STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675561	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Plaza Nursing Center	600 W 52nd St Texarkana, TX 75501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observations, interviews, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 13 residents (Resident #12) reviewed for resident rights. The facility failed to ensure Resident #12's catheter drainage bag was in a privacy bag. This failure could place residents at an increased risk of embarrassment and a diminished quality of life. The findings included: Record review of the face sheet, dated 04/23/25, reflected Resident #12 was a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses of unspecified dementia with behaviors (memory loss) and chronic kidney disease (gradual loss of kidney function). Record review of the quarterly MDS assessment, dated 01/30/2025, reflected Resident #12 had clear speech and was sometimes understood by staff. The MDS reflected Resident #12 was rarely/never able to understand others. The MDS reflected Resident #12 had a BIMS score of 0, which indicated severe cognitive impairment. The MDS reflected Resident #12 had inattention and disorganized thinking that was continuously present and did not fluctuate. The MDS reflected Resident #12 exhibited refusal of care behaviors 1 to 3 days during the 7 day look-back period. The MDS reflected Resident #12 was totally dependent upon staff for assistance with toileting and had an indwelling catheter. Record review of the comprehensive care plan, dated 11/14/24, reflected Resident #12 had a urinary catheter. The interventions included: use privacy bag. Record review of the treatment order, which started on 01/04/25, reflected Resident #12 had an order for a Foley catheter, which included privacy bag checked every shift. During an observation on 04/21/25 at 1:52 PM, Resident #12 was lying in her bed with her eyes closed. Resident #12's Foley catheter drainage bag was hanging on the bed rail visible from the doorway. No privacy bag was observed, and the drainage bag was filled halfway with yellow urine. Resident #12 was non-interviewable related to cognitive impairment. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/22/25 at 9:13 AM, Resident #12 was sitting up in her chair at the front lobby. Resident #12's Foley catheter drainage bag was hanging on the side of her chair. No privacy bag was observed, and the drainage bag had a small amount of yellow urine at the bottom of the bag. During an observation on 04/22/25 at 4:13 PM, Resident #12 was lying in the bed. Resident #12's Foley catheter drainage bag was hanging on the bed rail visible from the doorway. No privacy bag was observed, and the drainage bag had yellow urine. During an interview on 04/22/25 beginning at 4:38 PM, CNA L stated Resident #12 should have had a privacy bag on her catheter drainage bag. CNA L stated the CNAs should have made the nurses' aware if there was no privacy bag noted. CNA L stated it was important to ensure Resident #12 had a privacy bag on her Foley catheter drainage bag for dignity. During an interview on 04/23/25 beginning at 9:57 AM, CNA C stated Resident #12 should have had a privacy bag on her catheter drainage bag. CNA C stated she was nervous and did not notice if Resident #12's privacy bag was in place. CNA C stated if Resident #12 did not have a privacy bag available, she should have notified the nurse. CNA C stated it was important to ensure Resident #12 had a privacy bag on her Foley catheter drainage bag for dignity. During an interview on 04/23/25 beginning at 11:27 AM, LVN K stated Resident #12 should have had a privacy bag on her catheter drainage bag. LVN K stated she believed Resident #12 had a catheter drainage bag, but the CNAs probably lost it. LVN K stated she expected CNAs to report to the charge nurse if a privacy bag was missing so she could get another one. LVN K stated it was important to ensure a privacy bag was used for a catheter drainage bag for dignity. During an interview on 04/23/25 beginning at 11:42 AM, the DON stated she expected staff to notice if a privacy bag was missing, place a privacy bag if needed, or notify the charge nurse. The DON stated the CNAs should monitor to ensure privacy bags were in place, but any staff member could have noticed a missing privacy bag and notified the nursing staff. The DON stated it was important to ensure privacy bags were in place to maintain the dignity of the residents. During an interview on 04/23/25 beginning at 12:09 PM, the Administrator stated she expected staff to ensure a catheter drainage bag was inside a privacy bag. The Administrator stated the CNAs were responsible for ensuring privacy bags were used. The Administrator stated nursing management was responsible for monitoring to ensure privacy bags were utilized. The Administrator stated it was important to ensure privacy bags were used to promote the dignity of the residents. Record review of the Resident Rights policy, dated 08/14/2022, did not address dignity.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 3 of 13 residents and 1 of 1 dining room reviewed for environment. (Resident #1, Resident #33, and Resident #96) 1. The facility failed to ensure Resident #1, Resident #33, and Resident #96 had furniture in good repair. 2. The facility failed to ensure the activity cabinet in the dining room was in good repair. These failures placed residents at risk of injury, an uncomfortable environment, and a decrease in quality of life and self-worth. Findings included: 1. Record review of the face sheet 04/22/25 indicated Resident #1 was [AGE] years old and was admitted on [DATE] with diagnoses including dementia, pain, and convulsions (seizures). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #1 was usually understood and usually understood others. The MDS indicated a BIMS score of 08 indicating Resident #1 was moderately cognitively impaired. The MDS indicated Resident #1 required setup assistance from staff for ADL's. During an observation on 04/21/25 at 9:39 a.m., revealed Resident #1 was in bed. Resident #1's dresser was missing the front of the bottom drawer on the left side of the dresser. Resident #1's personal clothing items were exposed. The finish to the dresser was worn along the top edge and the front two lower corners and wood were exposed. During an observation and interview on 04/22/25 at 11:37 a.m., revealed Resident #1's dresser was missing the front of the bottom drawer on the left side of the dresser. Resident #1's personal clothing items were exposed. The finish to the dresser was worn along the top edge and the front two lower corners and wood were exposed. The resident said the dresser had been that way a long time. She said she had not reported it to anyone. 2. Record review of the face sheet 04/22/25 indicated Resident #33 was [AGE] years old and was admitted on [DATE] with diagnoses including dementia, impulse disorder (a mental health disorder that makes it difficult to resist urges), and hypoglycemia (low blood sugar). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #33 was usually understood and usually understood others. The MDS indicated a BIMS score of 10 indicating Resident #33 was moderately cognitively impaired. The MDS indicated Resident #33 required moderate to maximal assistance from staff for ADL's. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 04/21/25 at 9:49 a.m., revealed Resident #33 was in his chair in his room. Resident #33's dresser was missing the front of the second drawer down. Resident #33's personal items were exposed. During an observation an interview on 04/23/25 on 8:04 a.m., revealed Resident #33 was in his chair in his room. Resident #33's dresser was missing the front of the second drawer down. Resident #33's personal items were exposed. He said front of the drawer fell off a long time ago. He said he had not told anyone. He said, It is ugly like that. I thought they would bring me another dresser, but they have not. 3. Record review of the face sheet 04/22/25 indicated Resident #96 was [AGE] years old and was admitted on [DATE] with diagnoses including kidney failure, diabetes, and weakness. