Bed baths should be offered or given by same shift on non-shower days. All refusals should be reported immediately to charge nurse for follow-up and additional attempts or documentation of refusal. Report special request to DON or ADON so the plan of care can be updated to reflect.</p> <p>During an interview and observation on 03/4/2024 at 10:04 AM Resident #21 had oily hair. Resident #21's representative said she was washing her hair on 3/4/2024 and no one could tell her when Resident #21 was getting her showers. The representative said it was an issue.</p> <p>(continued on next page)</p>		

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 03/06/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/6/2024 at 8:45 AM, CNA C said Resident #21 received her showers on second shift on Monday, Wednesday, and Friday's. CNA C said on Monday, she gave Resident #21 a shower with the second shift Aide. CNA C said the resident would fight staff in the shower, but once she was in there, she enjoyed it. CNA C said when a resident refused a shower, she reported to the nurse according to the facility policy. CNA C said the residents had the right to refuse. CNA C said it was the responsibility of the DON to develop the care plans and staff notify her when a care area needed to be updated. CNA C said it was the responsibility of the nurse to notify the resident's representative if a resident refused care. CNA C said poor personal hygiene could lead to skin breakdown, odor, or sores on the skin.</p> <p>During an interview on 3/6/2024 at 8:55 AM, LVN D said there was a shower schedule posted in the shower room. LVN D said she thought Resident #21 received her showers on Monday, Wednesday, and Fridays. LVN D said the facility changed the schedule a couple of months ago. LVN D said the CNAs were responsible for providing the showers and hair care was part of the showering process and documented on the ADL plan of care when completed. LVN D said she had attempted to call the family if a resident refused care.</p> <p>During an interview on 3/6/2024 at 9:32 AM, MDS nurse said she was responsible for developing the plan of care after the admission assessment and orders were completed. The MDS nurse said the CNAs and nurses were responsible for providing showers and care. The MDS nurse said the nurses, ADON, and DON were responsible for ensuring the care had been performed by interviewing residents to ensure they were receiving care and baths. The MDS nurse said she did not know how many attempts needed to be made before contacting a resident's representative. The MDS nurse said poor hygiene could result in skin breakdown.</p> <p>During an interview on 3/6/2024 at 12:14 PM, the ADON said the Interdisciplinary Team was responsible for development of the plan of care. She said the ADL plan of care triggers the bathing schedule and refusals were documented and flagged for the nurses to review. The ADON said the CNAs were responsible for bathing and personal care. The ADON said personal care was getting ready for the day in the morning and not dependent on the bathing schedule. She said the bathing schedule was on the ADL plan of care indicating the resident's preference of a bed bath or shower. The ADON said the CNAs should offer residents who have no preference if they want a bed bath. The ADON said a total bed bath and a shower would include hair care such as shampoo. The ADON said poor personal hygiene could cause skin breakdown and she expected after 3 attempts for the representative to be notified of refusal.</p> <p>During an interview on 3/6/2024 at 2:20 PM, the ADM said the CNAs were responsible for performing the shower and hair care for residents. The ADM said any nursing staff can give a bath or shower and she expects the nursing staff to document care performed or refused. The ADM said if a resident refused a shower or bath, the nursing staff should document the refusal and check back with the resident and offer an altered shower or bed bath. The ADM said the CNA was expected to notify the nurse of refusals and the nurse can attempt to provide care. The ADM said reports were ran on percentages for charting and she would go to the nursing staff to identify what happened. The ADM said after 2 refusals the nursing staff should notify the family. The ADM said if she observes residents for odor, she will ask the resident if they received a bath. The ADM said she feels the care was being performed but does not feel the staff were documenting accordingly.</p> <p>(continued on next page)</p>		

