

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER The Waterton at Cowhorn Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 5524 Cowhorn Creek Texarkana, TX 75503	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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** 30527 Based on observation, interview and record review the facility failed to ensure each resident was treated with respect and dignity and care in a manner and in and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1of 5 residents (Residents #2) reviewed for dignity. The facility failed to ensure CNA B did not feed Resident #2 while standing on 10/23/2024. The failure could place residents at risk for a diminished quality of life, loss of dignity and self-worth. Findings: Record review of Resident #2's, undated, face sheet reflected a 49-years-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included amyotrophic lateral sclerosis (progressive muscle weakness leading to difficulties with moving, speaking, breathing and swallowing), muscle weakness, other abnormalities of gait and mobility, other speech disturbances, pain, nasal congestion, anxiety disorders (characterized by significant and uncontrollable feelings of anxiety and fear such that a person's social, occupational, and personal functions are significantly impaired), urinary tract infection (infection that affects a part of the urinary tract), dyspnea (difficulty breathing), hypertension (high blood pressure). Record review of Resident #2's most recent comprehensive MDS, dated [DATE], reflected Resident #2 sometimes made herself understood and understands. Resident #2 had a BIMS score of 99, which indicated Resident #2 was unable to complete the assessment. Resident #2's short term and long-term memory was okay. The assessment reflected Resident #2 rejected care necessary to achieve the resident's goals for health or well-being. Resident #2 required maximal assistance with bed mobility, transfers, toileting, dressing, personal hygiene, eating and was dependent with showering. Record review of Resident #2's care plan revised on 03/06/2024 indicated Resident #2 required assistance with ADLs with the intervention of required to be fed by staff related to bilateral hand contracture due to amyotrophic lateral sclerosis. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675949	Facility ID: 675949 If continuation sheet Page 1 of 20

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/23/2024 at 12:51 p.m., CNA B stood at the side of Resident #2's bed while feeding her lunch. CNA B gave Resident #2 a bite of food from a spoon then walked off to another area of the room. CNA B then returned to Resident #2's bedside and gave another spoonful of food to Resident #2. During an observation and interview on 10/24/2024 at 12:32 p.m., CNA C was sitting in a chair at Resident #2's bedside and was assisting Resident #2 with her lunch. CNA C said it was best to sit while assisting to feed residents, so the resident did not feel overpowered and baby like and could eat more slowly. During an interview on 10/29/2024 at 11:24 a.m., CNA B said she sat down to feed the residents so she could communicate with the resident. CNA B said she did not sit down beside Resident 2's bedside because Resident #2's communication electronic device stand was in the way. CNA B said she should had sat down at Resident #2's bedside to communicate with her. CNA B said Resident #2 refused to allow the communication electronic device stand be relocated from the side of the bed. During an interview on 10/29/2024 at 2:32 p.m., Resident #2 stated CNA B was always in a hurry while assisting to feed her. Resident #2 stated CNA B made her feel rushed while she attempted to eat. Resident #2 stated CNA B had never tried to move the communication electronic device stand while feeding her. Resident #2 said she had told CNA B she had feed her to fast but she ignored her. During an interview on 10/29/2024 at 3:37 p.m., CNA D said she sat down to feed residents because it was respectful. CNA D said the residents could feel rushed if staff stood over them while eating. CNA D said it was important for the resident to feel respected and not rushed to prevent weight loss. During an interview on 10/29/2024 at 4:07 p.m., the DON said the appropriate thing to do when feeding a resident was to sit at eye level facing the resident. The DON said these failures could be a dignity issue. The DON said this failure could cause weight loss or a decreased quality of life of the residents. DON said she expected the staff to treat all residents with respect and sit while feeding the residents. During an interview on 10/29/2024 at 04:40 p.m., the Administrator said it was important for staff to sit beside the residents for feedings to prevent choking. The Administrator stated standing while assisting to feed a resident could be a dignity issue and may result in a resident's weight loss. Record review of the facility's, undated, Quality of Life - Dignity policy reflected, be treated with dignity and respect at all times.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on interview and record review the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 5 residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #3 did not verbally abuse Resident #1 on 10/14/2024. This failure could place residents at risk of abuse, physical harm, mental anguish and emotional distress. Findings include: 1. Record review of Resident #1's, undated, face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included myocardial infarction (heart attack), muscle wasting, zoster (a viral infection that causes pain and blisters), convulsion (seizures), ocular pain (eye), renal disease (kidney), hypertension (high blood pressure), lack of coordination, Type 2 diabetes mellitus (high blood sugar), anxiety (characterized by significant and uncontrollable feelings of anxiety and fear such that a person's social, occupational, and personal functions are significantly impaired) and dementia (a group of thinking and social symptoms that interferes with daily functioning) Record review of Resident #1's Quarterly MDS assessment, dated 10/07/2024, reflected Resident #1 was able to usually understand others and was understood by others. Resident #1 had a BIMS score of 12, which indicated her cognition was mildly impaired. Resident #1 was independent with eating, oral hygiene, toileting, required supervision or touching assistance with upper and lower body dressing and personal hygiene. Record review of Resident #1's care plan, with date revised on 10/23/2024, reflected Resident #1 exhibited behavioral indicators of manipulative tendencies with family member. The care plan interventions were to provide supportive/appropriate opportunities for Resident #1 to freely express feelings/negative emotions. Anticipate care needs and provide them before Resident #1 becomes stressed. 