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #96 was usually understood and usually understood others. The MDS indicated a BIMS score of 12 indicating Resident #1 was moderately cognitively impaired. The MDS indicated Resident #96 required maximal assistance from staff for most ADL's. During an observation and interview on 04/21/25 at 11:51 a.m., revealed Resident #96 was in bed in her room. There was a wardrobe next to her bed. The front of the top drawer was only attached on one side and was hanging down. Resident #96's personal items were exposed. The handle to the door had a missing screw and was out of place. She said it had been broken the whole time she had been at the facility. During an observation on 04/22/25 at 11:39 a.m., revealed Resident #96 was in bed in her room. There was a wardrobe next to her bed. The front of the top drawer was only attached on one side and was hanging down. Resident #96's personal items were exposed. The handle to the door had a missing screw and was out of place. Record review of a Maintenance Work Order book that was kept at the nurse's station did not indicate work orders requesting repair of Resident #1 and Resident #33's dresser or Resident #96's wardrobe. During an interview on 04/23/25 at 9:05 a.m., CNA M said she had not noticed any broken furniture. She said any staff going in the room should notice broken furniture in a resident's room. She said any broken furniture should be entered into the Maintenance Work Order book at the nurse's stations. She said it is the Maintenance Supervisor's job to repair the furniture. She said broken furniture would not make her feel comfortable and like the staff did not care about her. During an interview on 04/23/25 at 9:20 a.m., LVN N said she had noticed the fronts of drawers missing off residents furniture. She said she never reported it to anyone. She said she had seen Resident #33's dresser missing a drawer front. She said furniture not being repaired could lead to a risk of splinters. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/23/25 at 9:47 a.m., the Maintenance Supervisor said he learned of furniture in need of repair either by work order or when he was in a room. He said he repaired what he could. He said sometimes he would go into a room and a drawer front would just be gone and someone had put it in the trash. He said he did not have extra furniture except for furniture from an empty room. He said he was not aware of the wardrobe in Resident #96's room. He said he had no clue where the front of the drawer was for Resident #33's dresser. He said he was not aware it was missing. He said he was not aware of the drawer missing a front in Resident #1's room. He said he had not been in her room in forever. He said none of these had been entered into the Maintenance Work Order book at the nurse's station. During an interview 04/23/25 at 10:23 a.m., the DON she said everyone was responsible for reporting broken furniture. She said there was a Maintenance Work Order book at the nurse's station and any request for repair should be entered into the book. She said she would then expect the Maintenance Supervisor to then address the issue. She said furniture in disrepair including loose handles could cause a balance issue and there could be sharp edges. She said also it could cause the residents personal items to be on display for everyone to see. During an interview on 04/23/25 at 10:40 a.m., the Administrator said all staff that entered a room that noticed anything that needed to be repaired should place a repair request in the Maintenance Work Order book. She said once it is entered into the Maintenance Work Order book, she then expected the maintenance supervisor to address the issue. She said furniture not being in good repair could be a care and concern for the resident. She said, I wouldn't like it. 4. During an observation on 04/21/25 at 11:28 AM, revealed the activity cabinet in the dining room had the right side of its doors removed, which were propped against the second cabinet. During an observation on 04/22/25 at 2:05 PM, revealed the activity cabinet in the dining room had the right side of its doors removed, which were propped against the second cabinet. During an interview on 04/23/25 at 10:44 AM, the Maintenance Supervisor stated the activity cabinet had not been reported to him, but he was aware the doors were broken. The Maintenance Supervisor stated the door was beyond repair and he had not been given approval to replace the cabinet. The Maintenance Supervisor stated he did not have extra furniture to replace the broken items. The Maintenance Supervisor stated it was important to ensure furniture was in good condition to prevent injuries and maintain a homelike environment. During an interview on 04/23/25 beginning at 12:09 PM, the Administrator stated she expected furniture to be in good repair. The Administrator stated the Maintenance Supervisor was responsible for ensure the furniture was fixed or replaced. The Administrator stated it was important to ensure furniture was in good repair to maintain a homelike environment. Record review of the Maintenance Service policy, undated, reflected Maintenance service shall be provided to all areas of the building, grounds, and equipment .the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .The following functions are performed by maintenance .maintain the building in good repair and free from hazards . providing routinely scheduled maintenance to all areas . 47006

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 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 2 of 13 residents reviewed for activities. (Residents #2 and Resident #33) The facility failed to provide Residents #2 and Resident #33 with consistent, scheduled activities. 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. Findings included: 1. Record review of the face sheet 04/22/25 indicated Resident #2 was [AGE] years old and was admitted on [DATE] with diagnoses including dementia, peripheral vascular disease (a condition where blood flow to the extremities, particularly the legs and arms, is restricted due to narrowing or blockage of blood vessels), and pain. Record Review of Physician's Orders for Resident #2 reviewed on 04/22/25 indicated an order for activities as tolerated with a start date of 08/18/23. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #2 was usually understood and usually understood others. The MDS indicated a BIMS score of 12 indicating Resident #2 was moderately cognitively impaired. The MDS indicated Resident #2 required supervision from staff for ADL's. Record review of a care plan last reviewed on 03/20/25 indicated Resident #2 had a need for socialization and had limited activity participation. There was an intervention to explore and obtain past interest and potential re-motivation. Record review of a Daily Participation form dated 02/20/25 indicated Resident #2 was active in all activities except for aromatherapy. Resident #2's electronic medical record did not indicate any Daily Participation forms since 02/20/25. During an observation and interview on 04/21/25 at 11:11 a.m., Resident #2 said she would like more activities. There was an activities calendar hanging on Resident #2's wall. She said, All we do is play bingo. She said when the previous Activity Director was there, they always had something to do. She said the previous Activity Director even had activities for them to do on the weekends. 2. Record review of the face sheet 04/22/25 indicated Resident #33 was [AGE] years old and was admitted on [DATE] with diagnoses including dementia, impulse disorder (a mental health disorder that makes it difficult to resist urges), and hypoglycemia (low blood sugar). Record Review of Physician's Orders for Resident #33 reviewed on 04/22/25 indicated an order for activities as tolerated with a start date of 08/20/24. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a quarterly MDS assessment dated [DATE] indicated Resident #33 was usually understood and usually understood others. The MDS indicated a BIMS score of 10 indicating Resident #33 was moderately cognitively impaired. The MDS indicated Resident #33 required moderate to maximal assistance from staff for ADL's. Record review of a care plan last revised on 02/13/25 indicated Resident #33 had a need for socialization with interventions to provide assistance to and from activities of interest, provide materials, equipment or supplies for preferred activity pursuits, and provide modifications and/or adaptations according to needs. Record review of a Daily Participation form dated 02/20/25 indicated Resident #33 was active in all activities except for aromatherapy and manicures. Resident #33's electronic medical record did not indicate any Daily Participation forms since 02/20/25. During an interview on 04/21/25 at 09:49 a.m., Resident #33 said the facility did not offer many activities. He said it was boring just sitting in his room. He said the other Activity Director sure kept us busy. He said the new Activity Director did not. Record review of an Activity Calendar for April 2025 indicated Balloon Volleyball was scheduled on 04/22/25 at 10:30 a.m. The calendar indicated Earth Day Scattergories was scheduled on 04/22/25 