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	06/02/2026

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain physician orders for the resident's immediate care for 2 (Resident #45 and Resident #46) of 5 residents reviewed for admission physician orders. 1.The facility failed to obtain physician orders for the immediate care of Resident #45's surgical wounds, diet, and isolation status. 2.The facility failed to obtain physician orders for the immediate care of Resident #46's surgical wound, pressure wounds, diet, and isolation status. These failures could affect residents who were admitted or readmitted to the facility by placing them at risk for not receiving the appropriate care, medication, and treatment services.Findings included: 1.Record review of an undated face sheet revealed Resident #45 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of End Stage Renal Disease (Stage 5 chronic kidney disease, occurs when the kidneys lose 85% to 90% of their function, meaning they can no longer filter waste and fluids), Diabetes type II (a chronic metabolic condition where the body resists insulin or cannot produce enough of it), heart failure (heart muscle doesn't pump blood as well as it should to meet your body's needs), and recent amputation (surgical removal) of toes 3, 4, and 5 on the left foot. Record reviews of the electronic health record on 05/31/2026 revealed Resident #45 admitted on [DATE] at 10:17 a.m. The EHR revealed no admission assessment, no pain assessment, no skin assessment was completed on admission for Resident #45. Resident #45 had no orders for wound care for his surgical wound from 05/28/2026 until 06/01/2026. He had no orders for contact isolation for suspected shingles from 05/28/2026 until 05/31/2026. He had no diet order from 05/28/2026 until 05/29/2026. Record review of the MD orders for Resident #45 revealed the following:05/29/2026- Liberal Renal Diet.05/29/2026- Atorvastatin 40mg each night05/29/2026- calcitriol 0.25 mg three times a week05/29/2026- furosemide 80mg twice daily05/29/2026- midodrine 5mg twice daily05/29/2026- sertraline 25mg daily05/29/2026- sevelamer carbohydrate 800mg three times a day with food05/29/2026- valacyclovir 500mg daily.05/31/2026-Enhanced Barrier Precaution (EBP) every shift for wounds and dialysis.05/31/2026-Isolation Contact every shift for suspected shingles each shift.06/01/2026-Monitor area to 4th digit on Right foot on day shift. Cleanse with normal saline or wound cleanser, pat dry and leave open to air once daily.06/01/2026- Monitor area to top of 4th digit on left foot on day shift. Cleanse with normal saline or wound cleanser, pat dry and leave open to air once daily. Record review Resident #45's discharge orders from the hospital dated 05/28/2026 included orders for atorvastatin, calcitriol, furosemide, Humalog, Lantus, midodrine, sertraline, sevelamer carbonate, and valacyclovir. Record review of Resident #45's MAR/TAR for May 2026 indicated Resident #45 did not receive any medications on 05/28/2026 and no treatment to his surgical wound until 05/31/2026. During an interview on 05/31/2026 at 10:30 a.m., Resident #45 stated that he had concerns because for the first day and a half of him being in the facility, he got no medications and no treatments to his surgical wound. He stated when he asked the nurses about the medications they told him no medications had arrived for him from the pharmacy. He stated he was giving them until the Director came in on Monday morning to figure something out or he was going to leave. Resident #45 stated no one wore gowns or masks when assisting him with care. He said the CNA wore gloves when she emptied his urinal. He stated he knew he had shingles in the hospital but (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Heritage Plaza Nursing Center	600 W 52nd St Texarkana, TX 75501

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	thought maybe it was resolved since no one was wearing the protective gear. 2. Record review of an undated face sheet revealed Resident #46 was a [AGE] year-old female that admitted on [DATE] with the diagnoses of End Stage Renal Disease (Stage 5 chronic kidney disease, occurs when the kidneys lose 85% to 90% of their function, meaning they can no longer filter waste and fluids), Diabetes type II (a chronic metabolic condition where the body resists insulin or cannot produce enough of it), heart failure (heart muscle doesn't pump blood as well as it should to meet your body's needs), and recent amputation (surgical removal) of 2nd digit on right foot. Record reviews of the electronic health record on 05/31/2026 revealed Resident #46 admitted on [DATE] at 3:17 p.m. The EHR revealed no admission assessment, no pain assessment, no skin assessment was completed on admission for Resident #46. Resident #46 had no orders for wound care for her surgical wound or her pressure wounds from 05/29/2026 until 05/31/2026. She had no orders for EBP from 05/29/2026 until 05/31/2026. She had no diet order from 05/28/2026 until 05/29/2026. Record review of the MD orders for May 2026 for Resident #46 revealed the following:05/30/2026-Amlodipine Besylate 5mg one time daily05/30/2026 Atorvastatin 20mg at bedtime05/31/2026- Renal Liberal Diet05/31/2026-Blood Glucose check twice daily05/30/2026-Amlodipine Besylate 5mg one time daily05/30/2026 Atorvastatin 20mg at bedtime05/31/2026-Carbamazepine 200mg twice daily05/31/2026-Levothyroxine 75mcg once daily05/31/2026-Metoprolol Succinate 50mg twice daily05/31/2026-Vitamin B Complex one time daily05/31/2026-Folic Acid 0.4 mg once daily05/31/2026-Vitamin C 500mg once daily05/31/2026-Restora once daily05/31/2026-Doxycyline 50mg twice daily for 14 days05/31/2026-Eliquis 2.5mg twice daily05/31/2026- Enhanced barrier precautions r/t vascular access05/31/2026-Cleanse distal wound on right buttocks on day shift05/31/2026-Cleanse proximal wound on right buttock on day shift05/31/2026-Cleanse surgical site to right 2nd digit amputation on foot. Record review Resident #46's discharge