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 03/06/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #35's face sheet dated 3/04/24 indicated Resident #35 was a [AGE] year-old male, who admitted to the facility on [DATE]. Resident #35 had diagnoses including traumatic amputation (loss of body part as the result of an accident/injury) at knee level of right leg, weakness, lack of coordination, severe kidney disease, diabetes (high blood sugar), heart disease, and heart failure.</p> <p>Record review of Resident #35's quarterly MDS assessment dated [DATE] indicated Resident #35 was usually understood and usually understood others. The MDS indicated Resident #35 had a BIMS score of 10 which indicated he had moderate cognitive impairment. The MDS indicated Resident #35 did not reject care. The MDS indicated Resident #35 had impairment of both lower extremities and used a wheelchair for mobility. The MDS indicated Resident #35 required moderate to maximal assistance with most ADLs. The MDS indicated Resident #35 was occasionally incontinent of urine and was always incontinent of bowel. The MDS indicated Resident #35 had a diagnosis of depression (persistent sadness) and took and antidepressant (medication to treat depression).</p> <p>Record review of Resident #35's care plan dated 3/04/24 indicated Resident #35 had impaired physical mobility and he had a self-care deficit with an intervention to provide assistance with self-care as needed.</p> <p>Record review of Resident #35's Results List of ADLs for the Month of January 2024 revealed there was no bathing documented for the month of January.</p> <p>Record review of Resident #35's Results List of ADLs for the Months of February and March 2024 revealed there was no bathing documented from February 1st through the 14th. There was documentation Resident #35 received and preferred a bed bath on 2/15/24, 2/16/24, 2/17/24, 2/18/24, 2/23/24, 2/24/24, 2/27/24, 2/28/24, 2/29/24, 3/01/24, and 3/02/24. There was also documentation the bathing was documented at the same time as incontinent care was documented on all dates except 2/15/24. There was documentation he refused bathing on 2/19/24 and 2/21/24. There was no documentation Resident #35 received bathing on 3/04/24 his scheduled bath day.</p> <p>Record review of the facility's shower schedule revealed Resident #35 was scheduled to be bathed/showered on Monday, Wednesday, and Fridays on the 2 PM-10 PM shift.</p> <p>During an observation on 3/04/24 at 11:54 AM, Resident #35 was observed sitting in the dining room feeding himself and he had a full beard of facial hair approximately 1/2 inch to 3/4 inch long.</p> <p>During an observation and interview on 3/04/24 at 3:35 PM, Resident #35 was sitting in his room in his wheelchair. Resident #35 said it was hard to get a shower and he had only received 6 showers since he admitted to the facility, and he said he needed a shave. Resident #35 said he had asked to be shaved and was told they did not have time. Resident #35 said he liked to be clean shaved, and he never had facial hair, because his mother always taught him a man should be clean shaved. Resident #35 was observed with continued full beard of facial hair approximately 1/2 inch to 3/4 inch long.</p> <p>During an observation and interview on 3/05/24 at 8:48 AM, Resident #35 was sitting up in his room in his wheelchair. Resident #35 continued to have a full beard of facial hair approximately 1/2 inch to 3/4 inch long. Resident #35 said he had to ask to be bathed but had only had 6 showers since he had been at the facility, and he had not been shaved.</p> <p>(continued on next page)</p>		

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 03/06/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 3/05/24 at 2:50 PM, Resident #35 was observed in his room sitting in his wheelchair with a full beard of facial hair approximately 1/2 inch to 3/4 inch long. Resident #35 said he did not know what days he was supposed to receive his baths/showers. Resident #35 said he would take a bath/shower every day because he liked to be clean, and he said his skin gets dry. Resident #35 said he saw himself in the mirror today (3/05/24) and just could not believe how long his facial hair had gotten and he hardly recognized himself. Resident #35 stated he would shave himself if he was able to. Resident #35 stated again that he had only received 6 showers since he came to the facility.</p> <p>During an observation and interview on 3/06/24 at 9:02 AM, Resident #35 was sitting in his wheelchair in his room. Resident #35 said after surveyor left his room yesterday (3/05/24), CNA N came into his room and said she was going to shave him. Resident #35 was clean shaved. Resident #35 said he still had not been showered in about 3 weeks. Resident #35 said they usually just clean his lower parts up when he had an incontinent episode. Resident #35 said he preferred to be showered and liked the water running over him to feel clean. Resident #35 said he did not receive a bath/shower Monday 3/04/24.</p> <p>During an interview on 3/05/24 at 3:08 PM, RN F said she had worked at the facility for approximately 8 months on the 6 AM-6 PM shift. RN F said as the nurse, she was responsible for ensuring the CNAs were bathing residents and the CNAs were responsible for bathing the residents. RN F said the the care they provided in the electronic health record. RN F said she could go into the electronic health record and verify baths were being done and RN F said she talked to alert residents and staff to follow up on bathing. RN F said Resident #35 had not told her he had not been bathed/showered or shaved. RN F said if a resident was not being bathed/showered or shaved, it could affect how they felt about themselves, it could be a dignity issue, and it could make them feel bad about their self.</p> <p>3/06/24 at 10:32 AM and 1:30 PM, attempted to call CNA N, but there was no answer and was unable to leave voicemail.</p> <p>(continued on next page)</p>		