2. Record review of Resident #3's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] and discharged [DATE]. Resident #3 had diagnoses which included congestive heart failure (the heart does not pump enough blood), upper respiratory infection (a viral infection that affects the nose, throat, and airway), angina pectoris (chest pain), dementia (a group of thinking and social symptoms that interferes with daily functioning insomnia [does not sleep at night]). Record review of Resident #3's Quarterly MDS assessment, dated 08/16/2024, reflected Resident #3 was able to understand others and was understood by others. Resident #3 had a BIMS score of 5, which indicated his cognition was severely impaired Resident #3 did not have any behavioral symptoms directed at others. Resident #3 was independent with eating, shower, toileting, upper and lower body dressing and personal hygiene. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's care plan, with date initiated 05/16/2024, reflected Resident #3 was a smoker and was able to smoke unsupervised in the designated smoking area. Record review of an email, dated October 1, 2024, from Resident #1's family member, sent to the Administrator, reflected the following: I was informed tonight about an altercation that resulted in my family member being called a 'BITCH' by another resident on 9/29/2024. Record review of an email, dated October 14, 2024, from Resident #1's family member, sent to the Administrator, reflected the following: I was made aware of another issue involving [Resident #3] and my family member. [Resident #3] called my family member a 'BITCH' again. Record review of the facility's Incidents and Accidents reports dated 09/01/24 - 10/23/2024, did not reflect any reported incidents which involved Resident #1 and Resident #3. Record review of the facility's Grievance report dated 09/01/2024 - 10/23/2024, did not reflect any grievances received from the family member of Resident #1 being cussed. Record review of Resident #1's progress notes, dated 09/01/24-10/23/24, did not reflect any incidents or altercations with other residents. Record review of the progress notes dated 09/01/2024 - 10/23/2024, did not reflect any incidents or altercations with other residents. During an interview on 10/24/2024 at 03:30 p.m., Resident #1 said Resident #3 called her a bitch on two separate occasions. Resident #1 said one incident occurred outside on the patio. Resident #1 said Resident #3 asked her for a cigarette. Resident #1 said she did not smoke, and she told Resident #3 she did not have a cigarette. Resident #1 said Resident #3 got mad and called her a bitch. Resident #1 said she went inside the facility to her room to get away from Resident #3. Resident #1 said the aide outside heard the name calling but she could not recall which aide it was at that time. Resident #1 said on the next occurrence Resident #3 uninvitedly came into her room and locked himself in her bathroom. Resident #1 said one of the nurses had to be called to get Resident #3 out of the bathroom. Resident #1 said Resident #3 cussed at her and at the staff when he left the bathroom. Resident #1 said it made her feel uncomfortable, so she attempted to stay away from the resident as much as possible. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/2024 at 03:40 p.m., the DON said she was aware of the incident with Resident #1 and Resident #3 calling each other names. The DON said there would be no further documentation regarding that incident because there was just name calling as Resident #3 called Resident #1 a name and then Resident #1 called Resident #3 a name and that was the end of it. The DON said that incident between Resident #1 and Resident #3 was not considered abuse. The DON stated we would be reporting the line at the beauty shop, bingo playing and such if we reported all those types of things. The DON said she did not witness the incident, but LVN L told her about the incident. The DON stated she never received a complaint or allegation of abuse from the family member. The DON said there were several types of abuse such as physical (hitting), mental (depression), misappropriation (belongings), neglect (no care provided), verbal (yelling). The DON said if she received an allegation of abuse or witnessed abuse she would report to the Administrator/Abuse Coordinator. The DON said it was the Abuse Coordinators responsibility to report and investigate allegations of abuse. The DON stated Resident #3 was already discharged from the facility on 10/15/2024 to another facility at the request of Resident #3's family member. The DON stated Resident #3 was only in the facility for short term care. The DON stated Resident #3 was discharged from the hospital and admitted at the facility after heart surgery for rehabilitation purposes. The DON said if alleged abuse was not reported timely and appropriately, it could put other residents at risk of abuse. During an interview on 10/24/2024 at 3:50 p.m., the Administrator said she was aware of the family member sending the email reporting the allegation of verbal abuse three days after it occurred. The Administrator stated she did not consider that as verbal abuse and did not report to HHSC that Resident #3 had called Resident #1 a name. The Administrator stated she had the discrepancy to decide what needed to be reported to HHSC after investigating the situation. The Administrator stated, for example, if a resident reported missing clothing that would be consider misappropriation. The Administrator stated she would first go look in the resident's room and in laundry to ensure was the items were missing before reporting to HHSC. The Administrator said she would not report to HHSC if she found the missing clothing item, nor would that be logged anywhere else. The Administrator stated she was to report allegations of abuse with injury within 2 hours to HHSC and without injury within 24 hours. The Administrator said, in this instance, there was nothing to investigate - it was more a question of who abused who because both Resident #1 and Resident #3 had called each other a name. The Administrator said the purpose of reporting timely and investigating properly was to prevent further abuse from occurring. The Administrator said that yelling harshly at a resident was considered verbal abuse. An attempted telephone interview with LVN L on 10/28/2024 at 04:00 p.m., no answer - left message requesting a call back. An attempted telephone interview with Resident #3's caregiver on 10/28/2024 at 04:00 p.m., - message stated out of service area and was unable to leave a message. During an interview on 10/29/2024 at 11:24 a.m., CNA B said she could not recall working directly with Resident #3, but thought she recalled he was transferred out to another facility due to cussing at a resident. CNA B stated cussing and yelling toward a resident was considered abuse and should be reported to the Abuse Coordinator. The reason the abuse would be reported would be to protect the residents. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/2024 at 11:35 a.m., LVN M stated Resident #3 was roomed on the long-term care side, and she worked the skilled side, so she had not worked with Resident #3. LVN M stated he was discharged to another facility, and she heard it was regarding cussing at other residents. LVN M stated cussing, screaming or talking hateful to a resident could be considered verbal abuse. LVN M stated she would report to the Abuse Coordinator for follow-up. During an interview on 10/29/2024 at 11:50 a.m., ADON K (over the skilled and rehabilitation hall) stated Resident #3 was discharged to another facility on 10/15/2024 after altercations which involved other residents and staff. ADON K said she had no personal experiences with Resident #3 because he was on the long-term care hall. ADON K stated yelling and cussing to a resident would need to be reported to the Abuse Coordinator for further investigation. During an interview on 10/29/2024 at 11:55 a.m., RN N said she worked at the facility approximately a month and a half on the long-term care side. RN N said she recalled Resident #3 faintly. RN N said she recalled he was discharged a week or more ago related to behaviors with residents and staff. RN N stated yelling at a resident would be abuse and she would immediately report to the Abuse Coordinator. An attempted telephone interview with LVN L on 10/29/2024 at 01:30 p.m., no answer - left message requesting a call back. An attempted telephone interview with Resident #3's caregiver on 10/29/2024 at 01:33 p.m., - message stated out of service area and was unable to leave a message. During an interview on 10/29/2024 at 02:31 p.m., LVN A said he provided care for Resident #3 on the long-term side on several occasions. LVN A said he thought Resident #3 was discharged from the facility due to some behavioral issues with some residents and staff. LVN A said he had not experienced those type behaviors with Resident #3. LVN A stated abuse of any type should be reported to the Administrator/Abuse Coordinator immediately to prevent and protect the residents. Record review of the facility's Abuse Prevention Policy dated 04/08/2021, reflected, . It is the policy of this facility to prevent abuse by providing residents, families and staff information and education on how, when and tow whom to report concerns, incident and grievance without the fear of reprisal. The facility will then provide feedback regarding those concerns or complaints .Upon receiving an allegation of abuse committed against a resident, the staff member receiving the allegation must ensure the safety of the resident and immediately notify the supervisor on duty .To protect the victim the facility has clear delineated roles of those responsible for investigating and will respond to ensure The alleged perpetrator will immediately be removed from the resident and the resident will be protected. The resident will be assessed, examined (if necessary) and interviewed to determine any injury and clinical interventions needed, and MD and family will be notified		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 5 residents (Resident #1) reviewed for abuse and neglect. The facility failed to report to Health and Human Services Commission Resident #1's family member's allegation that Resident #3 was verbally abused by Resident #1 on 09/29/2024. This failure could place residents at risk for abuse, humiliation, intimidation, fear, shame, agitation and a decreased quality of life. Findings include: 1. Record review of Resident #1's, undated, face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included myocardial infarction (heart attack), muscle wasting, zoster (a viral infection that causes pain and blisters), convulsion (seizures), ocular pain (eye), renal disease (kidney), hypertension (high blood pressure), lack of coordination, Type 2 diabetes mellitus (high blood sugar), anxiety (characterized by significant and uncontrollable feelings of anxiety and fear such that a person's social, occupational, and personal functions are significantly impaired) and dementia (a group of thinking and social symptoms that interferes with daily functioning) Record review of Resident #1's Quarterly MDS assessment, dated 10/07/2024, reflected Resident #1 was able to usually understand others and was understood by others. Resident #1 had a BIMS score of 12, which indicated her cognition was mildly impaired. Resident #1 was independent with eating, oral hygiene, toileting, required supervision or touching assistance with upper and lower body dressing and personal hygiene. Record review of Resident #1's care plan, with date revised on 10/23/2024, reflected Resident #1 exhibited behavioral indicators of manipulative tendencies with family member. The care plan interventions were to provide supportive/appropriate opportunities for Resident #1 to freely express feelings/negative emotions. Anticipate care needs and provide them before Resident #1 becomes stressed. 