orders from the hospital dated 05/29/2026 included orders for Amlodipine Besylate, Atorvastatin, Carbamazepine, Levothyroxine, Metoprolol Succinate, Vitamin B Complex, Folic Acid, Vitamin C, Restora, Doxycyline, and Eliquis. Record review of Resident #46's MAR/TAR for May 2026 indicated Resident #46 did not receive any medications on 05/29/2026 and no treatment to her surgical wound and pressure wounds until 05/31/2026. During an interview on 06/01/2026 at 10:45 a.m., LVN A stated it was the responsibility of the admitting nurse to ensure that all admission orders were entered and clarified by the physician. She stated it was the responsibility of the admitting nurse administer the first dose of medications due on their shift, to do the admission assessment, start the baseline care plan, and do as many of the assessments like pain and skin, as possible. What was not done on the admitting shift is to be done on the next shift. She stated not following these time guidelines can cause the newly admitted residents to miss doses of medication and treatments needed to prevent decline in skin integrity. During an interview on 06/02/2026 at 11:00 a.m., the DON stated the admission process for new residents was that the admitting nurse completes the admission assessment, enter all MD orders from the hospital discharge information, start the baseline care plan, clarify all orders with the physician and administer the initial dose of medications ordered on their shift. The DON stated it was the expectation that documentation would include vital signs, a full body assessment to include pain and skin issues that need to be addressed. She stated she was aware she had a nurse that failed to handle the admissions of Resident #45 and Resident #46 appropriately by not entering medications into the EHR, not completing the admission assessment that includes a skin assessment, not completing a pain assessment, not ensuring the residents had diet orders and isolation orders. She stated the oncoming shift failed to follow up and ensured the residents had orders and assessments completed. The DON stated not ensuring initial MD orders are in the EHR for all residents and not ensuring their assessments are completed can cause delay in care for the residents. She stated the department head nurses always check the orders and assessments for completion and accuracy on the first business day after the resident admits. During an interview on 06/02/2026 at 12:15 p.m., the Administrator stated it was the responsibility of the admitting nurse to ensure that the resident had (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	all orders in the HER and that the pharmacy was aware of the orders and was sending the medication. She stated it was the admitting nurse's responsibility to complete the admission assessment and notify the MD of the arrival of the resident and clarify any orders needed after assessing the resident. She stated she was unaware this process was not being followed. She stated it was the responsibility of the DON and administrative nurses to ensure the residents have all the orders they need and all assessments are completed correctly. She stated the failure to do so could lead to the residents feeling ignored and unimportant. An undated policy titled ?Admitting a Resident' indicated the following: .6. Assist resident into bed. Observe carefully for any open or draining areas, dressings, rashes, bruises or reddened areas and report these to the charge nurse.7. The licensed nurse interviews resident/family member and initiates the admission Nursing data Collection.The drug regimen review is to be completed.12. The licensed nurse notifies the attending physician of his/her arrival and orders.13. Complete and record resident's height, weight, temperature, blood pressure, pulse and respirations on the admission Nursing Assessment and other daily documentation per policy. This should be entered into the Vital sign module of EHR so the data will flow to the admission data collection21. Document activities in the Resident medical record as they are triggered in the data collection/admissions tab.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and records reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 (Resident #2, #5, #29, and #6) of 12 residents reviewed for care plans.1. The facility failed to develop a care plan for Resident #2's use of Eliquis (an anticoagulant medication that thins the blood and places the resident at an increased risk of bleeding and bruising more easily).2. The facility failed to update Resident #5's care plan to include he often refused to take his insulin or full dosage of insulin as prescribed by his physician.3. The facility failed to develop a care plan for Resident #29's use of Paroxetine (antidepressant medication used to treat depression (persistent sadness)), Lorazepam (antianxiety medication used to treat anxiety (feelings of worry)), Clopidogrel (antiplatelet medication that stops platelet cells from sticking together in the blood and could thin the blood and place the resident at an increased risk of bleeding and bruising), and the use of Nitrofurantoin (antibiotic used to treat and prevent urinary tract infections).4.The facility failed to develop a care plan for Resident #6's hospice status.These failures could place residents at risk of not having their individualized needs met and a decline in their quality of care and life. Findings included: 1. Record review of Resident #2's face sheet dated 6/01/26 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #2 had diagnoses including Parkinson's (disease that causes movement problems), fracture of left femur (upper leg), dementia (decline in cognitive abilities such as memory, reasoning, language, and behaviors that interfere with ADLs), atrial flutter (abnormal heart rhythm where the upper portion of the heart beats too quickly), and hypertension (high blood pressure). Record review of Resident #2's annual MDS assessment dated [DATE] indicated he was sometimes