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 03/06/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/06/24 at 10:39 AM, CNA M said she usually worked the evening shift from 2 PM-10 PM. CNA M said some residents were scheduled to be bathed on Monday, Wednesday, and Fridays and others were scheduled on Tuesday, Thursday, and Saturdays depending on whether the resident was in an even or odd bed # and A or B bed. CNA M said they really needed more staff on evening shift because it was hard to get the bathing in and baths were not always done. CNA M said sometimes there were 6-7 baths/showers on a hall, and it was hard to get everything done. CNA M said she offered residents a bed bath, shower, and shaving on their schedule bathing days. CNA M said she knew she missed Resident #35's bath/shower one day last week because she did not have time due to being caught up in another resident's room for over an hour. CNA M said Resident #35 had asked her for showers, but often she would do a bed bath because she was running behind schedule. CNA M said if a resident received incontinent care and she gave the resident a partial bed bath, it would be documented as a bed bath and the resident was only cleaned up on their lower half, but sometimes she would give a full bed bath if time allowed. CNA M said Resident #35 had not asked her to be shaved. CNA M said Resident #35 was alert and oriented and knew what was going on. CNA M said if he asked, she would shave him. CNA M said she asked the residents if they wanted to be shaved if she had time with each scheduled bathing. CNA M said the Personal Hygiene AM/PM in the ADL log list was where they documented getting the resident up for the day, brushing teeth, nails, grooming in AM and then getting them ready for bed in the evenings. CNA M said the CNAs were responsible for ensuring the residents were bathed, shaved, and they would tell the charge nurse if the resident refused. CNA M said if the resident was not receiving their scheduled baths/showers or not being shaved, the resident would feel like they were not getting the proper care when they asked for it.</p> <p>During an interview on 3/06/24 at 2:22 PM, the DON said Resident #35 had been refusing showers or staff would get stuff ready for his shower and he would not want to do it then and wait until a later time. The DON said herself and the ADON had given him showers in the past. The DON said they had a resident shower schedule they go by and documented in their electronic health record. The DON said their software system had an ADL alert and would alert the nurse with resident refusals or tasks that did not occur, such as no bowel movements. The DON said the alerts were reviewed by the nurse at end of the CNAs shift. The DON said they make Ambassador rounds every morning with every resident and talk to residents about any concerns and then discuss either in their morning meetings if there were any issues and/or at their stand down meetings at 2 PM daily. The DON said she had not been informed of Resident #35 stating he had only been receiving bed baths on his lower half of his body with incontinent care, had not received a shower in months, or had not been shaved. The DON said she would expect residents to be showered per their shower schedule, as needed, and per their request. The DON said bathing of only the lower half of the resident's body during incontinent care, would not be considered a scheduled bath/shower. The DON said the resident could have adverse psychological effects from not being bathed/showered or shaved.</p> <p>(continued on next page)</p>		

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 03/06/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/06/24 at 2:45 PM, the ADM said she expected residents to be showered on their scheduled shower days, as needed, and per their request. The ADM said Resident #35 told her about not liking the bed baths, but he did not mention he was only receiving bathing to his lower half during incontinent care. The ADM said the resident should have a shower or shave anytime they want one. The ADM said the resident should have a full bath at least three times weekly on their scheduled bath/shower days and be offered a shave. The ADM said she had ordered a special shower chair for Resident #35 because when he first came to the facility, he did not want to sit on the same chair as other residents. The ADM said the special shower chair was on backorder and had not been delivered to the facility. The ADM said there were other things they could do if the resident still had an issue with sitting on the same shower chair as other residents. The ADM said it was unacceptable to not shower or shave Resident #35 on his scheduled bath/shower days and per his request.</p> <p>Record review of policy and procedure titled Comprehensive care plan revised on 2/12/202 indicated It is the policy of this facility to develop and implementation a comprehensive person-centered care plan for each resident . Procedure #7 The physician, other practitioner, or professional will inform resident and/or resident representative of risks and benefits of proposed care, of treatment and treatment alternatives .The facility will attempt alternative methods for refusal of treatment and services and document such attempts in the clinical records, including discussion with the resident and resident representative .#8 Qualified staff responsible for carrying out the interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions .</p> <p>Record review of the facility's policy titled Bathing (Not Partial or Completed Bed Bath), dated revised 1/20/23 indicated . staff would provide bathing services for residents within standard practice guidelines .</p> <p>Record review of the facility's policy titled Hair Care-Combing and Shaving dated revised 2/12/2020 indicated . hair care, combing and shaving would be provided for residents in accordance with standard practice guidelines .</p> <p>46062</p>		

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 03/06/2024
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</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 provide an ongoing program of activities in accordance with the comprehensive assessment to meet the interests and the physical, mental, and psychosocial well-being for 1 of 12 residents reviewed for quality of life. (Residents #32)</p> <ol style="list-style-type: none"> 1.The facility failed to provide Residents #32 with consistent, scheduled activities . 2.The facility failed to provide Resident #32 with a calendar of scheduled activities. <p>This failure could place residents at risk for not having activities to meet their interests or needs and a decline in their physical, mental, and psychosocial well-being.</p> <p>Findings included:</p> <p>Record review of a face sheet dated 03/05/24 indicated Resident #32 was [AGE] years old and admitted on [DATE] with diagnoses including heart disease, diabetes, and anxiety disorder.</p> <p>Record review of an admission MDS dated [DATE] indicated Resident #32 was usually understood and usually understood others. The MDS indicated a BIMS score of 14 which indicated Resident #32 was cognitively intact. The MDS indicated it was very important for the resident do her favorite activities.</p> <p>Record review of a quarterly MDS dated [DATE] indicated Resident #32 was dependent on staff for chair/bed-to-chair transfer.</p> <p>Record review of a care plan revised on 02/13/24 indicated Resident #32 had limited activity participation with interventions to encourage participation and positive feedback and to provide resident a schedule of events to post in her room. The care plan did not indicate the resident refused to attend activities.</p> <p>Record review of one-on-one activities documentation for the months of 2/2024 and 3/2024 indicated Resident #32 was not provided one-on-one activities.</p> <p>Record review of an Activities Quarterly/Annually assessment dated [DATE] indicated Resident #32 preferred in room activities and refused activities. The assessment indicated, .Staff to provide verbal reminders, assistance to and from groups, encouragement, provide schedule of programs .</p> <p>Record review of Resident #32's electronic medical record from 01/05/24 - 03/05/24 indicated an activities Weekly Participation assessment was completed for 01/05/24 and 01/11/24. There were no other assessments during this time.</p> <p>Record review of an activities Weekly Participation assessment dated [DATE] indicated, .Resident had minimal group participation due to: Resting/Sleeping . The assessment did not indicate a refusal.</p> <p>(continued on next page)</p>		