2. Record review of Resident #3's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] and discharged [DATE]. Resident #3 had diagnoses which included congestive heart failure (the heart does not pump enough blood), upper respiratory infection (a viral infection that affects the nose, throat, and airway), angina pectoris (chest pain), dementia (a group of thinking and social symptoms that interferes with daily functioning insomnia [does not sleep at night]). (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/2024 at 03:40 p.m., the DON said she was aware of the incident with Resident #1 and Resident #3 calling each other names. The DON said there would be no further documentation regarding that incident because there was just name calling as Resident #3 called Resident #1 a name and then Resident #1 called Resident #3 a name and that was the end of it. The DON said that incident between Resident #1 and Resident #3 was not considered abuse. The DON stated we would be reporting the line at the beauty shop, bingo playing and such if we reported all those types of things such as, name calling. The DON said she did not witness the incident, but LVN L told her about the incident of Resident #3 calling Resident #1 a name but that was not considered verbal abuse. The DON stated Resident #1 called Resident #3 a name also right afterwards. The DON stated she never received a complaint or allegation of abuse from the Resident #1's family member. The DON said there were several types of abuse such as physical (hitting), mental (depression), misappropriation (belongings), neglect (no care provided), verbal (yelling/talking down). The DON said if she received an allegation of abuse or witnessed abuse she would report to the Administrator/Abuse Coordinator. The DON said it was the Abuse Coordinators responsibility to report and investigate allegations of abuse. The DON stated Resident #3 was already discharged from the facility on 10/15/2024 to another facility at the request of Resident #3's family member. The DON stated Resident #3 was only in the facility for short term care. The DON stated Resident #3 was discharged from the hospital and admitted at the facility after heart surgery for rehabilitation purposes. The DON said if alleged abuse was not reported timely and appropriately, it could put other residents at risk of abuse. During an interview on 10/24/2024 at 3:50 p.m., the Administrator said she was aware of the family member sending the email reporting the allegation of verbal abuse three days after it occurred. The Administrator stated she did not consider that as verbal abuse and did not report to HHSC that Resident #3 had called Resident #1 a name. The Administrator stated she had the discrepancy to decide what needed to be reported to HHSC after investigating the situation. The Administrator stated, for example, if a resident reported missing clothing that would be consider misappropriation. The Administrator stated she would first go look in the resident's room and in laundry to ensure was the items were missing before reporting to HHSC. The Administrator said she would not report to HHSC if she found the missing clothing item, nor would that be logged anywhere else. The Administrator stated she was to report allegations of abuse with injury within 2 hours to HHSC and without injury within 24 hours. The Administrator said, in this instance, there was nothing to investigate and nothing to report to HHSC- it was more a question of who abused who because both Resident #1 and Resident #3 had called each other a name. The Administrator said the purpose of reporting timely and investigating properly was to prevent further abuse from occurring. The Administrator said that yelling harshly at a resident was considered verbal abuse. An attempted telephone interview with LVN L on 10/28/2024 at 04:00 p.m., no answer - left message requesting a call back. An attempted telephone interview with Resident #3's caregiver on 10/28/2024 at 04:00 p.m., - message stated out of service area and was unable to leave a message. During an interview on 10/29/2024 at 11:24 a.m., CNA B said she could not recall working directly with Resident #3, but thought she recalled he was transferred out to another facility due to cussing at a resident. CNA B stated cussing and yelling toward a resident was considered abuse and should be reported to the Abuse Coordinator. The reason the abuse would be reported would be to protect the residents. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER The Waterton at Cowhorn Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 5524 Cowhorn Creek Texarkana, TX 75503	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/2024 at 11:35 a.m., LVN M stated Resident #3 was roomed on the long-term care side, and she worked the skilled side, so she had not worked with Resident #3. LVN M stated he was discharged to another facility, and she heard it was regarding cussing at other residents. LVN M stated cussing, screaming or talking hateful to a resident could be considered verbal abuse. LVN M stated she would report to the Abuse Coordinator for follow-up. During an interview on 10/29/2024 at 11:50 a.m., ADON K (over the skilled and rehabilitation hall) stated Resident #3 was discharged to another facility on 10/15/2024 after altercations which involved other residents and staff. ADON K said she had no personal experiences with Resident #3 because he was on the long-term care hall. ADON K stated yelling and cussing to a resident would need to be reported to the Abuse Coordinator for further investigation. During an interview on 10/29/2024 at 11:55 a.m., RN N said she worked at the facility approximately a month and a half on the long-term care side. RN N said she recalled Resident #3 faintly. RN N said she recalled he was discharged a week or more ago related to behaviors with residents and staff. RN N stated yelling/cussing at a resident would be abuse and she would immediately report to the Abuse Coordinator. An attempted telephone interview with LVN L on 10/29/2024 at 01:30 p.m., no answer - left message requesting a call back. An attempted telephone interview with Resident #3's caregiver on 10/29/2024 at 01:33 p.m., - message stated out of service area and was unable to leave a message. During an interview on 10/29/2024 at 02:31 p.m., LVN A said he provided care for Resident #3 on the long-term side on several occasions. LVN A said he thought Resident #3 was discharged from the facility due to some behavioral issues with some residents and staff. LVN A said he had not experienced those type behaviors with Resident #3. LVN A stated abuse of any type should be reported to the Administrator/Abuse Coordinator immediately to prevent and protect the residents. Record review of the facility's Abuse Prevention Policy dated 04/08/2021, reflected, .Upon receiving an allegation of abuse committed against a resident, the staff member receiving the allegation must ensure the safety of the resident and immediately notify the supervisor on duty will immediately notify the Abuse Prevention Coordinator of Designee. It is the policy of the facility to respond to all abuse, neglect, misappropriation of property of residents, and mistreatment of residents immediately. Care and attention will be given utmost priority to the resident involved in the incident. It is also policy of the facility to report all reportable incidents as identified by State and Federal guidelines. The alleged perpetrator will be asked to leave the facility, .The facility will report finding and disseminate investigative finding to: 1. The resident involved, 2. the legal guardian or designated responsible party, 3. Any required regulatory authorities, and 4. Law enforcement as necessary. The facility's immediate response is to protect the alleged victim, To protect the victim, the facility has clear delineated roles of those responsible for investigating and will respond to ensure protection of the victim and integrity of the investigation.