at 2:00 p.m. During an observation on 04/22/25 at 10:50 a.m., revealed there was no activity going on in the facility. During an interview on 04/22/25 at 11:01 a.m., the Activity Director said the morning activity did not happen. She said, Tthings got sidetracked. She said there would be an activity after lunch. During an observation 04/22/25 at 2:08 p.m., revealed there were 5 residents present in the dining room. There were no staff present. There was no activity in progress. During an observation on 04/22/25 at 2:15 p.m., revealed there were 5 residents present in the dining room. The residents were swatting balloons in the air with pool noodles. During an observation on 04/22/25 at 2:44 p.m., revealed there were residents in the dining room. There was not an activity in progress. During an interview on 04/23/25 at 8:04 a.m., Resident #33 said there was not an activity on the morning of 04/22/25. He said he did not know why. He said the Activity Director came and told him it was cancelled. He said, I just get bored sitting here. During an interview on 04/23/25 at 9:05 a.m., CNA M said she had not seen any activities while working at the facility. She said residents had not complained to her about not having enough activities. She said not having activities could affect them mentally and physically. It could cause someone to stay in the bed and could cause depression. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/23/25 at 9:20 a.m., LVN N said she knew residents had bingo and little activities. She said she had not heard any complaints about not enough activities. She said not having enough activities would not be fun and not having them could affect the resident's mentality. During an interview on 04/23/25 at 9:59 a.m., the Activity Director said she had made rounds to see what activities the residents would be interested in. She said no resident had complained to her about not having enough activities. She said in between her doing activities she also worked as the restorative aide and still drove the van occasionally. She said on the morning of 04/22/25 she was performing restorative aide duties and that was why the morning activity did not happen. She said she tried to arrange her restorative aide duties around the activities. She said her restorative duties could affect the activities on a daily basis. She said the restorative duties were causing her to not start activities at the scheduled time on the calendar. She said a lot of times it was hard to get the residents to attend activities. She said not having enough activities could cause the residents to be depressed. She said she would be bored out of her mind if she did not have activities to do. During an interview on 04/23/25 at 10:23 a.m., the DON said she had not received any complaints about residents not having enough activities. She said the Activity Director was very new to the position. She said the previous Activity Director held only one position. She said the new Activity Director was having to do the restorative program. She said the Activity Director should have been managing her time differently. She said she should be doing her restorative duties during other times. During an interview on 04/23/25 at 10:40 a.m., the Administrator said the Activity Director held two positions with the facility. She said she expected the Activity Director to provide activities to the resident. She said expected the Activity Director to be more spontaneous in the activities. She said Residents not having activities available could make them feel uninterested and bored. She said she would expect the Activity Director to follow the calendar or put another activity in the place of the one on the calendar. Record review of a Lifetime Wellness Policies and Procedures dated 01/01/23 indicated, .The wellness staff provides a variety of wellness and life enrichment activities that are designed to engage and enhance the quality of life for each resident we serve. Each facility and its residents have individualized programing needs. In response to these needs, services are customized for each facility .Group activities are scheduled daily and residents are given the opportunity to contribute to the planning, preparation, conducting and evaluation of the program .The program consists of facility-sponsored group (large and small) and individual activities and independent opportunities that are .designed to meet the interest of each resident .support the physical, mental and psychosocial well-being of each resident .

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the activities program is directed by a qualified professional. 44128 Based on interview and record review, the facility failed to ensure their activities program was directed by a qualified professional for 1 of 1 facility reviewed for Activity Director. The facility failed to employ a certified activities director. This failure could place the residents at risk of not receiving a program of activities that meets their assessed activity needs. Findings included: Record review of a personnel file for the Activity Director revealed did not indicate an Activity Director Certification and the Activity Director had 2 years of experience in a social or recreational program. The personnel file indicated a hire date of 05/08/19. Record review of a letter dated 04/02/25 and addressed to the Activity Director indicated confirmation of enrollment in a course to begin in August 2025 that taught the standardized National Council of Certified Activity Profession curriculum. During an interview on 04/23/25 at 9:59 a.m., the Activity Director said she became the Activity Director on 01/06/25. She said before that she was a CNA on the floor and worked in transportation. She said she had no experience being an activity director before she took the position. She said she had one training class but did not have her certification yet. She said in between her doing her activities she also worked as the restorative aide and still occasionally drove the van. During an interview on 04/23/25 at10:40 a.m., the Administrator said the Activity Director had been in the position since January 2025. She said the Activity Director had two positions. She said the Activity Director was enrolled for her Activities Directors class to begin in August 2025. She said the Activity Director had assisted the prior Activity Director with activities. She said not being certified, the Activity Director might not have all the knowledge needed for the position, but the Activity Director was being overseen by someone else that offers assistance and suggestions. She the Activity Director did have support. She said it would different if she did not have support. Record review of a Lifetime Wellness Policies and Procedures dated 01/01/23 indicated, .The wellness staff provides a variety of wellness and life enrichment activities that are designed to engage and enhance the quality of life for each resident we serve. Each facility and its residents have individualized programing needs. In response to these needs, services are customized for each facility .Group activities are scheduled daily and residents are given the opportunity to contribute to the planning, preparation, conducting and evaluation of the program .The program consists of facility-sponsored group (large and small) and individual activities and independent opportunities that are .designed to meet the interest of each resident .support the physical, mental and psychosocial well-being of each resident . The policy did not indicate the required qualifications for an Activity Director.