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 03/06/2024
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of an activities Weekly Participation assessment dated [DATE] indicated, .Resident had minimal group participation due to: Resting/Sleeping . The assessment did not indicate a refusal.</p> <p>During an observation and interview on 03/04/24 at 2:00 p.m., Resident #32 said if activities were provided in the facility, she did not know about it. She said she had not been provided an activities calendar. There was not an activities calendar in her room or hanging on her wall.</p> <p>During an observation and interview on 03/05/24 at 9:42 a.m., Resident #32 said no one had ever come by her room and talked to her about activities. She said depending on what the activity was, she would get up out of bed and attend some of them. There was no activity calendar hanging in her room.</p> <p>During an observation on 03/05/24 at 2:15 p.m., there was an arts and crafts activity in progress in the dining room. Resident #32 was in her room in bed asleep.</p> <p>During an observation on 03/05/24 on 3:02 p.m., a group of residents were sitting in the dining room listening to music. Resident #32 was not present.</p> <p>During an observation on 03/05/24 on 3:03 p.m., Resident #32 was in bed sleeping.</p> <p>During an interview on 03/06/24 at 8:21 a.m., Resident #32 said there were entire weeks that she was not gotten out of bed at all. She said she had refused to get up for activities at times, but there were times she would like to attend. She said she was not aware that there were arts and crafts or music playing in the dining room on 03/05/24. She said she would have liked to have attended one or both of those activities. She said no one offered the activities to her. She said no one came to her room to do one-on-one activities with her. She said she felt ignored. She said she felt annoyed by the whole situation. She said staff will probably say they come down here and I am asleep. She said, That is my answer to the whole thing. Just go to sleep. She said she did like to socialize at times and visit with other people.</p> <p>During an interview on 03/06/24 at 9:02 a.m., CNA G said she had not known Resident #32 to attend activities. She said Resident #32 just did crossword puzzles and read magazines.</p> <p>During an interview on 03/06/24 at 9:12 a.m., the Activity Director said she hung calendars in each residents' room. She said she went in Resident 32's room every day and talked to her. She said she did not do one-on-one activities with Resident #32. She said Resident #32 liked to watch television She said Resident #32 became frustrated during activities and threw things. She said she had not charted any refusals in awhile. When asked how not being provided activities could negatively affect a resident she said, She reads a lot of magazines.</p> <p>During an observation on 03/06/24 at 9:58 a.m., a Resident Rights posting was hanging in a hallway near the nurse's station. The positing indicated, .You have the right to .participate in activities inside and outside the facility .</p> <p>During an interview on 03/06/24 at 10:00 a.m., LVN H said she had seen Resident #32 up out of bed maybe twice. She said that had been a long time ago. She said she had not witnessed her at any activities. She said a resident not being gotten up can affect their will to live, depression, general attitude and quit eating. She said not attending activities could affect her in the same way.</p> <p>(continued on next page)</p>		

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 03/06/2024
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/06/24 at 10:21 a.m., the DON said Resident #32 was asked every day if she wanted to get up and the resident said no. She said the resident did not want to get up. She said she had seen her up a few times and did not stay up long. She said she would have expected the resident to have been provided an activity calendar and be offered activities. She said any refusals should have been charted by the activity director. She said a resident not getting up or attending activities could cause them to feel isolated and cause depression.</p> <p>During an interview on 03/06/24 at 10:48 a.m., the Administrator said if a resident wanted to get out of bed they should be gotten out of bed. She said she has been down to Resident #32's room and had talked to her. She said because she refused 90 percent of the time, it could be the reason staff were not asking her to get up. She said she expected for an activity calendar in her room and out on time so the residents could attend activities. She said if a resident did not want to get up, one-on-one in room activities should be provided to the resident. She said the resident did like to read and do cross word puzzles.</p> <p>Review of a One-on-one Program facility policy dated 01/01/23 indicated, .One-on-one wellness visits will be provided for those residents whose physical or intellectual impairments prohibit their active involvement in group programs and/or those resident who prefer not to attend group programs .Wellness staff will utilized the One-on-One tracking form .to maintain an up to date list of residents identified for one-on-one programming each month .If a one-on-one intervention is offered but the resident refuses, it must also be documents with reason for refusal .</p>		