understood and sometimes understood others. The MDS indicated he had a BIMS score of 11, which indicated he had moderate cognitive impairment. The MDS indicated Resident #2 had fluctuating inattention and disorganized thinking. The MDS indicated Resident #2 had physical and verbal behavioral symptoms. The MDS indicated Resident #2 was dependent on staff assistance for most ADLs. The MDS indicated Resident #2 had a history of falls. The MDS indicated Resident #2 was taking an anticoagulant. Record review of Resident #2's Physician Orders dated 6/01/26-6/30/26 revealed an order for Eliquis 5 mg tablet one tablet by mouth twice a day for surgical incision with a start date of 5/13/26. Record review of Resident #2's care plan dated 6/01/26 did not show a care plan for his use of an anticoagulant, Eliquis. During an observation and interview on 5/31/26 at 11:14, Resident #2 was observed to have multiple bruises to his upper and lower right arm. Resident #2 said he fell and busted his hip and was getting therapy and it was going very well. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #5's face sheet dated 6/02/26 indicated he was [AGE] years old and admitted to the facility on [DATE] initially and readmitted [DATE]. Resident #5 had diagnoses including Diabetes mellitus and Schizoaffective disorder, bipolar type (mental health disorder that combined symptoms such as hallucinations {sensory experiences that appear real but created by the mind}), delusions (belief something was real with clear evidence that it was not), with a major mood disorder such as depression or bipolar disorder (causes extreme shifts in mood, energy, and activity levels)). Record review of Resident #5's quarterly MDS assessment dated [DATE] indicated he had a BIMS score of 15, which indicated he was cognitively intact. The MDS did not indicate Resident #5 had behavioral symptoms or refused care. The MDS indicated he took insulin injections daily. Record review of Resident #5's care plan dated 6/01/26 indicated he had potential for hyperglycemic (high blood sugar)/hypoglycemic (low blood sugar) episodes secondary to diabetes. Resident #5 used insulin. The care plan interventions included administering medications as ordered and monitoring for adverse side effects and insulin injections as ordered by physician. The care plan did not indicate Resident #5 refused to take insulin or refused to take the full dose of insulin as ordered by the physician. Record review of Resident #5's Active Orders Report dated 6/02/26 revealed an order for Lantus (long-acting insulin used to treat diabetes) 30 units injected twice daily, nurse may administer less than prescribed dosage per resident preference with a start date of 6/02/26. There was an order for Novolin R (fast-acting regular insulin used to treat diabetes) per sliding scale before meals and at bedtime with a start date of 11/17/25. Sliding Scale as follows: BS 0-60= call physician BS 0-149= 0 units of insulin BS 150-199= 3 units of insulin BS 200-249= 6 units of insulin BS 250-299= 9 units of insulin BS 300-349= 12 units of insulin BS 350 or greater = 15 units of insulin BS over 400, administer insulin per sliding scale and recheck BS in an hour, if still over 400 then call physician. Record review of Resident #5's Medication Record dated 5/04/26-6/02/26 revealed he did not take his sliding scale Novolin R insulin as ordered for his 7:00 AM dose 9 times, 11:30 AM dose 12 times, 4:30 PM dose 14 times, and 9:00 PM dose 11 times. Resident #5's Medication Record revealed he did not take his Lantus 30 units twice daily as ordered for his 7:00 AM dose 12 times and his 4:30 PM dose 10 times, with only taking a reduced dose or none at all. Record review of Resident #5's Interdisciplinary Progress Notes dated 5/01/26-5/31/26 revealed he (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refused his insulin on multiple occasions and had said he was afraid he would bottom out. During an observation and interview on 6/01/26 at 11:15 AM, Resident #5 had a BS of 311. The nurse attempted to administer the ordered 12 units of insulin and Resident #5 stated he would take 6 units, but he was not taking 12 units. LVN A administered 6 units of regular insulin to Resident #5. LVN A stated Resident #5 always refused the ordered amount of insulin and dictated how many units he would take. LVN A stated his blood sugar was never in the normal range when she checked it. She stated it was always higher than normal. 3. Record review of Resident #29's face sheet dated 6/01/26 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #29 had diagnoses including Malignant neoplasm of left kidney (abnormal growth of cancerous cells in the kidney), history of urinary tract infection, kidney stones, malignant pleural effusion (abnormal buildup of fluid containing cancerous cells in the space between the lungs and the chest wall), cardiomegaly (enlarged heart), depression (persistent sadness), and altered mental status. Record review of Resident #29's quarterly MDS assessment dated [DATE] indicated she had a BIMS score of 15, which indicated she was cognitively intact. The MDS indicated Resident #29 was taking antianxiety, antidepressant, antibiotic, and an antiplatelet. Resident #29 was receiving hospice services (end of life care). Record review of Resident #29's Physician Orders dated 6/01/26-6/30/26 revealed the following orders: Paroxetine 10 mg one tablet by mouth at bedtime for depression with a start date of 3/09/26. Lorazepam 1 mg 1 tablet by mouth twice a day for anxiety/agitation with a start date of 8/29/25. Nitrofurantoin 100 mg by mouth at bedtime for diagnostic with a start date of 8/01/25. Clopidogrel 75 mg 1 tablet by mouth at bedtime for diagnostic with a start date of 8/01/25. Record review of Resident #29's care plan dated 6/01/26 revealed there were no care plans developed for her use of antianxiety, antidepressant, antibiotic, and antiplatelet medications. 