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 13 residents (Resident #196) reviewed for accidents and supervision. The facility failed to ensure CNA H performed a safe mechanical lift transfer for Resident #196. This failure could place residents at risk of injury. Findings include: Record review of Resident #196's face sheet dated 4/22/25 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #196 had diagnoses which included dementia (forgetfulness), heart failure, hypertension (high blood pressure), and anxiety (feeling of worry). Record review of the MDS assessment list, accessed 04/22/25, reflected Resident #196's admission MDS had not been completed yet. Record review of Resident #169's Care Plan dated 4/22/25 indicated he was at risk for falls, and he had impaired physical mobility with intervention to provide appropriate level of assistance to promote safety of resident. Record review of Resident #196's weight dated 4/17/25 indicated he weighed 250.2 pounds. During an observation on 4/22/25 at 8:47 AM, CNA H performed a mechanical lift transfer for Resident #196 from his bed to his high back wheelchair and was assisted by CNA J. The lift pad was already positioned under Resident #196 upon entering the room. CNA H placed the mechanical lift over Resident #196 while CNA J was on opposite side of bed and they both hooked the straps to the mechanical lift. CNA H then lifted Resident #196 up without spreading the legs of the lift to the wide position. CNA J lowered the bed down so the mechanical lift and Resident #196 would clear bed. Then CNA H pulled the mechanical lift out from over the bed with Resident #196 suspended in the lift pad and turned the mechanical lift to the left and pushed the lift over to the high back wheelchair while CNA J guided Resident #196, without spreading the mechanical lift legs to the wide position. As CNA H pushed the mechanical lift toward the high back wheelchair approximately five feet away, CNA J said open the legs to CNA H. CNA H then spread the legs of the lift to go around the high back wheelchair, while CNA J locked the wheels on the wheelchair and pulled Resident #196 to the back of the wheelchair as CNA H lowered Resident #196 into the high back wheelchair. They then unhooked the lift pad and moved the mechanical lift away from Resident #196 and positioned him in the wheelchair for comfort and combed his hair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/25 at 1:32 PM, CNA J said she had worked at the facility for three days this time but had worked at the facility previously. CNA J said the mechanical lift legs should be opened wide and locked prior to lifting the resident, so the lift would be balanced and would not tip over with the resident. CNA J said CNA H did not open the mechanical lift legs to the wide position prior to lifting Resident #196 off the bed and did not open the lift legs until CNA H had turned the lift toward the chair and opened the legs of the mechanical lift when she (CNA J) told CNA H to open the lift legs when she realized CNA H had not opened the lift legs to the wide position. CNA J said the mechanical lift could have tipped over and could have caused injury to the resident. During an interview on 4/22/25 at 1:37 PM, CNA H said she had worked at the facility since the end of January 2025. CNA H said the legs of the mechanical lift should be opened wide when going around the chair to be able to get around the chair when transferring a resident from the bed to the chair. CNA H said the purpose of the legs being open wide was to balance the lift and to be able to get around the chair to get the resident straight and even. CNA H again stated the legs of the mechanical lift should not be opened until going over and around the chair during the transfer. CNA H said she would have to look up the policy to know what the policy said about when to open the mechanical lift legs during mechanical lift transfers. During an interview on 04/23/25 at 10:52 AM, the DON said the legs of the mechanical lift should be opened wide when lifting and moving residents. The DON said the purpose of the mechanical lift legs being in the wide position was for stability. The DON said if the legs of the mechanical lift was not in the wide position during lifting or moving the resident, it placed resident at risk for injury if the mechanical lift was to fall over. The DON said they do competencies for safe mechanical lift transfers upon hire, and they did yearly skills check offs to ensure staff were performing safe mechanical lift transfers. During an interview on 4/23/25 at 11:10 AM, the ADM said she would expect staff to perform safe mechanical lifts per the facility's policy. The ADM said there was a risk of the resident falling or the mechanical lift falling over and injuring the resident if the legs of the lift were not in the wide position during lifting and moving the resident. During an interview on 4/23/25 at 12:33 PM, the DON said she was unable to locate the mechanical lift competency check off form for CNA H. Record review of the facility's policy titled Mechanical Lifts (Hoyer/Sit-to-Stand) dated revised February 12, 2020, indicated . residents would be assisted with their Activities of Daily Living, utilizing lifts according to manufacturer's guidelines . mechanical lift operators . c. inform resident of procedure . g. fold sling and place under patient in correct position . h. open feet of mechanical lift for wide stance . k. lift resident slowly and safely, just until off bed . l. move resident to other location and lower safely . Record review of Patient Lifts by the U.S. Food and Drug Administration (FDA), (Patient Lifts | FDA) was accessed on 4/24/25 indicated . the FDA has compiled a list of best practices that, when followed, can help mitigate the risks associated with patient lifts . users should . keep the base (legs) of the patient lift at maximum open position and situate the lift to provide stability . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Best Practices for Using Patient Lifts by the U.S. Food and Drug Administration (FDA), Best Practices For Using Patient Lifts (fda.gov) was accessed on 4/24/25 indicated . patient lifts were designed to lift and transfer patients from one place to another . found improper use of patient lifts have led to patient falls . resulted in head traumas, fractures, deaths . can mitigate risks by doing the following . receive training and understand how to operate the lift . keep the base (legs) of the patient lift in the maximum open position .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 2 residents (Resident #12) reviewed for treatment and services related to indwelling catheters. 1. The facility failed to ensure CNA L changed her gloves and performed hand hygiene during Foley catheter care. 2. The facility failed to ensure Resident #12's indwelling Foley catheter had a catheter securement device to anchor the catheter to her leg. 3. The facility failed to ensure Resident #12's Foley catheter drainage bag was kept off the floor. These failures could place residents at risk for urinary tract infections, injuries, and a decreased quality of life. The findings included: Record review of the face sheet, dated 04/23/25, reflected Resident #12 was a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses of unspecified dementia with behaviors (memory loss) and chronic kidney disease (gradual loss of kidney function). Record review of the quarterly MDS assessment, dated 01/30/2025, reflected Resident #12 had clear speech and was sometimes understood by staff. The MDS reflected Resident #12 was rarely/never able to understand others. The MDS reflected Resident #12 had a BIMS score of 0, which indicated severe cognitive impairment. The MDS reflected Resident #12 had inattention and disorganized thinking that was continuously present and did not fluctuate. The MDS reflected Resident #12 exhibited refusal of care behaviors 1 to 3 days during the 7 day look-back period. The MDS reflected Resident #12 was totally dependent upon staff for assistance with toileting and had an indwelling catheter. Record review of the comprehensive care plan, dated 11/14/24, reflected Resident #12 had a urinary catheter. The interventions included: use leg strap to avoid pulling to catheter. Record review of the treatment order, which started on 01/04/25, reflected Resident #12 had an order for a Foley catheter, which included placement of leg strap checked every shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/22/25 beginning at 4:13 PM, CNA L and CNA C entered Resident #12's room to perform Foley catheter care. Resident #12's pants were removed and there was no catheter securement device to anchor Resident #12's Foley catheter in place. CNA L did not change her gloves or perform hand hygiene after wiping Resident #12's buttocks. CNA L placed the clean linens under Resident #12, pulled Resident #12's pants up, and re-placed her covers with the same gloves. CNA C lowered Resident #12's bed to the floor after performing catheter care, in which her Foley catheter drainage bag was observed touching the floor. During an interview on 04/22/25 beginning at 4:38 PM, CNA L stated her gloves should have been changed and hand hygiene performed when moving from dirty areas to clean areas. CNA L was unsure if she should have changed her gloves and performed hand hygiene after cleaning Resident #12's buttocks. CNA L stated she did not normally work at the facility, but she was picking up extra shifts. CNA L stated CNA C did not want to perform the Foley catheter care because she was nervous. CNA L stated she noticed Resident #12's Foley catheter bag was on the ground after CNA C lowered her bed. CNA L stated a Foley catheter drainage bag should not have been touching the floor. CNA L stated Resident #12 did not