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 03/06/2024
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents received appropriate treatment and services to prevent urinary tract infections (UTI) for 1 of 3 residents (Resident #193) who were reviewed for quality of care.</p> <p>The facility failed to ensure Resident# 193 had an indwelling urinary catheter (tube inserted into the bladder to drain urine) securement/anchor device (used to secure an indwelling urinary catheter).</p> <p>This failure could place residents at risk for indwelling urinary catheter dislodgement, urethral (empties urine from the bladder and out of the body) damage, pain, and urinary tract infections.</p> <p>Findings included:</p> <p>Record review of Resident #193's face sheet dated 3/04/24 indicated Resident #193 was a [AGE] year-old female, who admitted to the facility on [DATE]. Resident #193 had diagnoses including cerebral infarction (lack of adequate blood supply to brain cells depriving them of oxygen causing parts of the brain to die), depression (persistent sadness), hypertension (high blood pressure), and Stage 4 pressure ulcer of left buttock.</p> <p>Record review of Resident #193's admission MDS assessment dated [DATE] indicated Resident #193 was usually understood and usually understood others. The MDS indicated Resident #193 had a BIMS score of 1 which indicated she had severe cognitive impairment. The MDS indicated Resident #193 did not reject care. The MDS indicated Resident #193 required maximal to total assistance with most ADLs. The MDS indicated Resident #193 had an indwelling urinary catheter and was always incontinent of bowel. The MDS indicated Resident #193 had a stage 4 pressure ulcer/injury (deep wounds that may extend into muscle, tendons, ligaments, and bone).</p> <p>Record review of Resident #193's care plan dated 3/04/24 indicated Resident #193 had impaired physical mobility with generalized weakness, left sided weakness, and right lower extremity weakness. The care plan indicated Resident #193 had a urinary catheter with an intervention for care/changing of urinary catheter as ordered and a goal for the resident to be free of complications of indwelling catheter. The care plan indicated Resident #193 was at risk for/actual skin breakdown.</p> <p>Record review of Resident #193's Consolidated Orders dated 3/05/24 indicated an order for a foley catheter to continuous gravity drainage and catheter care with ***Privacy bag checked and placement of leg strap verified every shift***.</p> <p>Record review of Resident #193's eTAR dated 3/01/24-3/31/24 revealed foley catheter 16 Fr (French-size of catheter) every AM and night shift to continuous gravity drainage and catheter care, bulb size 10 mL, ***Privacy bag checked and placement of leg strap verified every shift**** and indicated these had been checked/completed on each shift including the day shift on 3/05/24.</p> <p>(continued on next page)</p>		

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 03/06/2024
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 3/05/24 at 9:50 AM, RN F performed wound care to Resident #193's stage 4 pressure ulcer on her buttocks. While observing wound care, Resident #193's indwelling urinary catheter tubing was observed pressed between both of her upper legs and there were red lines where the catheter tubing was pressed between both inner upper legs and there was no indwelling urinary catheter securement device attached to her indwelling urinary catheter.</p> <p>During an observation an interview on 3/05/24 at 2:40 PM, surveyor was accompanied to Resident #193's room by RN F. Resident #193 was lying on her back in bed and surveyor asked RN F to lift Resident #193's bedding to observe her indwelling urinary catheter tubing. Resident #193 continued to have no indwelling urinary catheter securement device attached to Resident #193's indwelling urinary catheter and the indwelling urinary catheter tubing was laid tightly across Resident #193's left leg with the rest of the tubing hanging toward the floor and emptying into a urine collection bag attached to the bed frame. RN F said Resident #193 did not have an indwelling urinary catheter securement device attached to her indwelling urinary catheter and she had noticed it was missing when she had performed Resident #193's wound care the morning of 3/05/24. RN F said she was planning on getting a catheter securement device for Resident #193's indwelling urinary catheter, but she had not had time to locate one yet.</p> <p>During an interview on 3/05/24 at 3:08 PM, RN F said she had worked at the facility for approximately 8 months on the 6 AM-6 PM shift. RN F said the catheter securement device was used to secure the indwelling urinary catheter to ensure it did not get pulled out. RN F said she was pretty sure Resident #193 had a catheter securement device on 3/04/24 when she performed Resident 193's wound care, but she did not know what happened to it, if it got wet & came off, or what happened. RN F said that brand of catheter securement device was subject to come off if it became wet. RN F said not having a catheter securement device in place could place the resident at risk for having the indwelling urinary catheter pulled out, pressure injury, and if the catheter was moving around in the bladder, it could increase the risk of infection/UTI. RN F said she had meant to replace the catheter securement device the morning of 3/05/24 after she saw it was missing, but she had not had a chance yet.</p> <p>During an interview on 3/06/24 at 2:22 PM, the DON said residents with indwelling urinary catheters should have a catheter securement device, if they don't refuse one. The DON said she would expect the catheter securement device to be replaced immediately in the perfect world or as soon as possible. The DON said Resident #193's catheter securement device should have been replaced sooner than five hours after it was discovered missing. The DON said not having a catheter securement device on an indwelling urinary catheter, increased the resident's risk of urethral trauma, dislodgement, infection, and skin breakdown. The DON said the nurses were responsible for ensuring the catheter securement devices were in place and it was placed on the eTAR to monitor for placement on each shift.</p> <p>During an interview on 3/06/24 at 2:45 PM, the ADM said she said she was not a nurse and did not know what a catheter securement device was, but she would expect if there was an order from a physician for Resident #193 to have one, then the orders should be followed.</p> <p>Record review of the facility's policy titled Care and Removal of an Indwelling Catheter dated revised 1/2020 revealed . staff would provide care and removal of an indwelling catheter in accordance with standard practice guidelines .</p> <p>(continued on next page)</p>		

