

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 04/09/2025
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062</p> <p>Based on observation, interviews, and record review, the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 7 residents (Resident #1) reviewed for resident rights.</p> <p>The facility failed to ensure Resident #1 was treated with respect, dignity, and provided with care that enhanced her quality of life when:</p> <p>* CNA B told Resident #1 she wished she would tell her not to come back in her room and she guessed she would not be back in on that day.</p> <p>* CNA C hid a can of air freshener and sprayed the top of Resident #1's top of bed, pillow, and her head and then told Resident #1 It stank up in here, it stank up in here.</p> <p>* CNA D told Resident #1 she had 10 minutes; he would be in her room [ROOM NUMBER] minutes or less; it was frustrating for the both of them; and she should be thankful for the care she did receive.</p> <p>* CNA D did not provide Resident #1 with privacy while providing incontinent care.</p> <p>* CNA E asked Resident #1 twice in a loud and then in a louder voice if she needed anything else before she ate and then told her to not do all that hollering. CNA E did not give Resident #1 time to respond on her communication device and only quickly repeated the question louder.</p> <p>* CNA F did not take the time to listen to the needs of Resident #1 before telling her, she did not have time for all of it.</p> <p>These failures could place residents at risk of humiliation, diminished quality of life, loss of dignity and self-worth.</p> <p>Findings included:</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675949
		If continuation sheet Page 1 of 19

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's face sheet dated 4/08/25 indicated she was [AGE] years old and was admitted to the facility on [DATE]. Resident #11 had diagnoses which included ALS (Amyotrophic Lateral Sclerosis-progressive neurodegenerative disease that affects nerve cells in the brain and spinal cord, which progressively leads to the loss of the ability to speak, eat, move and breathe), muscle weakness, lack of coordination, anxiety (feeling of worry, dread, and uneasiness), speech disturbances, and hypertension (high blood pressure).</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was sometimes understood but understood others. Resident #1 had a BIMS score of 99 which indicated she was not able to complete the interview. Resident #1's short-term and long-term was okay and she was able to recall the location of her room, staff names and faces, and she was in a nursing home. Resident #1 did not have any behaviors and did not reject care. Resident #1 had impairment to upper and lower extremities. Resident #1 required substantial assistance in performing most ADLs. Resident #1 was occasionally incontinent of bowel and bladder. Resident #1 had shortness of breath or trouble breathing when lying flat. Resident #1 had coughing or choking during meals or when swallowing medications. Resident #1 received oxygen therapy.</p> <p>Record review of Resident #1's undated Care Plan indicated she had elected to use a camera/electronic monitoring device in her room with interventions to ensure staff and other residents were aware they were being recorded, ensure privacy was provided while providing personal care to resident; Resident #1 preferred not to be awakened to be checked on throughout the night and she would call for assistance when needed; Resident #1 had behavioral symptoms of exhibiting depressive/manipulative behaviors and agitation with staff with interventions if resident becomes agitated, exit and wait until a later time and reproach and staff to speak calmly, explain the procedure prior to providing care, give ample time for resident to respond, if she becomes upset, they will ensure her safety and allow her time to calm down before resuming care; Resident #1 had behavioral symptoms of resisting care with interventions to encourage resident to express feelings and fears, clarify misunderstandings, maintain a calm environment and approach to the resident, prepare and organize supplies before caring for resident, avoid delays and interruptions in care; Resident #1's ADL function stated she was maximum assist with all ADLs related to ALS, she used a bedpan for her bowel and bladder with staff assistance and would use her call light to alert staff; Resident #1 was on hospice services; Resident #1 had difficulty making herself understood related ALS with interventions to allow resident time to express herself, avoid interrupting, provide a quiet, non-hurried environment, free from distractions, and repeat what the resident had expressed to validate.