have a catheter securement device on her leg to anchor the catheter. CNA L stated a catheter securement device should always be utilized to prevent injury from pulling. CNA L stated it was important to ensure gloves were changed, hand hygiene was performed, and the Foley catheter bag was kept off the ground to prevent infection. During an interview on 04/23/25 beginning at 9:57 AM, CNA C stated gloves should have been changed and hand hygiene performed when going from a dirty area to a clean area. CNA C stated she noticed CNA L did not change her gloves or perform hand hygiene when she performed catheter care but was unsure if she was supposed to tell her. CNA C stated not changing gloves or performing hand hygiene could have caused contamination of bacteria. CNA C stated Resident #12 normally had a clamp on her leg to prevent pulling of the catheter. CNA C stated she was unsure if it was policy to ensure catheter securement devices were in place. CNA C stated missing leg clamps should have been reported to the nurse. CNA C stated it was important to ensure the catheter securement devices was in place to prevent injury or pain from pulling. CNA C stated the Foley catheter drainage bag should not have been touching the ground. CNA C stated that was her fault and she was just thinking about Resident #12's safety. CNA C stated it was important to ensure the catheter draining bag was kept off the ground to prevent contamination of bacteria. During an interview on 04/23/25 beginning at 11:27 AM, LVN K stated she expected the CNAs to perform proper catheter care, ensure the catheter securement device was in place, and ensure the drainage bag was kept off the ground. LVN K stated gloves should have been changed and hand hygiene performed when moving from a dirty to clean area. LVN K stated it was important to ensure gloves were changed and hand hygiene was performed to prevent contamination. LVN K stated Resident #12 should have had a catheter securement device. LVN K stated the CNAs should have reported Resident #12 did not have one in place. LVN K stated she was unaware Resident #12's catheter securement device was missing. LVN K stated it was important to ensure Resident #12 had a catheter securement device in place to prevent pulling on the bladder. LVN K stated the catheter drainage bag should not have been touching the ground. LVN K stated it was important to ensure the catheter bag was kept off the ground to prevent leaking, degradation of the bag, or contamination. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/23/25 beginning at 11:42 AM, the DON stated she expected the CNAs to follow the policy and procedure for peri-care whether a resident has a catheter or not. The DON stated she expected gloves to be changed and hand hygiene performed when going from a dirty to a clean area. The DON stated the CNAs were responsible for monitoring to ensure catheter care was performed properly. The DON stated skills checkoffs were completed during orientation and annually. The DON stated it was important to ensure gloves were changed and hand hygiene was performed to prevent infection or being gross. The DON stated she expected the CNAs to ensure the nurse was made aware if a catheter securement device was missing. The DON stated it was important to ensure a catheter securement device was in place to prevent injuries. The DON stated she expected the CNAs to ensure the catheter drainage bags were kept off the ground. The DON stated everyone was responsible for ensuring catheter drainage bags were kept off the ground. The DON stated it was important to ensure the catheter drainage bag was kept of the ground to decrease the risk for infection. During an interview on 04/23/25 beginning at 12:09 PM, the Administrator stated she expected facility staff to ensure proper catheter care was performed, a catheter securement device was in place, and the catheter drainage bag was kept off the ground. The Administrator stated nursing management was responsible for monitoring to ensure those things were completed. The Administrator stated it was important to ensure proper catheter care was performed and the catheter drainage bag was kept off the floor to prevent potential infections. The Administrator stated a catheter securement device was important to prevent injuries from pulling. Record review of the Urinary Catheter Infection Prevention policy, dated 08/2018, reflected hand hygiene is essential and the single most effect way to prevent the spread of infection .the catheter is secured to the resident's leg to prevent unnecessary trauma . gravity drainage bags are kept off the floor .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observations, interviews, and record review, the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 1 resident (Resident #38) reviewed for trauma-informed care. The facility did not ensure Resident #38 had a trauma screening completed upon admission to the facility that identified possible triggers when Resident #38 had a history of trauma. This failure could put residents at an increased risk for psychological distress due to re-traumatization. The findings included: Record review of the face sheet, dated 04/22/25, reflected Resident #38 was a [AGE] year-old male who initially admitted to the facility on [DATE] with a diagnosis of unspecified dementia (memory loss). Record review of the admission referral packet, dated 11/08/24, reflected Resident #38 had a history of PTSD (mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations). Record review of the admission MDS assessment, dated 11/15/24, reflected Resident #38 had clear speech and was usually understood by others. The MDS reflected Resident #38 was usually able to understand others. The MDS reflected Resident #38 had a BIMS score of 11, which indicated moderately impaired cognition. The MDS reflected Resident #38 had wandering behaviors 1 to 3 days during the 7-day look-back period. The MDS assessment reflected Resident #38 had an active diagnosis of PTSD. Record review of Resident #38's comprehensive care plan, initiated 11/08/24, did not address a diagnosis of PTSD. The care plan did not identify potential triggers for re-traumatization. Record review of the admission assessment, signed 11/09/24, reflected Resident #38 had a mental health diagnosis of PTSD. Record review of the social services note, signed 11/13/24, reflected Resident #38 had no trauma screening or identification of potential triggers. Record review of the admission records list, accessed 04/22/25, reflected Resident #38 had no trauma screening completed upon admission. Record review of the social services record list, accessed 04/22/25, reflected Resident #38 had no trauma screening or trauma assessment completed since admission. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 04/21/25 beginning at 10:12 AM, Resident #38 was sitting up in the bed. Resident #38 had a military plaque on his walls. Resident #38 stated he was in the military, specifically the air force. Resident #38 stated it messed me up. Resident #38 started fidgeting, moving around in the bed, and conversation became confused related to cognitive status. During an interview on 04/23/25 beginning at 10:23 AM, the Social Services Director stated trauma screenings were completed upon admission. The Social Services Director stated the nursing staff were responsible for completing the trauma screening. The Social Services Director stated she completed a more comprehensive assessment if the screening was flagged positive. The Social Service Director stated she was unsure if a trauma assessment was completed for Resident #38. The Social Services Director looked in the medical record and stated she was unable to find the trauma screening. The Social Service Director stated she was unsure if a diagnosis of PTSD would trigger a positive trauma screening. The Social Services Director stated a trauma assessment should have been completed upon admission to the facility. The Social Services Director stated Resident #38 should have been assessed further for potential triggers. The Social Services Director stated it was important to make sure residents were assessed for a history of trauma to ensure appropriate care and services were provided to the residents. During an interview on 04/23/25 beginning at 11:42 AM, the DON stated trauma screenings were completed on admission for all residents. The DON stated the admitting nurse was responsible for completing the trauma screening. The DON stated she was only made aware this week that the trauma assessment was not completed for Resident #38. The DON stated a diagnosis of PTSD would trigger a positive trauma screening and a more comprehensive assessment should have been completed by the Social Services Director. The DON stated it was important to ensure trauma screening were completed upon admission so residents who had a history of trauma could be treated appropriately with provided services. During an interview on 04/23/25 beginning at 12:09 PM, the Administrator stated she was just made aware this week that a trauma screening or assessment were not completed for Resident #38. The Administrator stated she was unsure what the policy and procedures were for PTSD or trauma assessments. The Administrator stated it was important to ensure trauma was identified so staff could prevent residents from reliving traumatic experiences and to provide the appropriate care and services. Record review of the Trauma Informed Care policy, dated 12/19/19, reflected Resident will be screened for Trauma upon admission, annually and as needed using the Trauma Screening and Recommendation in EMR . residents identified with a history of trauma, based on trauma screening and recommendations, will have trauma informed observations completed .traumatic events and triggers identified through the screening will be used to develop care plan .