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 03/06/2024
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the undated CDC Indwelling Urinary Catheter Insertion and Maintenance revealed CAUTI were costly and increased morbidity . maintenance catheter care essentials . when an indwelling urinary catheter was indicated, the following interventions should be in place to help prevent infection . properly secure indwelling catheters to prevent movement and urethral traction .</p>		

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 03/06/2024
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643</p> <p>Based on interviews and record review, the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice for 1 of 10 residents reviewed for quality of care. (Resident #144)</p> <p>The facility failed to manage Resident #144's pain by not administering his ordered pain medication.</p> <p>This failure placed residents at risk for increased pain, decline in mobility, functioning, inability to perform activities of daily living and decreased quality of life.</p> <p>Findings Include:</p> <p>Record review of a face sheet dated 03/01/24 revealed Resident #144 was [AGE] years old and was admitted on [DATE] with diagnoses including fracture of the right scapula (the scapula is a thick, flat bone lying on the thoracic wall), fracture of ribs right side, fracture of left tibia (the tibia is the shinbone, the larger of the two bones in the lower leg).</p> <p>Record review of the MDS assessment indicated Resident #144 did not have a MDS created yet as he was admitted to the facility on [DATE] and did not have a MDS created as of 3/6/2024.</p> <p>Record review of a baseline care plan dated 03/02/2024 indicated Resident #144 was care planned for chronic pain over three months.</p> <p>Record review of a care plan dated 03/05/2024 indicated Resident #144 did not have a care area listed for lidocaine patches. Care plan completion timeframe within compliance.</p> <p>Record review of current physician's orders indicated an open-ended order with a start date of 03/01/24 for Lidocaine 5% topical patch (relief of neuropathic pain), 1 patch topically daily.</p> <p>Record review of a Medication Administration History dated 03/01/24 - 03/05/24 indicated a Lidocaine 5% patch had not been administered to Resident #144 on any of the 5 days in the date range. Lidocaine 5% was administered on 03/05/24 after facility was notified of Resident #144 was in pain and he had not been administered Lidocaine 5% patch.</p> <p>During an interview on 03/05/24 at 09:15 a.m. Resident #144 said that he was in pain. He said that he received hydrocodone several times a day. He said that he has never received a lidocaine patch and did not know he could get one. He said his shoulder was hurting where his motorcycle fell on his arm and shoulder. He said he could use the lidocaine patch to ease the pain he was feeling.</p> <p>During an interview on 03/05/24 at 2:08 p.m., Resident #144 said he was still in pain and wanted his lidocaine patch. He said that he has not received a lidocaine patch since being admitted to the nursing facility. He said he received the lidocaine patch at the hospital.</p> <p>(continued on next page)</p>		

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 03/06/2024
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/05/24 at 2:11 p.m., the Family Member of Resident #144 said that Resident #144 had lived with chronic pain for some time even before the accident. She said he has been very confused, and he could benefit from the lidocaine patch. She said he was receiving a lidocaine patch when he was at the hospital before being admitted to the nursing facility. She said she would appreciate if a nurse was told to place the patch on his upper back where he was feeling the most pain.</p> <p>During an interview on 03/05/24 at 2:37 p.m., LVN E said 3/5/24 was her first day treating Resident #144. She said she did not know he was ordered a lidocaine patch. She said she did not see one on him 3/5/24 She said as far as she knew, Resident #144 has not received his lidocaine patch.</p> <p>During an interview on 03/05/24 at 3:28 p.m., with the Family Member of Resident #144 she said that Resident # 144 did not receive a lidocaine patch 3/5/24at 9:00 a.m. She said he was given his lidocaine patch 3/5/24 after the surveyor spoke to her earlier. She said a staff came and applied the patch.</p> <p>During an interview on 03/05/24 at 3:37 p.m. Medication Aide B said that she did not give Resident #144 his lidocaine patch 3/5/24 morning. She said that she got too busy and forgot. She said that Resident #144 was given his lidocaine patch after it was brought to their attention today.</p> <p>During an interview on 03/06/24 at 10:53 a.m., with the Director of Nursing she said an order for Resident # 144's lidocaine patch came from the hospital. She said they had received the order from the pharmacy. She said the med aide must not have given him the lidocaine patch. She said the lidocaine patch should have been retimed and given to Resident #144 if the medication aide forgot to give it to him and entered into the MAR at the correct time. She said residents could be placed at risk for decreased participation in therapy and healing times. She said the medication aide should have communicated that she was unable to give the lidocaine patch to the resident if she was too busy.</p> <p>During an interview on 03/06/24 at 11:15 a.m., with the Administrator she said it was the responsibility of the medication aide to give the lidocaine patches. She said the resident's mood could be affected by their pain level. She said Resident #144 was getting confused and may not have been able to communicate if he was in pain. She said she was unsure if they could take him at his word if he said he was in pain or if he was actually just confused and was really not. She said depending on the person pain could affect their quality of life.</p> <p>Review of a Pain Management and Basic Comfort Measures facility policy dated 8/2020 indicated, Staff will evaluate pain and provide basic comfort measures in accordance with standard practice guidelines .Provide pain medication as prescribed by an authorized prescriber.</p>		