4. Record review of an undated face sheet revealed Resident #6 was a [AGE] year-old male admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (chronic lung disease), acute and chronic respiratory failure (acute failure develops suddenly as an emergency, chronic failure builds gradually over time), and diabetes. Record review of Physician's Orders dated 06/01/26 for Resident #6 indicated an order to admit to hospice with a start date of 04/03/26. Record review of a significant change MDS assessment dated [DATE] revealed Resident #6 had a BIMS score of 13 which indicated no cognitive impairment. The MDS indicated Resident #6 received hospice care while he was a resident in the facility. Record review of the care plan revised on 05/11/26 revealed Resident #6 was not care planned for hospice services. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/02/2026 at 11:40 a.m., the MDS Coordinator stated the care plans should include all items that were coded on the MDS. She stated the care plan should be reviewed by the nursing staff to know the individual care instructions for each resident. The MDS Coordinator stated items such as falls, high risk medication usage, hospice services, and diagnoses should be care planned for resident safety. She stated not care planning an important item with the interventions could result in the staff not knowing what is needed for the management of the individual resident condition. She stated Resident #2's anticoagulant medication, Resident #5's refusal of insulin, Resident #29's psych medications, and Resident #6's hospice status should have all been care planned. During an interview on 06/02/2026 at 1:00 p.m., the DON stated it was the responsibility of the MDS nurse to create the comprehensive care plan and all nurses' responsibility to ensure that acute changes be updated on the care plan. She stated all major diagnoses, conditions, medications, and falls should be care planned with interventions to alert the staff of the potential of these situations recurring and to give instructions on what to do in those cases. The DON stated she did not feel care planning had a negative impact on the residents. During an interview on 06/02/2026 at 1:30 p.m., the Administrator stated she expected the MDS nurse and administrative nurses to ensure the care plans were complete and accurate for each individual. She stated care plans were meant to be a blueprint to individual resident care and were important to individualized care. Record review of the Care Plans, Comprehensive Person-Centered policy, dated April 2021, reflected A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.the comprehensive, person-centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment;.and which professional services are responsible for each element of care; includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions.the interdisciplinary team reviews and updates the care plan. at least quarterly.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the state mental health authority promptly after a significant change in their mental condition for 1 of 5 residents screened for PASRR (Resident # 37). The facility failed to refer a resident with a newly identified serious mental illness for a PASRR Resident Review following a significant change in status. Resident #37 received a new diagnosis of bipolar disorder on 07/24/2025; however, the facility did not complete a PASRR Level II Resident Review referral (form 1012) until 01/26/2026. This failure could delay the identification of specialized services and support needed to address the residents' mental health needs.Findings included: Record review of an undated face sheet revealed Resident #37 was a [AGE] year-old, female and admitted on [DATE] with diagnoses cerebral infarction (a critical medical emergency that occurs when blood flow to a specific area of the brain is blocked or significantly reduced, preventing brain tissue from receiving essential oxygen and nutrients), seizure disorder (a neurological condition diagnosed when a person experiences two or more unprovoked seizures), and bipolar disorder (a chronic mental health condition characterized by severe shifts in mood, energy, and activity levels). Record review of an annual MDS assessment dated [DATE] indicated Resident #37 had a BIMS score of 15, which indicated no cognitive impairment. Resident #37 was coded as not considered by the state level II PASRR process to have a serious mental illness. Resident #32 required supervision/ set up assistance with for ADLs. Resident #37 had depression, PTSD, and bipolar disorder. Record review of a care plan dated 03/17/2026 indicated Resident #37 had bipolar disorder with potential for mood swings. Record review of Resident #37's PASRR level I screening dated 04/08/2025, completed by the RN case manager at a local hospital, indicated .mental illness .is there evidence or an indicator this is an individual that has a mental illness .No . Record review of Resident #37's physician progress notes dated 07/24/2025 indicated to add the diagnosis of bipolar disorder to Resident #37's health record. Record review of Resident #37's Form 1012 dated 01/26/2026 indicated Resident #37 had a diagnosis of bipolar disorder added to her health record on 07/24/2025. During an interview with the MDS Coordinator on 06/01/2026 at 2:15 p.m., she stated she had not immediately done the Form 1012 to inform PASRR services of the change in Resident #37's diagnosis because she was not aware of the addition to her diagnosis until she prepared to do her MDS in January of 2026. She stated most of the time the IDT discusses new diagnosis in the morning clinical meetings, but she must have been absent because she did not recall the new diagnosis of bipolar disorder for Resident #37 being added. She stated the PASRR reviewers should have been notified within 30 days of the added diagnosis. The MDS Coordinator stated not having Resident #37 screened could have resulted in missed specialized services and support she may have needed for her mental health. During an interview on 06/02/2026 at 11:00 