</p> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of video footage dated 12/26/24 beginning at 07:48 AM, began with Resident #1 sitting up in bed, with oxygen tubing in her nose, in her room with her communication device on a stand in front of her. CNA B entered the room first and went to the head of Resident #1's right side (door side) and CNA C closely followed and went around the bed to Resident #1's left side (wall side). CNA C was holding an aerosol can down by her right side with the can held behind her upper leg/thigh area. Resident #1's attention was on CNA B as CNA B leaned over the top back of Resident #1's bed to look at the communication device screen and said, I can't read this. CNA C also leaned forward as if looking at the communication device and then took her right arm with the aerosol can in her hand and took her arm around the top of the bed and then with her pointer finger on the top of the aerosol can appeared to have sprayed the top of Resident #1's bed, pillow, and top of her head and then suddenly jerked her hand behind Resident #1's bed. Resident #1 then began to make noises that sounded between a cry and holler, and she had facial grimacing. CNA B left the view of the camera. CNA C then walked to the end of Resident #1's bed and she said what {Resident #1's name}, what is wrong, it was stank up in here, it was stank up in here. Resident #1 begun to holler louder and had increased facial grimacing and moving her legs. CNA C left the view of the camera but could be heard saying you don't won't me up in here and then returned and went to the head of Resident #1's bed and asked, you don't won't me up in your room and Resident #1 shook her head no and CNA C said alright and walked toward the door and off camera. CNA B could be heard saying out of the camera's view I wished you'd tell me that, well I don't guess I will come back in here today, I don't know. Then there was some other un-understandable conversation between CNA B and CNA C as they were apparently leaving Resident #1's room. End of video clip.</p> <p>Record review of video footage dated 12/27/24 beginning at 12:22 PM, started with Resident #1 sitting up in bed with her communication device on a stand in front of her and CNA E standing at the side of the bed with linen in her right hand. Resident #1 was making moan-like noises. CNA E quickly put the linen down on top of Resident #1's leg area of bed and abruptly reached up and grabbed Resident #1 by both shoulders and roughly moved her to a more upright position. CNA E then said, anything else you need before you eat and then said in a louder voice anything else you need before you eat, don't do all that hollering, cause, cause, I can't do it. End of video clip.</p> <p>Record review of video footage dated 3/18/25 beginning at 6:45 AM, started with Resident #1 sitting up in the bed with her communication device in front of her on a stand. CNA F was in Resident #1's room gathering supplies and Resident #1's communication device was telling CNA F that she needed her call light moved down, she needed her mouth wiped, to brush her hair, and to not put her butt on the bed after she wiped her because she was on her period. CNA F then moved Resident #1's communication device away from the resident to get ready to provide care and while the communication device was telling what Resident #1 needed, CNA F told Resident #1 I can't do all that this morning, honey, because I'm on the other and the device was continuing to talk in the background and the video clip ended.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of video footage dated 4/02/25 beginning at 15:22 PM (3:22 PM), started with Resident #1 sitting up in bed with her communication device in front of her on a stand. CNA D entered Resident #1's room and he said it's 3:23. Resident #1's communication device said, I need to be safe before you leave. CNA D did not respond. CNA D then went to Resident #1's right side of her bed and moved her communication device away from the bed and had a bedpan and a blue waterproof pad in his hand. CNA D as he walked around Resident #1's bed to her left side, said, this is gonna be frustrating for both of us, cause I like to play games too. CNA D then picked up her bed remote and walked back around Resident #1's bed to her right side and then placed the bedpan on the floor and as he was removing her top linens he said I'm not gonna be in here for more than 10 minutes. I'm in here 10 minutes or less and that is it. CNA D said, as he looked toward Resident #1's roommate, I did her in 7 minutes. Then with Resident #1 lying on the bed with only a brief on her lower body, CNA D began placing the blue waterproof pad under Resident #1's bottom and he said, you ought to be grateful for the help that you do get. Resident #1 could be heard making grunting like noises throughout the video. CNA D then began to unfasten Resident #1's adult brief without providing privacy for her and then the video clip ended.