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 03/06/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49019</p> <p>Based on observation, record review, and interview, the facility failed to store all drugs and biologicals in locked compartments for 2 of 4 medication carts (100 hall cart and 300/400 hall cart) reviewed for pharmacy services.</p> <ol style="list-style-type: none"> 1. The facility failed to lock 2 medication carts for hall 100 and 300/400 Halls split cart. 2. The facility failed to ensure LVN E removed expired eye drops from the nurse medication cart for 100-hall. <p>These failures could place residents at risk of not having their medications available as prescribed, a drug diversion, and an adverse reaction to expired medications.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. During an observation on 3/5/2024 at 8:02 a.m., of the 100-hall nurse medication cart, when Multiple staff and residents were present in the hallway. There was no staff present at the medication cart. The ADM was nearby and approached the medication cart and locked it. LVN E said the cart was the 100-hall cart and the staff member for the cart was not in the facility. The unlocked medication cart had various medications for residents including multivitamins, eye drops, Levetiracetam 500 mg (a medication used for the treatment of seizures), Gabapentin 300 mg, liquid Potassium 20 MEQ (a mineral supplement used to treat low potassium), liquid Levetiracetam (used for the treatment of seizures), Lisinopril 40 mg (used for treatment of elevated blood pressure), and benzonatate 100 mg (used for treatment of cough). The ADM said she was putting out an in-service immediately concerning unlocked medication carts. <p>During an observation and on 3/5/2024 at 9:07 AM, the medication cart located at the nurse's station for split cart for 300/400 hall was observed to be unlocked. RN F noticed the medication cart was unlocked and attempted to lock it. She said medication carts were to be locked when not in use. Multiple residents and staff were walking in the entrance and main area of the facility near the unlocked medication cart. The medications reviewed for unlocked cart included Ondansetron HCL 4 mg (used for treatment of nausea), Spironolactone 25 mg (used for treatment of blood pressure and fluid retention) and Eliquis 5 mg (a blood thinner used to treat blood clots). Narcotics remained secured in lock box located within the medication cart.</p> <p>During an interview on 3/6/2024 at 9:27 AM, MA A said everyone was responsible for ensuring the carts were locked. MA A said she was responsible for her cart while passing meds. MA A said Residents could get in the cart and take a medication that were not prescribed. She said she did not know what the policy said. She said when she steps away, the medication cart should be locked.</p> <p>(continued on next page)</p>		

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 03/06/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/6/2024 at 9:08 AM, LVN D said MA's and nurses assigned to the cart were responsible for carts. LVN D said the medication carts was supposed to be unlocked only when pulling medications. Resident could get into the medications; family members could get on the cart or other staff members. Insulin needles was on there and someone could get hurt and it could be a HIPPA violation. LVN D said the facility has 1 nurse cart, 2 MA carts, 1 treatment cart. She said she knew it was policy to lock cart even if cart was at the door.</p> <p>During an interview on 3/6/2024 at 12:11 p.m., the ADON said the nurses and MA assigned to cart for passing medications were responsible for ensuring the medication carts are locked. The ADON said the medication carts should be locked when not passing medications. The ADON said residents could get medication that is not prescribed to them.</p> <p>During an interview on 3/6/2024 at 1:48 p.m., the DON said the MA and nurse who were assigned to the cart were responsible for ensuring the medication carts are securely locked. The DON said if a nurse or MA steps away from the cart, it should be locked to prevent someone from stealing medications. The DON said the policy indicated medication carts should remained locked.</p> <p>2. During an interview and observation on 3/5/2024 at 8:02 a.m., the medication cart for 100-hall had Lumigan 0.01% eye drops with a label indicating an expiration date of 9/28/2024 and Simbrinza 1%-0.2% eye drop indicating an expiration date of 9/28/2023. LVN E confirmed the expired medications and removed eye drops from the medication cart. LVN E said she would re-order the medications if they were to be continued.</p> <p>During an interview on 3/6/2024 at 9:10 AM LVN D said all nurses and MA assigned to medication cart were responsible for checking for expired medications on the cart. LVN said the staff were to put expired medications in the medication storage room. LVN D said discontinued or expired narcotics were to be taken to the DON or ADON, counted for appropriate destruction. LVN D said a resident could get sick or have a reaction to an expired medication if administered.</p> <p>During an interview on 3/6/2024 at 9:27 a.m., MA A said she was supposed to place expired and discontinued medication in the medication storage room. MA A said she would notify the DON if a narcotic medication had been discontinued. MA A said she did not know what would happen if she administered an expired medication. MA A said she does not provide resident care, but she would report to the nurse any observed changes in a resident.</p> <p>During an Interview on 3/6/2024 at 1:55 p.m., the DON said the nurses or MA administering medications were responsible for ensuring medications on cart are not expired. During business hours the narcotic should be removed and brought to DON unless on the weekend. She said the discontinued medications can stay on cart until seen by ADON/DON during business hours. The DON said if a resident were administered an expired medication, it could cause an adverse side effect could occur.</p> <p>During an interview on 3/6/2024 at 2:20 PM, the ADM said the person administering the medication were responsible for ensuring medication cart is locked. The ADM said the staff with the keys are responsible to ensuring medications are not expired. The ADM said it is the responsibility of the nurses and pharmacy to destroy the medications but did not know the process. The ADM said discontinued narcotics are given to the DON or ADON and double locked in the DON's office. The ADM said she expects the nurses and MA to remove expired and discontinued medications from the medication carts and to call for a new prescription if the medication is expired.</p> <p>(continued on next page)</p>		