a.m., the DON said she felt like it was discussed in the clinical meeting when the NP wrote the diagnosis of bipolar disorder for Resident #37 and she was unaware the PASRR reviewers were not notified of the change in her diagnosis. She stated it was the responsibility of the MDS nurse to notify PASRR and that not doing so could have prevented Resident #37 from receiving benefits that she may have benefitted from related to mental illness. During an interview on 06/02/2026 at 12:15 p.m., the Administrator stated it was discussed in the clinical meeting when Resident #37 had documentation of having bipolar disorder. She stated the MDS Coordinator should have informed the PASRR reviewers of the change so that appropriate action could be taken to ensure Resident #37 received all the benefits of the PASRR program. PASRR policy was requested on 06/02/2026 at 12:45 p.m. by the Administrator. No policy was received related to PASRR.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the baseline care plan that included the instructions for resident care needed to provide effective and person-centered care was completed and provided to the resident and/or their representative for 1 of 2 residents reviewed for new admissions (Resident #45) The facility did not complete a baseline care plan or have a baseline care plan meeting with Resident #45 within 48 hours of admission. This failure could place residents at risk of not receiving care and services to meet their needs.Findings included: Record review of an undated face sheet revealed Resident #45 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of End Stage Renal Disease (Stage 5 chronic kidney disease, occurs when the kidneys lose 85% to 90% of their function, meaning they can no longer filter waste and fluids), Diabetes type II (a chronic metabolic condition where the body resists insulin or cannot produce enough of it), heart failure (heart muscle doesn't pump blood as well as it should to meet your body's needs), and recent amputation (surgical removal) of toes 3, 4, and 5 on the left foot. Record reviews of the electronic health record on 05/31/2026 revealed no admission assessment, no MDS, no baseline care plan, and no comprehensive care plan were completed for Resident #45. During an interview on 05/31/2026 at 10:30 a.m., Resident #45 stated everyone was very nice at the facility, but he really just wanted to know what was going on with his care. He stated he was unsure what medications he was taking, was unsure who would do his wound care, when his MD appointments were, and when he was supposed to be evaluated by therapy. He stated no one had a meeting with him since he arrived on 05/28/2026 and he was unaware of what a baseline care plan was. During an interview on 06/02/2024 at 1:13 p.m., LVN A stated the charge nurse that admitted the new resident was responsible for starting the baseline care plan the day of admission and the social worker and administrative nurses were responsible for completing the baseline care plan. She did not know the baseline care plan needed to be completed within 48 hours. She stated the baseline care plan was important because it gave the residents a sense of ease knowing what the plan for their care was during their stay. During an interview on 06/02/2026 at 2:00 p.m., the DON said baseline care plans are used in place of a comprehensive care plan until one can be developed to direct resident care according to their goals and choices. The DON said the baseline care plan needed to be completed with each department and discussed with the resident and resident representative. The DON stated she was unaware of any negative effects that not having a baseline care plan could have on the residents. During an interview on 06/02/2024 at 2:15 p.m., the Administrator said the baseline care plans were an interdisciplinary form that was discussed with the residents on admit. The Administrator said it was the DON's responsibility to ensure the floor nurses completed the baseline care plan and provided a copy to the residents and family. Review of the undated facility policy titled Base Line Care Plan revealed .Completion and implementation of the baseline care plan within 48 hours of a resident's admission {was} intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and ensure the resident and representative, if applicable, are informed of the initial plan of delivery of care and services by receiving a written summary of the baseline care plan.

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	675561	A. Building B. Wing	06/02/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure dialysis services were provided consistently with professional standards of practice for 1 of 3 resident reviewed for dialysis services. (Residents #7)The facility failed to document Resident #7's Post (after) Dialysis assessment on his Dialysis Communication (Pre/Post-before/after) Forms on 5/04/26, 5/08/26, 5/13/26, 5/18/26 and 5/20/26.This failure could place residents who received dialysis at risk for complications and not receiving proper care and treatment to meet their needs.Findings included:Record review of Resident #7's face sheet dated 6/01/26 indicated he was [AGE] years old and admitted to the facility on [DATE] originally and re-admitted [DATE]. Resident #7 had diagnoses including end stage renal disease (condition where the kidney reaches advanced state of loss of function), hypertensive (high blood pressure) heart disease with chronic kidney disease, heart failure and diabetes mellitus (high blood sugar).Record review of Resident #7's Active Orders Report dated 6/02/26 indicated he had an order dated 12/05/25 for Dialysis on day shift, monitor shunt/graft/fistula for signs/symptoms of infection and adequate circulation, right chest Permacath (long-term tunneled dialysis catheter used to access the blood stream for dialysis) and left arm shunt (surgically created high-flow access point required to cycle a patient's blood during hemodialysis (life-sustaining treatment