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 5 residents (Resident #1) reviewed for abuse and neglect. The facility failed to investigate Resident #1's family member's allegation that Resident #3 was verbally abused by Resident #1 on 09/29/2024. This failure could place residents at risk for abuse, humiliation, intimidation, fear, shame, agitation and a decreased quality of life. Findings include: 1. Record review of Resident #1's, undated, face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included myocardial infarction (heart attack), muscle wasting, zoster (a viral infection that causes pain and blisters), convulsion (seizures), ocular pain (eye), renal disease (kidney), hypertension (high blood pressure), lack of coordination, Type 2 diabetes mellitus (high blood sugar), anxiety (characterized by significant and uncontrollable feelings of anxiety and fear such that a person's social, occupational, and personal functions are significantly impaired) and dementia (a group of thinking and social symptoms that interferes with daily functioning) Record review of Resident #1's Quarterly MDS assessment, dated 10/07/2024, reflected Resident #1 was able to usually understand others and was understood by others. Resident #1 had a BIMS score of 12, which indicated her cognition was mildly impaired. Resident #1 was independent with eating, oral hygiene, toileting, required supervision or touching assistance with upper and lower body dressing and personal hygiene. Record review of Resident #1's care plan, with date revised on 10/23/2024, reflected Resident #1 exhibited behavioral indicators of manipulative tendencies with family member. The care plan interventions were to provide supportive/appropriate opportunities for Resident #1 to freely express feelings/negative emotions. Anticipate care needs and provide them before Resident #1 becomes stressed. 2. Record review of Resident #3's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] and discharged [DATE]. Resident #3 had diagnoses which included congestive heart failure (the heart does not pump enough blood), upper respiratory infection (a viral infection that affects the nose, throat, and airway), angina pectoris (chest pain), dementia (a group of thinking and social symptoms that interferes with daily functioning insomnia [does not sleep at night]). (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's Quarterly MDS assessment, dated 08/16/2024, reflected Resident #3 was able to understand others and was understood by others. Resident #3 had a BIMS score of 5, which indicated his cognition was severely impaired Resident #3 did not have any behavioral symptoms directed at others. Resident #3 was independent with eating, shower, toileting, upper and lower body dressing and personal hygiene. Record review of Resident #3's care plan, with date initiated 05/16/2024, reflected Resident #3 was a smoker and was able to smoke unsupervised in the designated smoking area. Record review of an email, dated October 1, 2024, from Resident #1's family member, sent to the Administrator, reflected the following: I was informed tonight about an altercation that resulted in my family member being called a 'BITCH' by another resident on 9/29/2024. Record review of an email, dated October 14, 2024, from Resident #1's family member, sent to the Administrator, reflected the following: I was made aware of another issue involving [Resident #3] and my family member. [Resident #3] called my family member a 'BITCH' again. Record review of the facility's Incidents and Accidents reports dated 09/01/24 - 10/23/2024, did not reflect any reported incidents which involved Resident #1 and Resident #3. Record review of the facility's Grievance report dated 09/01/2024 - 10/23/2024, did not reflect any grievances received from the family member of Resident #1 being cussed. Record review of Resident #1's progress notes dated 09/01/24-10/23/24, did not reflect any incidents or altercations with other residents. During an interview on 10/24/2024 at 03:30 p.m., Resident #1 said Resident #3 called her a bitch on two separate occasions. Resident #1 said one incident occurred outside on the patio. Resident #1 said Resident #3 asked her for a cigarette. Resident #1 said she did not smoke, and she told Resident #3 she did not have a cigarette. Resident #1 said Resident #3 got mad and called her a bitch. Resident #1 said she went inside the facility to her room to get away from Resident #3. Resident #1 said the aide outside heard the name calling but she could not recall which aide it was at that time. Resident #1 said on the next occurrence Resident #3 uninvitedly came into her room and locked himself in her bathroom. Resident #1 said one of the nurses had to be called to get Resident #3 out of the bathroom. Resident #1 said Resident #3 cussed at her and at the staff when he left the bathroom. Resident #1 said it made her feel uncomfortable, so she attempted to stay away from the resident as much as possible. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/2024 at 03:40 p.m., the DON said she was aware of the incident with Resident #1 and Resident #3 calling each other names. The DON said there would be no further documentation regarding that incident because there was just name calling as Resident #3 called Resident #1 a name and then Resident #1 called Resident #3 a name and that was the end of it. The DON said that incident between Resident #1 and Resident #3 was not considered abuse. The DON stated we would be reporting the line at the beauty shop, bingo playing and such if we reported all those types of things such as, name calling. The DON said she did not witness the incident, but LVN L told her about the incident of Resident #3 calling Resident #1 a name but that was not considered verbal abuse. The DON stated Resident #1 called Resident #3 a name also right afterwards. The DON stated she never received a complaint or allegation of abuse from the Resident #1's family member. The DON said there were several types of abuse such as physical (hitting), mental (depression), misappropriation (belongings), neglect (no care provided), verbal (yelling/talking down). The DON said if she received an allegation of abuse or witnessed abuse she would report to the Administrator/Abuse Coordinator. The DON said it was the Abuse Coordinators responsibility to report and investigate allegations of abuse. The DON stated Resident #3 was already discharged from the facility on 10/15/2024 to another facility at the request of Resident #3's family member. The DON stated Resident #3 was only in the facility for short term care. The DON stated Resident #3 was discharged from the hospital and admitted at the facility after heart surgery for rehabilitation purposes. The DON said if alleged abuse was not reported timely and appropriately, it could put other residents at risk of abuse. During an interview on 10/24/2024 at 3:50 p.m., the Administrator said she was aware of the family member sending the email reporting the allegation of verbal abuse three days after it occurred. The Administrator stated she did not consider that as verbal abuse and did not report to HHSC that Resident #3 had called Resident #1 a name. The Administrator stated she had the discrepancy to decide what needed to be reported to HHSC after investigating the situation. The Administrator stated, for example, if a resident reported missing clothing that would be consider misappropriation. The Administrator stated she would first go look in the resident's room and in laundry to ensure was the items were missing before reporting to HHSC. The Administrator said she would not report to HHSC if she found the missing clothing item, nor would that be logged anywhere else. The Administrator stated she was to report allegations of abuse with injury within 2 hours to HHSC and without injury within 24 hours. The Administrator said, in this instance, there was nothing to investigate and nothing to report to HHSC- it was more a question of who abused who because both Resident #1 and Resident #3 had called each other a name. The Administrator said the purpose of reporting timely and investigating properly was to prevent further abuse from occurring. The Administrator said that yelling harshly at a resident was considered verbal abuse. An attempted telephone interview with LVN L on 10/28/2024 at 04:00 p.m., no answer - left message requesting a call back. An attempted telephone interview with Resident #3's caregiver on 10/28/2024 at 04:00 p.m., - message stated out of service area and was unable to leave a message. During an interview on 10/29/2024 at 11:24 a.m., CNA B said she could not recall working directly with Resident #3, but thought she recalled he was transferred out to another facility due to cussing at a resident. CNA B stated cussing and yelling toward a resident was considered abuse and should be reported to the Abuse Coordinator. The reason the abuse would be reported would be to protect the residents. (continued on next page)		

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/2024 at 11:35 a.m., LVN M stated Resident #3 was roomed on the long-term care side, and she worked the skilled side, so she had not worked with Resident #3. LVN M stated he was discharged to another facility, and she heard it was regarding cussing at other residents. LVN M stated cussing, screaming or talking hateful to a resident could be considered verbal abuse. LVN M stated she would report to the Abuse Coordinator for follow-up. During an interview on 10/29/2024 at 11:50 a.m., ADON K (over the skilled and rehabilitation hall) stated Resident #3 was discharged to another facility on 10/15/2024 after altercations which involved other residents and staff. ADON K said she had no personal experiences with Resident #3 because he was on the long-term care hall. ADON K stated yelling and cussing to a resident would need to be reported to the Abuse Coordinator for further investigation. During an interview on 10/29/2024 at 11:55 a.m., RN N said she worked at the facility approximately a month and a half on the long-term care side. RN N said she recalled Resident #3 faintly. RN N said she recalled he was discharged a week or more ago related to behaviors with residents and staff. RN N stated yelling/cussing at a resident would be abuse and she would immediately report to the Abuse Coordinator. An attempted telephone interview with LVN L on 10/29/2024 at 01:30 p.m., no answer - left message requesting a call back. An attempted telephone interview with Resident #3's caregiver on 10/29/2024 at 01:33 p.m., - message stated out of service area and was unable to leave a message. During an interview on 10/29/2024 at 02:31 p.m., LVN A said he provided care for Resident #3 on the long-term side on several occasions. LVN A said he thought Resident #3 was discharged from the facility due to some behavioral issues with some residents and staff. LVN A said he had not experienced those type behaviors with Resident #3. LVN A stated abuse of any type should be reported to the Administrator/Abuse Coordinator immediately to prevent and protect the residents. Record review of the facility's Abuse Prevention Policy dated 04/08/2021, reflected, .Upon receiving an allegation of abuse committed against a resident, the staff member receiving the allegation must ensure the safety of the resident and immediately notify the supervisor on duty will immediately notify the Abuse Prevention Coordinator of Designee. It is the policy of the facility to respond to all abuse, neglect, misappropriation of property of residents, and mistreatment of residents immediately. Care and attention will be given utmost priority to the resident involved in the incident. It is also policy of the facility to report all reportable incidents as identified by State and Federal guidelines. The alleged perpetrator will be asked to leave the facility, .The facility will report finding and disseminate investigative finding to: 1. The resident involved, 2. the legal guardian or designated responsible party, 3. Any required regulatory authorities, and 4. Law enforcement as necessary. The facility's immediate response is to protect the alleged victim, To protect the victim, the facility has clear delineated roles of those responsible for investigating and will respond to ensure protection of the victim and integrity of the investigation.		