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 03/06/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Training In-service Form dated 3/5/2024 indicated, Medication carts are to be locked at all times . This includes but not limited to after count was completed and in between passing medications .</p> <p>Review of a Storage of Medication dated January 2024 indicated, Medications and biologicals are stored properly . In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications . Medication rooms, cabinets and medication supplies should remain locked when not in use or attended to by persons with authorized access .Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock .</p>

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 03/06/2024
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 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643</p> <p>Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 1 of 6 resident personal refrigerators reviewed for food and nutrition services (Resident #11).</p> <p>The facility failed to ensure the refrigerator for Resident #11 did not contain expired and decomposing meat products.</p> <p>This failure could place resident at risk for food borne illnesses.</p> <p>Findings include:</p> <p>Record review of a face sheet dated [DATE] indicated Resident #11 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses including Dementia (the loss of cognitive functioning), Anxiety (a feeling of fear, dread, and uneasiness), and Heart Failure (occurs when the heart muscle doesn't pump blood as well as it should).</p> <p>Record review of an annual MDS assessment dated [DATE] indicated Resident #11 understood others and made herself understood. The MDS indicated Resident #11 had moderate cognitive impairment with a BIMS score of 09. The MDS indicated Resident #11 did not reject evaluation or care.</p> <p>During an observation and interview on [DATE] at 9:54 a.m., Resident #11's personal refrigerator was observed with expired foods. Pickle and pimento loaf expired on [DATE]. Salami expired [DATE]. Package of bologna expired [DATE]. Package of bologna expired [DATE]. Package of smoked sausage expired [DATE]. The pickle and pimento loaf appeared to have released gasses and the package was expanding and appeared as it was about to burst. The package of salami was open and exposed to the air and was gray in color.</p> <p>During an interview on [DATE] at 2:08 p.m., with Housekeeper J, she said she was not sure who was supposed to clean out the personal refrigerators in residents' rooms. She said if she was told to clean out the refrigerators she would have helped out and cleaned them. She said if she saw expired meat in the refrigerator, she would throw it away. She said residents could be placed at risk for foodborne illness if they ate expired foods. Surveyor informed Housekeeper J that Resident #11 had meat that expired in his refrigerator as far back as 2022.</p> <p>During an observation on [DATE] at 9:14 a.m. of Resident # 11's room, it was observed in his refrigerator that the expired meat was not thrown away after speaking to housekeeping staff.</p> <p>During an interview on [DATE] at 9:36 a.m., Housekeeper J was showed expired food in Resident #11's refrigerator. Housekeeper J said she would throw it away.</p> <p>During an interview on [DATE] at 10:53 a.m. with the Director of Nursing she said anyone that observed food in a resident's refrigerator should have thrown it away if it was expired or decomposing. She said that residents could be placed at risk of food poisoning and foodborne illness if they consume food that was expired or decomposing.</p> <p>(continued on next page)</p>

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 03/06/2024
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 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:15 a.m., with the Administrator she said it was the housekeeping staff who should ensure that personal refrigerators were free from expired foods. She said Resident #11's family should have cleaned out the refrigerator as well since Resident #11 could be difficult to deal with. She said Resident #11 sometimes understood about the meat in his refrigerator that was expired but she will go again on [DATE] and address the issue. She said residents can be placed at risk from illness from eating expired meat.</p> <p>Review of a Storage and Handling Food from Outside Sources facility policy dated [DATE]st, 2018 indicated, Food from outside sources should be stored and handled consistent with department policies .Residents are not prohibited from consuming foods not procured by the facility .Storage and handling of these foods should be consistent with departmental policies .Foods will be stored in a way which is separate or easily identifiable from facility foods.</p>		