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 4/08/25 at 2:10 PM, Resident #1 was sitting up in bed and used a communication tablet on a stand in front of her that she used by having a metal like dot on her forehead that acted like a wireless mouse, and she was able to use slight head movements to type her conversations. The communication tablet allowed for Resident #1 to turn the typed words to be read aloud by the device if she chose to. Resident #1 said she had little to no movement of her body but was able to push the touch pad call light for assistance when needed. Resident #1 said on the day of the air freshener incident on 12/26/24, CNA B had previously sprayed air freshener in her room, and she had asked CNA B then to not spray air freshener in her room because it irritated her breathing, and she had no way to cover her nose or mouth. Resident #1 said then later, CNA C snuck air freshener into her room and sprayed it right on her and then laughed. Resident #1 said when she realized CNA C had sprayed air freshener, she became very upset and felt it was done intentionally to hurt her because she had already told CNA B it irritated her breathing. Resident #1 said with her disease she was unable to effectively cough to clear secretions in her lungs. Resident #1 said CNA C did not work at the facility any longer. Resident #1 said she sent an email to ADON A reporting the incident. The resident said the air freshener had to stop because she had compromised breathing, used oxygen, was in an enclosed space with no outside ventilation, and she no way to cover her mouth or eyes. Resident #1 said the staff did not take the time to let her explain what she needed due to it took her a while to type out her needs on the tablet. Resident #1 said the staff did not check on her every two hours and when she pushed her call light, they did not answer it timely. Resident #1 said she felt like the staff intentionally ignored her at times because they know she takes longer than the other residents. Resident #1 said often when staff do come in to assist her with the bed pan or other care, they are rough and talk rudely and made it very apparent they did not want to be providing her care. Resident #1 said staff would also come in and turn her light off and then tell her she would have to wait until they finished their rounds on the other residents before they could get her on the bedpan. Resident #1 said her bladder and bowels were one of the few things she had control over, and she felt that the staff should provide her care when she needed it, so it did not put her in a hardship to be holding it until they finished their rounds. Resident #1 said she felt a continent resident needing to be put on the bed pan should take precedent over an incontinent resident that had a brief. Resident #1 said it was emotionally and physically hard on her. Resident #1 said she would also type up notes prior to staff coming in to play for the staff when they did come in to try to get them to do everything she needed, but often times they would tell her they did not have time or did not even take the time to listen to what she needed and rushed in and rushed out. Resident #1 said she had to be fed by the staff and the staff would get irritated at her because it took her so long to eat and they would talk bad to her. Resident #1 said often times she was still trying to swallow one bite of food and the staff were trying to feed her another bite and when she could not take another bite right then, the staff would say I guess you're done eating and take her food away and she was still hungry. Resident #1 said the staff often do not give her time to respond and let them know she was still hungry and rush out. Resident #1 said her muscles in her mouth, tongue, and throat are weak and it took her a long time to maneuver the food in her mouth and to be able to swallow it, and they had to often take her food back and re-blend it because it had clumps in it and her food had to be the consistency of baby food. Resident #1 said it did take a long time to feed her, but it was not something she could help or change because of her disease. She said there was one time she pushed her call light because she could not move her head, could not type her needs, was having difficulty breathing, and the only thing she could do was scream trying to get help and instead of trying to help her or try to figure out what was wrong, the nurse treated her like a kid and told her to calm down and she would be back when she calmed down. Resident #1 said it was a scary situation to not be able to breathe and no one would help her. Resident #1 said she often hollers or screams when staff would not give her time to communicate on her tablet and she knew once they left her room it would be a long time before they returned. Resident #1 said in the video where CNA E was rough with her when she positioned her more upright in bed and then hollered at her anything else before I leave, anything else before I leave and CNA E told her do not do all that hollering and would not even give her time to respond. Resident #1 said she felt CNA E was trying to harm her and she knew the aide was irritated