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements. 1. The facility failed to ensure an opened box of powdered sugar was securely closed or stored in a secure container with a label and date. 2. The facility failed to ensure a plastic container with a lid, containing what appeared to be a red sauce in it, was labeled and dated. 3. The facility failed to ensure a plastic container with a lid, containing what appeared to be green beans, corn, and potatoes in it, was labeled and dated. 4. The facility failed to ensure a plastic bag containing an unknown meat with ice particles covering it was labeled and dated. 5. The facility failed to ensure a plastic bag containing what appeared to be chicken, with ice particles covering approximately half of it, was labeled, and dated. These failures could place residents at risk of foodborne illness and food contamination. Findings included: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During initial tour observations and interviews of the kitchen on [DATE] beginning at 9:20 AM and accompanied by the DM, there was a box of powdered sugar that had been opened in the dry goods pantry with the top of the box tabs closed,. tThe DM opened the box and the plastic bag on the inside of the box had a corner cut off and was not securely closed and it was not in a secured plastic zippered bag with label and date. The DM said the opened box of powdered sugar should have been placed in a plastic zipper bag and labeled and dated after it was opened. The DM went and got a plastic zipper bag and placed the opened box of powdered sugar in it. In the refrigerator, there was a clear plastic container with a lid containing what appeared to be a red sauce and there was no label or date on the container. There was also a clear plastic container with a lid containing what appeared to be green beans in the bottom, then yellow corn, and white cubes potatoes on top and there was no label or date on the container. DA G came over to the refrigerator and said the red sauce in the clear plastic container was ketchup and she had just put it in the refrigerator that morning and the other clear plastic container had mixed vegetables in it, but she did not know how long the mixed vegetables had been in the refrigerator. The DM came over and told DA G to toss both containers because they should have been labeled and dated. DA G told the DM she had just put the ketchup in the refrigerator that morning and would label and date it. The DM told DA G to toss the mixed vegetables because she did not know when they were put in the refrigerator. The DM said they should have been dated and labeled to show what was in the containers and when they were placed in the refrigerator. The DM was standing in front of the freezer, and she took a plastic bag of unknown meat, covered with ice particles, out and placed it on the counter and it was not labeled or dated. There was another plastic bag of frozen meat that appeared to be chicken with ice particles covering approximately half of it and it was not labeled or dated. The DM said everything should be labeled and dated. [NAME] F came over and said she had put the mixed vegetables in the clear plastic container and placed it in the refrigerator that morning prior to State Surveyor coming into the kitchen and the mixed vegetables were being served for lunch. [NAME] F said she should have labeled and dated the clear plastic container of vegetables when she placed it in the refrigerator. During an interview on [DATE] at 9:08 AM, [NAME] D said after opening a box of powder sugar, it should have been placed in a plastic bag and labeled, dated, and seal. [NAME] D said by placing the box in a plastic bag and sealing it, ensured nothing could get in it. [NAME] D said you should label and date anything before placing in the refrigerator or freezer. [NAME] D said it was important to label and date the food, so you could tell that it was not old or spoiled. [NAME] D said meat should be labeled and dated prior to placing it in the freezer. [NAME] D said the ice on the meat could mean it was freezer burnt. [NAME] D said she would not serve anything with ice covering it because it was not good. [NAME] D said the cook was responsible for ensuring food was labeled, dated, and stored properly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 9:16 AM, DA E said she had worked at the facility for about ten years. DA E said when they open a package of powdered sugar, they should make sure the package was folded down and closed then placed in a plastic bag to keep it fresh and keep anything from getting in it. DA E said staff should label and date a container placed in the refrigerator prior to placing it in the refrigerator. DA E said containers in the refrigerator should be labeled and dated, so they can know what was in the container, and if dated, they know how long it had been in the refrigerator and whether it was still good. DA E said everything should be labeled and dated in the freezer. DA E said if food was placed in a plastic bag and was not labeled or dated in the freezer, then staff would not know how long it had been in the freezer and if it had ice on it, it could be freezer burnt and it meant it was not properly sealed and it had been in there too long. DA E said she would discard it after letting her supervisor know. DA E said they were all responsible for ensuring food was labeled, dated, and stored properly, but DM was the one ultimately responsible. During an interview on [DATE] at 9:25 AM, the DM said the powdered sugar was not stored properly. The DM said the powdered sugar should have been in a plastic bag and labeled and dated, because it was open, and it was not properly sealed. The DM said it was a constant battle to get her staff to label and date and she checked behind them regularly. The DM said the plastic containers in the refrigerator should have been labeled and dated prior to the staff placing them in the refrigerator so everyone would know when it was placed in it and if it was still good. The DM said the items in the freezer should have been labeled and dated and if there was ice on it, the staff know not to use it. The DM said ice on the meat meant it was freezer burnt and should not be served. The DM said the plastic unlabeled or dated bag of unknown meat was a hamburger patty. The DM said they have seen pests, roaches, in the kitchen occasionally, and when they see any pests, they notify the pest control man, and he was there on Friday [DATE]. The DM said she was responsible for ensuring staff stored and labeled/dated the food appropriately. The DM said they have gone through everything in the kitchen, the refrigerator, and the freezers, and they looked good now. During an interview on [DATE] at 11:10 AM, the ADM said she would expect food in the kitchen to be labeled, dated, and stored per the facility's policies. The ADM said the purpose of labeling, dating, and storing food per the facility's policies was to ensure the freshness of the food and to ensure that it was not expired. Record review of the facility's policy titled Nutrition Services dated revised February 6, 2024, indicated . food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination . Storeroom . air-tight containers or bags were used for all opened packages of food . all containers are accurately labeled with the item and date opened . Refrigerator . all foods are covered, labeled and dated . Freezer . foods are covered, labeled and dated . any item out of the original case must be properly secured and labeled .