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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** 30527 Based on observation, interview and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 (Resident #4) residents reviewed for accidents. The facility failed to ensure CNA E used two-person assistance to transfer Resident #4 out from the recliner to the bed which resulted in a fall without injury on 10/10/2024. This failure could place residents at risk of injuries, falls and hospitalization s. Findings include: Record review of Resident #4's, undated, face sheet reflected an 89-years-old who was readmitted to the facility on [DATE]. Resident #4 had diagnoses which included parkinsonism (a disorder of the central nervous system that affects movement, often including tremors), depression, hypertension, (high blood pressure) open wound of the buttocks, shortness of breath, urinary incontinence, dementia (a group of thinking and social symptoms that interferes with daily functioning) , abnormalities of gait (walking) and lack of coordination. Record review of Resident #4's most recent comprehensive MDS, dated [DATE], reflected Resident #4 sometimes made himself understood and understands. Resident #4 had a BIMS score of 15, which indicated Resident #4 was cognitively intact. Resident #4 had impaired limited range of motion on both sides of the upper and lower extremities. Resident #4 was dependent (the assistance of two or more helpers is required for the resident to complete the activity) with transfers, toileting, dressing, personal hygiene, eating and showering. Record review of the facility's Event Detail report, created by LVN F and dated 10/10/2024, reflected Resident #4 slid off the bed and landed on his buttocks without injury during a transfer from the recliner provided by CNA E. CNA E did not notice the lift pad was under Resident #4's feet when pulling back the lift. The Event Detail report reflected no pain or discomforts noted or delayed injury. Record review of the Visual/Kardex (a system that gives a brief overview of the resident's care) on 10/24/2024 used by the CNAs reflected Resident #4 required extensive assistance for lift transfers. Record review of the care plan, revised on 10/28/2024, reflected Resident #4 required assistance with ADLs with the interventions of Stand to Sit lift for transfers, required extensive assist from staff for all transfers, and keep call light within reach at all times. (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 observation on 10/29/2024 at 03:14 p.m., of a video provided by Resident #4's family, date stamped 10/10/2024, with muffled audio and visual revealed Resident #4 was sitting on the edge of the right side of the bedside. The Sit to Stand lift was in front of the resident. CNA E was standing behind the Stand to Sit lift and pulled the lift towards her. Resident #4 toppled to the right side and fell off the bed to the floor. CNA E was seen rushing toward Resident #4 as he was heard yelling. During an interview on 10/23/2024 at 10:47 a.m., Resident #4 said the facility staff dropped him approximately two weeks ago during a transfer. Resident #4 said when he was transferred sometimes only one staff assisted, and staff always seemed to be in a hurry. Resident #4 said he had not received any injury from the fall. An attempted telephone interview on 10/23/2024 at 10:55 a.m. to CNA E was unsuccessful. A recording was received which stated not accepting calls and unable to leave a message. During an interview on 10/24/2024 at 12:05 p.m., CNA G said she was aware of how to take care of residents by the report the charge nurse gave her or by the CNA who was on the previous shift would tell her what the resident required. CNA G said she did not look at the Kardex on the electronic charting system to verify how to take care of the residents because she received the information from the charge nurse or the previous shift CNA. CNA G said all residents who required a lift were a two-person assistance. CNA G said it was important for residents who required maximum or extensive assistance for transfers to have a two person staff assistance to prevent falls and injuries. During an interview on 10/24/2024 at 12:10 p.m., CNA C said she was aware of how to take care of residents by the report the charge nurse gave to her or by the CNA who was on the previous shift that would tell her what the resident required. CNA C said she did not look at the Kardex on the electronic charting system to verify how to take care of the residents because she received the information from the charge nurse or the previous shift CNA. CNA C said all residents who required a lift were a two-person assistance. CNA C said it was important for residents who required maximum or extensive assistance for transfers to have two person staff assistance to prevent falls and injuries. During an interview on 10/24/2024 at 12:55 p.m., LVN A said the CNA's got the information of how to take care of the residents from the 24-hour report or at shift change report from the previous shift CNA. LVN A said the DON was responsible of informing the CNA's of how to take care of the residents. LVN A stated he did not tell the CNA's how to take care of the residents while working as the charge nurse and he was not aware of how the CNAs would look at the resident's care plan. LVN A said it was important to follow the resident plan of care to prevent injuries and take care of the residents safely. An attempted telephone interview on 10/24/2024 at 01:55 p.m. with CNA E was unsuccessful. A recording was received which stated not accepting calls and unable to leave a message. (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 observation and interview on 10/29/2024 at 11:24 a.m., CNA B said Resident #4 was a two person assist for all transfers with a lift. CNA B said Resident #4 used the Hoyer lift or the Stand to Sit lift for all transfers. CNA B said all lifts required a two person assist. CNA B said she was trained at hire and maybe since then by Inservice on the Hoyer lift and the Stand to Sit lift. CNA B stated maximum and extensive assistance transfer required a two per assist. CNA B said she received all information on how to take care of the resident from the CNA on the previous shift. CNA B said if she had other questions regarding the resident's care, she asked the charge nurse. CNA B said she used the computer to chart the residents' activities of daily living and look up the plan of care to see any information on how to take care of the residents such as the required staff needed for performing an ADLs. CNA B was unable to show the State Surveyor how to access Resident #4's plan of care. CNA B showed the state surveyor the documentation requirement for ADLs but was not aware to click on the Plan of Care box at the top of the documentation page. Once CNA B was shown the Plan of Care box, CNA B was not aware of how to expand out the arrows to show the care requirements. CNA B required assistance from LVN M to find the plan of care on Resident #4 in the electronic computer system. CNA B said, what I meant was I would have to ask the charge nurse to show me the resident's plan of care. CNA B stated it was important for the safety of the resident and the staff to know how to take care of the resident properly to prevent injuries. During an interview on 10/29/2024 at 11:45 a.m., ADON K said the residents' status of a newly admitted resident was relayed in report from the discharging facility, found in the discharge paperwork, or relayed by the physician. ADON K said the status of a resident should be entered into the plan of care which populated into the care