to filter waste and excess fluid from the blood due to kidney failure)), Hemodialysis every M-W-F . must be weighed before and after treatment and communicated with office staff due to geri-chair (specialized, highly padded reclining chair on wheels).Record review of Resident #7's MDS assessment dated [DATE] indicated he had a BIMS score of 11, which indicated moderate cognitive impairment. The MDS indicated Resident #7 had no behaviors or refusal of care. The MDS indicated Resident #7 received dialysis while a resident at the facility.Record review of Resident #7's Plan of Care dated 6/01/26 indicated he had ESRD (End stage renal{kidney}disease) and was at risk for complications of renal failure and was receiving dialysis M-W-F. The interventions included: observe for edema, warmth and color of extremities, shortness of breath, vital signs daily, report abnormalities to the physician with follow up as indicated.Record review of Resident #7's Dialysis Communication (Pre/Post) Forms for the month of May 2026, revealed he had incomplete dialysis communication forms for the following dates: 5/04/26, 5/08/26, 5/13/26, 5/18/26, and 5/20/26. The Dialysis Communication Forms revealed there was no documentation in the Post Dialysis Report section, to be completed by the Nursing Staff upon the resident's return to the facility, which included vital signs (blood pressure, pulse, respirations, and temperature), whether there was any new orders, and there was no assessment of the dialysis access site for swelling, redness, signs of infection, and whether reinforcement of the dressing was needed. Resident #7's Dialysis Communication (Pre/Post) Forms indicated RN A had completed the Pre Dialysis Report section on 5/04/26, 5/08/26, 5/13/26 and 5/18/26.During an interview on 06/02/2026 at 12:44 PM, RN A said she had worked at the facility for about a month. RN A said before a resident was sent to dialysis, she would get a set of vital signs, assess the resident, fill out the top portion of the Dialysis Communication Form and send it to dialysis with the resident. RN A said Resident #7 went to dialysis by the ambulance service and she sent the form and his lunch with the ambulance service. RN A said when the resident comes back from dialysis, they get the form, then transfer the dialysis unit's part to the Dialysis Communication Form. RN A said then she checks the resident's vital signs, assesses the dialysis access site for bleeding and documents it on the bottom portion of the Dialysis Communication Form. RN A said there had been a few times Resident #7 had come back the facility after her shift ended, but the Dialysis Communication Form and assessment should be completed by the nurse on shift when the resident came back from dialysis. RN A said the Dialysis Communication Form was a tool to communicate between the dialysis center and the facility and to make sure the resident was in stable condition. RN A said the nurse on duty would be responsible for ensuring the Dialysis Communication Form was (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed and the resident was assessed when he came back from dialysis. RN A said if the resident was not assessed after dialysis, he may be not feeling well after dialysis, and they could miss something that could be life harming. During an interview on 06/02/2026 at 12:54 PM, the ADON said the nurse was supposed to open the dialysis form and send with the resident to dialysis. The ADON said then the dialysis center fills in their part and sends the form back to the facility. The ADON said the Dialysis Communication Form then would be put in the scan box to be scanned into the EHR and then the receiving nurse fills in section 3 (bottom portion) to include assessing the access site dressing and a set of vital signs. The ADON said the Dialysis Communication Form was to let the dialysis center know if there have been any changes and for the dialysis center to let the facility know if there had been any changes or anything out of the norm. The ADON said the nurses should be completing the Dialysis Communication Forms and the administration team should be auditing to ensure they were being completed. The ADON said Resident #7 sometimes came back during or after shift change. The ADON said there could be a delay in care of a condition they may not be aware of, if the nurse was not assessing/checking the dialysis access site and vital signs after dialysis. During an interview on 06/02/2026 at 1:27 PM, the DON said the top portion of the Dialysis Communication Form was filled out and printed and sent with the resident, then the dialysis unit completed their portion, and then the nurse completed the portion after dialysis when the resident returned. The DON said the nurse on duty was responsible for completing the form. The DON said the purpose of the form was to monitor their vital signs and make sure the resident was stable when they returned from dialysis and not having any adverse effects from dialysis. The DON said if the resident was not being assessed after dialysis, they could have a negative outcome after returning from dialysis and they may not know it.During an interview on 6/02/26 at 1:27 PM, the ADM said she would expect staff to complete the Dialysis Communication forms if that was what was required. The ADM said she was not clinical and did not know what the adverse effect for the resident would be for not completing the Dialysis Communication Form.Record review of the facility's policy dated revised February 12, 2020 and titled Dialysis-Hemodialysis - Guidelines for Care of the Dialysis Resident's Competency, Shunt Care, indicated . Staff would ensure that residents who require dialysis receive such services consistent with standards of practice . The dialysis staff and the community staff will participate in ongoing communication by completing the dialysis collection form as follows . b. Pre-Dialysis: Section A to be completed by the sending community licensed nurse and to accompany patient to the dialysis center . c. Post Dialysis: Community nurse to complete Section B with dialysis center information. Community nurse to assess and complete Section C . d. Place document in the appropriate section of the medical record .