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	675561	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Plaza Nursing Center	600 W 52nd St Texarkana, TX 75501

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 47006 Based on observations, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 13 residents (Resident #12, #22, and #196) reviewed for infection control practices. 1. The facility failed to ensure signage was located outside Resident #196's room to indicate he required transmission-based droplet precautions. 2. The facility failed to ensure CNA C used transmission-based droplet precautions when entering Resident #196's room. 3. The facility failed to ensure CNA L changed her gloves and perform hand hygiene during Resident #12's indwelling foley catheter care. 4. The facility failed to ensure LVN A and CNA B followed the Enhanced Barrier Precautions (EBP) (interventions to prevent spread of infection in high-risk residents) policy of wearing a gown during Resident #22's wound care to right hip on 4/22/25. 5. The facility failed to ensure CNA B and CNA C followed the Enhanced Barrier Precautions (EBP) policy of wearing a gown during Resident #22's incontinent care on 4/22/25. These failures could place residents and staff at risk for cross contamination and the spread of infection. The findings included: 1. Record review of the face sheet, dated 04/22/25, reflected Resident #196 was a [AGE] year-old male who initially admitted to the facility on [DATE] with a diagnosis of post COVID-19 condition and COPD (progressive lung disease characterized by chronic respiratory symptoms and airflow limitation). Record review of the MDS assessment list, accessed 04/22/25, reflected the admission MDS had not been completed yet. Record review of the comprehensive care plan, initiated 04/10/25, reflected Resident #196 had a contagious or infectious disease. The interventions included: isolation as ordered. Record review of the treatment order, accessed 04/22/25, reflected Resident #196 had an order, which started on 04/10/25 for isolation: droplet/respiratory x 21 days for diagnosis of post COVID-19 condition and positive test on 03/31/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 04/21/25 beginning at 10:38 AM, Resident #196's door was open. There was no signage or PPE supply cart located outside room. There was a PPE supply cart across the hallway that had shoe covers, barrier cream, and biohazard bags in it. Resident #196 was sitting up in his chair with a mechanical lift pad underneath him. Resident #196 stated he had been on quarantine for a couple of weeks because he had COVID-19 in the hospital. Resident #196 stated today was supposed to have been his last day on quarantine. Resident #196 stated staff had not been wearing PPE when coming into his room. During an interview and observation on 04/21/25 beginning at 10:45 AM, CNA J stated she was responsible for the residents on 400 halls. CNA J stated she was unsure if Resident #196 required transmission-based droplet precautions. CNA J walked away to ask the nurse. CNA J returned to the surveyor and stated the charge nurse informed her Resident #196 was on transmission-based droplet isolation precautions. CNA J stated she did not ask the nurse why he was on transmission-based droplet precautions. CNA J stated she had not worn PPE in his room because she was not aware he required transmission-based droplet precautions. CNA C entered Resident #196's room during the interview with no PPE supplies on. During an observation and interview on 04/21/25 beginning at 10:47 AM, CNA C walked out of Resident #196's room and went into the clean linen closet. CNA C walked out of the clean linen closet with a blanket. CNA C stated she was getting Resident #196 a blanket because he asked for one. CNA C stated she believed Resident #196 was on transmission-based droplet precautions but was unsure why. CNA C stated she was not assigned to Resident #196's hallway. CNA C stated she should have worn PPE inside the room if he was on quarantine. CNA C stated it was important to ensure PPE was worn inside the room for someone on isolation precautions to prevent the spread of infection. During an interview on 04/21/25 beginning at 10:49 AM, LVN K stated Resident #196 was on transmission-based droplet precautions [isolation precautions related to an infectious disease, in which PPE should be worn] related to a COVID-19 diagnosis. LVN K stated there should have been signage located on the door to alert staff and visitors that PPE was required. LVN K stated the PPE worn should have included a mask. LVN K stated a mask should have been worn by anyone entering Resident #196's room. LVN K stated it was important to ensure signage was on the door to alert staff and visitor PPE was required, PPE was located outside the room, and staff wore the appropriate PPE to prevent the spread of infection. During an observation on 04/21/25 beginning at 10:51 AM, the ADON placed an isolation precaution sign outside Resident #196's room. The ADON moved the PPE supply cart in front of Resident #196's room and stocked it with gowns, masks, and gloves. During an interview on 04/23/25 beginning at 11:42 AM, the DON stated signage to alert staff or visitor that Resident #196 was on transmission-based droplet precautions should have been visible on his door. The DON stated all staff and visitors should have worn the appropriate PPE supplies when they entered Resident #196's room. The DON stated all the staff know the polices for infection control and were responsible for following them. The DON stated it was important to ensure signage was placed on the door and PPE was worn for residents with transmission-based precautions to reduce the spread of infection. The DON stated if there was no signage on the door, the facility staff should have reported it and placed a sign on the door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/23/25 beginning at 12:09 PM, the Administrator stated she expected the facility staff to ensure appropriate signage and PPE supplies were available for residents who required transmission-based droplet precautions. The Administrator stated nursing staff were responsible for ensure the infection control policies and procedures were followed. The Administrator stated it was important to ensure signage was placed on the door and PPE was worn for residents with transmission-based precautions to reduce the spread of infection. 2. Record review of the face sheet, dated 04/23/25, reflected Resident #12 was a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses of unspecified dementia with behaviors (memory loss) and chronic kidney disease (gradual loss of kidney function). Record review of the quarterly MDS assessment, dated 01/30/2025, reflected Resident #12 had clear speech and was sometimes understood by staff. The MDS reflected Resident #12 was rarely/never able to understand others. The MDS reflected Resident #12 had a BIMS score of 0, which indicated severe cognitive impairment. The MDS reflected Resident #12 had inattention and disorganized thinking that was continuously present and did not fluctuate. The MDS reflected Resident #12 exhibited refusal of care behaviors 1 to 3 days during the 7 day look-back period. The MDS reflected Resident #12 was totally dependent upon staff for assistance with toileting and had an indwelling catheter. Record review of the comprehensive care plan, dated 11/14/24, reflected Resident #12 had a urinary catheter. Record review of the treatment order, which started on 01/04/25, reflected Resident #12 had an order for a foley catheter. During an observation on 04/22/25 beginning at 4:13 PM, CNA L and CNA C entered Resident #12's room to perform foley catheter care. CNA L did not change her gloves or perform hand hygiene after wiping Resident #12's buttocks. CNA L placed the clean linens under Resident #12, pulled Resident #12's pants up, and re-placed her covers with the same gloves. During an interview on 04/22/25 beginning at 4:38 PM, CNA L stated her gloves should have been changed and hand hygiene performed when moving from dirty areas to clean areas. CNA L was unsure if she should have changed her gloves and performed hand hygiene after cleaning Resident #12's buttocks. CNA L stated she did not normally work at the facility, but she was picking up extra shifts. CNA L stated CNA C did not want to perform the foley catheter care because she was nervous. CNA L stated it was important to ensure gloves were changed and hand hygiene was performed to prevent infection. During an interview on 04/23/25 beginning at 9:57 AM, CNA C stated gloves should have been changed and hand hygiene performed when going from a dirty area to a clean area. CNA C stated she noticed CNA L did not change her gloves or perform hand hygiene when she performed catheter care but was unsure if she was supposed to tell her. CNA C stated not changing gloves or performing hand hygiene could have caused contamination of bacteria. During an interview on 04/23/25 beginning at 11:27 AM, LVN K stated she expected the CNAs to perform proper catheter care. LVN K stated gloves should have been changed and hand hygiene performed when moving from a dirty to clean area. LVN K stated it was important to ensure gloves were changed and hand hygiene was performed to prevent contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/23/25 beginning at 11:42 AM, the DON stated she expected the CNAs to follow the policy and procedure for peri-care whether a resident has a catheter or not. The DON stated she expected gloves to be changed and hand hygiene performed when going from a dirty to a clean area. The DON stated the CNAs were responsible for monitoring to ensure catheter care was performed properly. The DON stated skills checkoffs were completed during orientation and annually. The DON stated it was important to ensure gloves were changed and hand hygiene was performed to prevent infection or being gross. During an interview on 04/23/25 beginning at 12:09 PM, the Administrator stated she expected facility staff to ensure proper catheter care was performed. The Administrator stated nursing management was responsible for monitoring to ensure proper catheter care was completed. The Administrator stated it was important to ensure proper catheter care was performed to prevent potential infections. 