plan and activities of daily living for the CNAs to access. ADON K said the CNAs were able to look in the computer at the care plan, ask the nurse, or should have been given report by the nurse to know how to take care of the resident. ADON K said the DON was responsible for hiring and both ADONs assisted to complete the CNAs training. ADON K said the CNA's completed skills competency and worked with a seasoned CNA prior to working alone with residents. ADON K said it was important to follow the plan of care for each resident to prevent falls/injuries. ADON K said Resident #4 was an extensive assist for transfers which indicated he was a two person assist. ADON K said if two person assistance was not used the resident could suffer from an injury/injuries. Attempted telephone interview on 10/29/2024 at 2:29 p.m. to CNA E was unsuccessful. A recording was received which stated not accepting calls and unable to leave a message. During an interview and observation on 10/29/2024 at 4:07 p.m., the DON said the CNAs should have used the care plan which was located on the computer for necessary information on how to take care of the residents. The DON said the ADON was responsible upon hiring to train the CNAs to use the electronic charting system which contained the Kardex with the residents' plan of care. The DON said the new hire CNAs trained with an experienced CNA for further training after being educated on the electronic system. The DON said it was important for the plan of care to be used by all staff to prevent injuries and harm to the staff and residents while care was provided. After the DON reviewed the video of Resident #4, the DON said Resident #4 required a two person assistance when transferring and another staff member should had assisted to stabilize Resident #4 ton the bedside to prevent the fall. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER The Waterton at Cowhorn Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 5524 Cowhorn Creek Texarkana, TX 75503	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/2024 at 04:40 p.m., the Administrator said it was the responsibility of the DON, the ADONS and other clinical staff to train the CNA staff which included the care plan in the electronic system. The Administrator said the DON knew the needs of the residents and was able to verbally communicate the needs of the residents to the staff. The Administrator said the importance of staff knowing how to take care of the residents appropriately was to prevent falls and injuries. Record review of In-Service dated 10/11/2024, titled Hoyer Lift/Transfer Policy and Procedures- General Guidelines: Two (2) nursing assistants are required to perform this procedure. Equipment and Supplies: Lift and Sling. Procedure - To transfer a resident . Record review of CNA E's Staff Competency standards of practice for Hoyer Lift/Transfer was documented as met on 10/11//2024. Record review of the facility's Fall Prevention Program, revised 02/2020, reflected A successful fall risk management program requires organizational commitment and interdisciplinary team approach to prevent and minimize falls. Care Plan: Planned interventions that address the individualized intrinsic and extrinsic fall risk factors identified during the fall assessment		

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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** 30527 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 1 of 5 residents (Resident #2) reviewed for infection control practices and transmission-based precautions. The facility failed to ensure LVN A performed hand hygiene after he removed his gloves when he provided incontinent care to Resident #2 on 10/24/2024. This failure could place residents at risk for cross-contamination and the spread of infection. Findings include: Record review of Resident #2's care plan, revised on 03/06/2024, reflected Resident #2 required assistance with ADLs with the intervention of use of a bedpan for bowel and bladder with staff assistance. Record review of Resident #2's, undated face sheet reflected a [AGE] year-old female, who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included amyotrophic lateral sclerosis (progressive muscle weakness leading to difficulties with moving, speaking, breathing and swallowing), muscle weakness, other abnormalities of gait and mobility, other speech disturbances, pain, nasal congestion, anxiety disorders (characterized by significant and uncontrollable feelings of anxiety and fear such that a person's social, occupational, and personal functions are significantly impaired), urinary tract infection (infection that affects a part of the urinary tract), dyspnea (difficulty breathing) and hypertension (high blood pressure). Record review of the most recent comprehensive MDS, dated [DATE], reflected Resident #2 sometimes made herself understood and understands. Resident #2 had a BIMS score of 99, which indicated Resident #2 was unable to complete the assessment. Resident #2's short term and long-term memory was okay. Resident #2 rejected care necessary to achieve the resident's goals for health or well-being. Resident #2 required maximal assistance with bed mobility, transfers, toileting, dressing, personal hygiene, eating and was dependent with showering. During an observation on 10/24/2024 at 12:25 p.m. revealed LVN A and CNA C with gloved hands placed Resident #2 on the bedpan. LVN A then removed the bedpan and provided peri care. LVN A removed the dirty blue pad from under Resident #2 and disposed of it. LVN A removed his dirty gloves and applied clean ones. LVN A did not perform hand hygiene after removing his dirty gloves, prior to applying clean gloves. LVN A then applied Resident #2's panties, and then repositioned Resident #2 in the bed. LVN A removed his gloves and performed hand hygiene. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/2024 at 12:55p.m., LVN A said when providing incontinent /peri care, he was supposed to perform hand hygiene after removing his gloves. LVN A said he did not perform hand hygiene in between glove changes because he forgot. LVN A said he should have used hand sanitizer or washed his hands in the bathroom between glove changes. LVN A said it was important to perform hand hygiene while providing peri care, so he did not cross contaminate and increase the possibilities of urinary tract infections. During an interview on 10/29/2024 at 4:01 PM, the DON said she was the infection control preventionist. The DON said hand hygiene should be performed in between glove changes. The DON said she, the charge nurses, and the ADONs, were responsible for ensuring the CNAs performed adequate hand hygiene during incontinent and peri care. The DON said random checks were done with the CNAs to ensure they were performing proper hand hygiene and incontinent care. The DON said it was important to perform hand hygiene properly during incontinent care because the residents could get a urinary tract infection and sepsis (infection in the bloodstream). During an interview on 10/29/2024 at 4:41 PM, the Administrator said she expected all the staff to do proper hand washing and glove changes. The Administrator said the charge nurses and nurse management were responsible for ensuring the CNAs were performing proper hand hygiene. The Administrator said not performing hand hygiene adequately during incontinent care and peri care could lead to the spread of disease, bacteria and infections. The Administrator said she would email the handwashing policy. Record review of the facility's policy titled, Infection Prevention and Control Program, dated 11/2017, did not address handwashing - hand hygiene.		