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications (is a medication used: In excessive doses (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indication for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued) for 1 of 6 residents (Resident #2) reviewed for unnecessary medications.The facility failed to ensure Resident #2 had monitoring for an anticoagulant medication, Eliquis (an anticoagulant medication thins the blood and could cause serious, potentially fatal bleeding and bruising more easily).The facility failed to ensure Resident #2's order for Eliquis had an appropriate diagnosis.These failures could place residents at risk for adverse drug reactions (unintended, harmful events attributed to the use of medicines).Findings included:Record review of Resident #2's face sheet dated 6/01/26 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #2 had diagnoses including Parkinson's (disease that causes movement problems), fracture of left femur (upper leg), dementia (decline in cognitive abilities such as memory, reasoning, language, and behaviors that interfere with ADLs), atrial flutter (abnormal heart rhythm where the upper portion of the heart beats too quickly), and hypertension (high blood pressure).Record review of Resident #2's annual MDS assessment dated [DATE] indicated he was sometimes understood and sometimes understood others. The MDS indicated he had a BIMS score of 11, which indicated he had moderate cognitive impairment. The MDS indicated Resident #2 had fluctuating inattention and disorganized thinking. The MDS indicated Resident #2 had a history of falls. The MDS indicated Resident #2 was taking an anticoagulant.Record review of Resident #2's Physician Orders dated 6/01/26-6/30/26 revealed an order for Eliquis 5 mg tablet one tablet by mouth twice a day for surgical incision with a start date of 5/13/26.Record review of Resident #2's care plan dated 6/01/26 did not show a care plan for his use of an anticoagulant, Eliquis.Record review of Resident #2's MAR dated 5/03/26-6/01/26 indicated Eliquis 5 mg, give 1 tablet by mouth twice daily for surgical incision with a start date of 5/13/26. Resident #2 received twice daily doses as ordered. The MAR did not indicate assessment or monitoring for side effects of Eliquis to include signs or symptoms of bleeding or bruising.During an observation and interview on 5/31/26 at 11:14, Resident #2 was observed to have multiple bruises to his upper and lower right arm. Resident #2 said he fell and busted his hip and was getting therapy and it was going very well.During an interview on 6/02/26 at 12:54 PM, the ADON said Eliquis should have monitoring in place for bruising and any abnormalities. She said having monitoring in place brought more attention to the resident being on the medication, so they could notify the MD if additional testing may need to be done. The ADON said if staff were not monitoring for adverse effects of Eliquis, there could be internal processes that they may not be aware of. The ADON said their previous EHR software would have automatically added monitoring to the MAR when Eliquis was ordered. The ADON said their current EHR software did not automatically add monitoring to the MAR, and it must have been missed by mistake.During an interview on 6/02/26 at 1:27 PM, the DON said there should be monitoring for bleeding, and it should be documented on the MAR. The DON said for an anticoagulant medication, such as Eliquis, they should be monitoring for bleeding/bruising. The DON said if they were not monitoring for bleeding, the resident could be bleeding, and they would not know it. The DON said it must have been missed because he had just started on it after his fall and went into Atrial Flutter in the hospital. The DON said the indication for use, surgical incision, was not an appropriate diagnosis attached to the order for Eliquis. The DON said Resident #2 did have the diagnosis of Atrial Flutter, which was the reason he was on the medication, and it should be attached to the order for Eliquis. The DON said they could miss something, if they were not monitoring for adverse effects of the medication and would not catch it.During an interview on 6/02/26 at 1:27 PM, the ADM said she would expect the monitoring for an anticoagulant to be in place and care planned if (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it was supposed to be. The ADM said the resident had the potential to bleed if they had an accident. The ADM said if staff were not monitoring for bleeding and the bleeding was not stopping, depending on the injury, it could cause some serious issues.During an interview on 6/03/26 at 10:20 AM, the Consulting Pharmacist returned surveyor's call from 6/02/26. She said when she did her monthly reviews, she looked for medications including anticoagulants to ensure there was monitoring for bleeding/bruising in place and if the medication had an appropriate diagnosis for the use of the medication. She said the monitoring of the medication would be looking for any adverse reactions or side effects of the medication that could warrant a change in medication or dosage. She said if Resident #2 had started the Eliquis 5/13/26, she has not been back to the facility to do her monthly review for June 2026 yet.Record review of the facility's policy titled, Medication Administration dated 1/2024 indicated . Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices . 1. Medications are administered in accordance with written orders or the prescriber . if a dose seems excessive . or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification . if necessary, the nurse contacts the prescriber for clarification . The policy did not address monitoring for adverse reactions/effects of medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 2 of 14 (Resident #6, Resident #45) residents reviewed for infection control practices. 