3. Record review of Resident #22's face sheet dated 4/22/25 revealed she was [AGE] years old and admitted to the facility on [DATE] and readmitted on [DATE]. Resident #22 had diagnoses including dementia (forgetfulness), cerebral infarction (stroke-lack of oxygen to the brain resulting in brain tissue death), weakness, and skin changes. Record review of Resident #22's annual MDS assessment dated [DATE] indicated she was sometimes understood and sometimes understood others. Resident #22 scored 0 on her BIMS, which indicated she had severe cognitive impairment. Resident #22 was dependent on staff for toileting and moderate assistance for most ADLs. The MDS indicated Resident #22 was always incontinent of bowel and bladder. Record review of Resident #22's Care Plan dated 4/22/25 indicated she had self-care deficit, skin breakdown, at risk for/actual, and infection control as evidenced by Enhanced Barrier Precautions with interventions for gown and glove use during high-contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, wound care, and any skin opening requiring a dressing. Record review of Resident #22's Orders dated 4/23/25 revealed an order for Enhanced Barrier Precautions (EBP) every AM shift (6 AM-2 PM) with a reason of wound, with a start date of 3/19/25. During an observation on 4/22/25 at 2:16 PM, LVN A performed wound care to Resident #22's right hip and was assisted by CNA B. Resident #22 had a blue name tag outside of her room door. CNA B sanitized hands and put on gloves, raised the bed, allowing the front of her clothing to touch Resident #22's bedding. CNA B then leaned over Resident #22 and pulled the blankets down to the end of the bed and assisted LVN A to pull the back of Resident #22's pants down allowing her clothing to touch Resident 22's bedding. CNA B then softly said, we forgot something, but did not say what they forgot. LVN A removed the old dressing from Resident #22's right hip, performed hand hygiene using hand sanitizer, changed gloves, then cleansed the wound with wound cleanser and gauze, then applied calcium alginate (used to heal wounds) on the wound, then covered the wound with the adhesive dressing. Then LVN A applied barrier cream (used to protective the skin from moisture) on Resident #22's bottom and then removed gloves and said Resident #22 had a bowel movement. CNA B then reached under resident to pull the draw pad out from under the resident, repositioned Resident #22 in bed by putting her arm under Resident 22's shoulders with her right arm and pulling her more upright in bed, allowing the front of her clothing to come in contact with Resident 22's clothing and bedding. CNA B said she would gather supplies and come back to provide incontinent care for Resident #22. CNA B and LVN A did not wear a gown as part of EBP while providing wound care to Resident #22. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/22/25 at 2:37 PM, CNA B performed incontinent care on Resident #22, assisted by CNA C. CNA C allowed Resident #22 to hold her hands during the care. CNA B pulled down Resident #22's bedding to the foot of bed and pulled down Resident #22's pants. CNA B then folded the soiled brief to contain the bowel movement away from the resident, then cleansed the rest of the bowel movement from Resident 22's bottom using cleansing wipes and pulled the soiled brief from under resident then cleansed her bottom again with cleansing wipes placing soiled items in a trash bag. CNA B then removed her gloves, sanitized her hands, and put on clean gloves. CNA B then reached over the top of the resident and reached under Resident #22 on the opposite side and pulled the clean brief from under Resident 22. CNA C assisted to turn Resident #22 leaning over resident and allowed the front of her clothing to come in contact with Resident #22's clothing and bedding. CNA B and CNA C did not wear a gown as part of EBP while performing Resident #22's incontinent care. During an interview on 4/22/25 at 2:52 PM, CNA B said she had worked at the facility for two days. CNA B said the blue name tags outside the residents' doors indicated they were on EBP. CNA B said if a resident was on EBP it meant you had to wear a gown and gloves to protect the resident from getting anything from the staff. CNA B said she knew they were in trouble when they provided wound care to Resident #22 and did not wear gowns. CNA B said not wearing gowns during wound care placed the resident at risk of catching any kind of germ or infection from the staff. CNA B said they should have been wearing gown and gloves during the wound care and incontinent care to protect Resident #22 from infections. CNA B said she had received training on EBP. During an interview on 4/22/25 at 2:56 PM, LVN A said she had worked at the facility for four months. LVN A said she did not remember what the blue name tags outside the resident's door was for. State Surveyor asked if the blue name tags had to do with EBP and LVN A said yes. LVN A said if a resident was on EBP, it meant to keep the resident turned and make sure their skin was good. State Surveyor asked what type of residents were on EBP, and LVN A said residents with wounds or urinary catheters were on EBP. LVN A said she did not know Resident #22 had a blue name tag and she then walked to Resident 22's door and verified there was a blue name tag and then said she should have worn a gown and gloves during the wound care to prevent the spread of infections. LVN A said not wearing gown and gloves while performing wound care placed the resident at risk for infections. LVN A said she had received training on EBP. During an interview on 4/22/25 at 3:02 PM, CNA C said she had worked at the facility for three days. CNA C said the blue name door tags meant staff had to wear a gown and gloves during personal care as precautions for residents with wounds or catheters. CNA C said staff should wear a gown and gloves to protect the resident from anything the staff may have on them. CNA C said when she went in to answer Resident #22's call light, when CNA B pushed the call light to get help, she (CNA C) didn't know she was going to be providing direct resident care and did not bring a gown. CNA C said they both should have been wearing gowns and gloves during the incontinent care to protect the resident from infections. CNA C said she had received training on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/25 at 10:52 AM, the DON said the staff knew residents were on EBP by the blue name tags by the door. The DON said residents with open wounds, urinary catheters, feeding tubes, or any implanted device in the body would be on EBP. The DON said Resident #22 was on EBP because she had wounds. The DON said gowns and gloves should be worn when providing care for residents on EBP. The DON said when staff were performing wound care and/or incontinent care they should be wearing a gown and gloves during care. The DON said the purpose of the EBP was to protect the resident from anything staff could bring into them. The DON said when staff did not follow the EBP policy of wearing a gown during care, it placed the resident at risk of infection. The DON said all staff were responsible for ensuring EBP was being followed and if she saw staff were not following the EBP policy, then she would definitely in-service the staff. The DON said they provided training on infection control and EBP policies upon hire and annually. During an interview on 4/23/25 at 11:10 AM, the ADM said the residents who were on EBP had a blue name tag on the door. The ADM said residents with wounds, urinary catheters, or any device inserted into the body would require the resident to be on EBP. The ADM said she would expect the staff to be following the EBP policy. The ADM said if staff did not follow the EBP policy it could place the resident at risk of contamination and/or infection. Record review of the Isolation Precautions policy, dated August 2018, reflected droplet precautions: intended to reduce the risk of respirator droplet transmission of infectious agents .enhanced barrier precautions: used when the resident does not require transmission-based precautions but has a higher risk of known colonization with MDROs .modified isolation precautions necessitates use of N95/KN95, face shield or goggles, gown, and gloves when entering the room .droplet precautions necessitates the use of a surgical/procedural mask and eye protections when entering the room .modified isolation precautions were used for the following situation: COVID-19 .place disease specific isolation sign on door .all personnel entering the room must wear isolation gown, gloves, N95/Kn95 mask, and eye protections such as goggles or face shield . Record review of the Urinary Catheter Infection Prevention policy, dated 08/2018, reflected hand hygiene is essential and the single most effect way to prevent the spread of infection .