1. The facility failed to wear PPE when providing direct care to Resident #6 on EBP. 2. The facility failed to wear PPE when providing direct care to Resident #45 on contact isolation. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections.Findings included: 1. Record review of an undated face sheet revealed Resident #6 was a [AGE] year-old male was originally admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (chronic lung disease), acute and chronic respiratory failure (acute failure develops suddenly as an emergency, chronic failure builds gradually over time), and diabetes. Record review of Physician's Orders dated 06/01/26 for Resident #6 indicated an order for tracheostomy (a surgical procedure that creates a small opening in the front of the neck and directly into the windpipe (trachea). A tube is placed into this opening to bypass the nose and mouth, providing a direct airway for breathing) skin care every shift by replacing split dressing with a start date of 02/24/26. There was an order to replace the inner cannular (a removable, tube-like liner that sits inside the outer tracheostomy tube) daily on day shift and as needed with a start date of 02/24/26. There was an order for enhanced barrier precautions every shift for tracheostomy with a start date of 04/23/26. Record review of a significant change MDS assessment dated [DATE] revealed Resident #6 had a BIMS score of 13 which indicated no cognitive impairment. The MDS indicated Resident #6 received tracheostomy care while being a resident in the facility. Record review of the care plan revised on 05/11/26 revealed Resident #6 had enhanced barrier precautions to prevent multidrug-resistant organisms (refers to bacteria or fungi that are resistant to one or more classes of antimicrobial drugs, making an infection they cause highly difficult to treat). There was an intervention for gown and glove use during high-contact resident care activities such as.wound care, and any skin opening requiring a dressing. During an observation on 06/01/26 at 1:00 p.m., RN A provided tracheostomy care, including changing the split dressing, to Resident #6. RN A did not wear a gown during the care. During an interview on 06/01/26 at 1:38 p.m., RN A said Resident #6 was on enhanced barrier precautions due to him having a tracheostomy. She said she was supposed to have worn a gown. She said enhanced barrier precautions were meant to protect the patients with wounds or open areas from infection. 2. Record review of an undated face sheet revealed Resident #45 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of End Stage Renal Disease (Stage 5 chronic kidney disease, occurs when the kidneys lose 85% to 90% of their function, meaning they can no longer filter waste and fluids), Diabetes type II (a chronic metabolic condition where the body resists insulin or cannot produce enough of it), heart failure (heart muscle doesn't pump blood as well as it should to meet your body's needs), and recent amputation (surgical removal) of toes 3, 4, and 5 on the left foot. Record reviews of the electronic health record on 05/31/2026 revealed no admission assessment, no MDS, no baseline care plan, and no comprehensive care plan were completed for Resident #45. Record review of MD orders dated 06/01/2026 revealed Resident #45 had an order for contact isolation related to shingles (a viral infection caused by the varicella-zoster virus). He also had an order for Valtrex 500mg daily for suspected shingles infection dated 05/29/2026. During an observation on 05/31/2026 at 10:30 a.m., CNA B entered Resident #45's room and assisted Resident #45 up to sit on the side of the bed and with the use of a urinal. CNA B failed to wear any PPE while assisting Resident #45. There was no PPE located inside the room, bathroom, or outside the door including gloves. During an interview on 05/31/2026 at 10:45 a.m., CNA B stated she was not aware Resident #45 was on isolation. She stated the electronic health record normally had an alert for all residents on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	isolation. She stated Resident #45 did not have indications he was on contact isolation or EBP and with no isolation set up in the room or outside the door, she was completely unaware she needed to wear PPE in his room. She stated not knowing this could mean she spread infections to other residents she is caring for, as well as herself and her family. During an interview on 06/02/26 at 12:20 p.m., the DON said she expected staff to know when a resident was on enhanced barrier precautions and the process they should be following. She said she would have expected RN A to have worn a gown along with gloves while providing care to Resident #6. She said she would have expected CNA B to have worn appropriate PPE while providing care to Resident #45. She said it was important to follow enhanced barrier precautions and contact isolation precautions to prevent possible infection control issues. During an interview on 06/02/26 at 12:20 p.m., the Administrator said she would have expected staff to be aware of enhanced barrier precautions and contact isolation and wear appropriate PPE while providing care. She said it was important to wear PPE to keep from transmitting any possible bacteria or infection. Record review of an Enhanced Barrier Precautions facility policy revised in March 2025 indicated, .Many resident in nursing homes are at increased risk of becoming colonized and developing infections with multi-drug resistant organisms.This facility utilizes Enhanced Barrier Precautions (EBP) as a strategy to decrease transmission of CDC (Centers for Disease Control) -targeted and epidemiologically important MDROs (multidrug-resistant organisms) when contact precautions do not apply.Indications.Wounds and/or indwelling medical devices.High Contact Resident Care Activities.Device care or use: Central line, Urinary Catheter, feeding tube, tracheostomy.