at her. Resident #1 said CNA E no longer worked at the facility. Resident #1 said when she was not given time to respond on her tablet, the only thing she could do was make hollering type noises and it was very frustrating to her and caused her a lot of anxiety when the staff would not take</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/08/25 at 5:46 PM, Resident #1's RP said there was a camera in Resident #1's room. Resident #1's RP said she took the video of the aide spraying something over Resident #1's head to the ADM the day after it happened and told the ADM she wanted something done about it and nothing was done. Resident #1's RP said when they had her last care plan meeting in March, she got with the OMB and showed them several videos of how staff were treating Resident #1 during the meeting. Resident #1's RP said the staff often rushed Resident #1 to eat, and if she did not take a bite quick enough, the staff would say, I guess you are done eating, and would not allow her time to respond and then took her food away. Resident #1's RP said Resident #1 had to eat slow because her muscles used to swallow were weak and she had to move her food around in her mouth and get things just right to swallow. Resident #1's RP said staff have even said things in front of her about not giving a damn about the camera and talk bad and treat her bad even with the camera. Resident #1's RP said staff were slow to put her on the bed pan if she called and needed it, then one aide even told her she had 7 minutes to finish. Resident #1's RP said it was very sad how the staff treated Resident #1 when she was totally dependent on staff for all her care and ADLs.</p> <p>During an interview on 4/09/25 at 10:45 AM, the DON said the only video she had seen was when CNA C sprayed the air freshener behind Resident #1's head. The DON viewed the other videos and identified the staff member in the turquoise uniform as CNA E, the staff member in the red uniform as CNA F, and CNA B as the other aide with CNA C.</p> <p>On 4/09/25 at 11:29 AM, called CNA C but it was not a working number and requested another number if available from the ADM. On 4/09/25 at 11:39 AM, an email was sent to the email listed in her employment application documents. On 4/09/25 at 11:52 AM, called the other number provided by the ADM and it was also not a working number. On 4/09/24 at 12:36 PM, the DON also messaged CNA C on Facebook Messenger requesting a return call. The DON said CNA C no longer worked at the facility and she did not have any other way to contact her. CNA C did not return any of the messages prior to exiting the facility.</p> <p>On 4/09/25 at 12:04 PM and at 4:30 PM, called CNA E but there was no answer and was unable to leave a message because the mailbox had not been set up. The DON said CNA E no longer worked at the facility and she did not have another phone number for her. CNA E did not return call prior to exiting the facility.</p> <p>On 4/09/25 at 12:10 PM and 4:35 PM, called CNA F but there was no answer and voicemails were left requesting a return call. The DON said she did not have any other numbers for CNA F. CNA F did not return call prior to exiting the facility.</p> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/09/25 at 1:57 PM, CNA B said she had worked at the facility for almost a year and normally worked the 6AM-2PM on the 300/400 halls. CNA B said she had not witnessed any abuse or neglect in the facility, and she would report to the ADM if she did. CNA B said if a resident turned on their call light during her rounds, she would stop and see what they wanted/needed, and would take care of their needs at that time. CNA B said she did not tell residents that she had to complete rounds first but she might have to find help to assist on the 2 person assistance residents. CNA B said Resident #1 was at times very needy, but they do the best of their ability to meet her needs and do what she wants. CNA B said she did feed Resident #1 and it usually took 1-2 hours to feed her. CNA B said a lot of times they had to stop and fix her something else and puree (blend) it because she kept food in her room. CNA B said if Resident #1 did not finish the food, she would usually ask for it to be put in her refrigerator and then she would eat the rest for supper. CNA B said she had not witnessed any staff talk to Resident #1 in a mean manner, but sometimes you have to be stern with her. CNA B said sometimes Resident #1 just did not seem to understand why they were able to come right to her, if they had other things going on with other patients at the time. CNA B said sometimes Resident #1 probably waited longer than she wanted because she may have to find help because Resident #1 required two staff for assistance and Resident #1 would start screaming and she also had an alarm on her device that she would set off. CNA B said Resident #1 was always continent in the bed pan and had not used the bathroom in a brief with her. CNA B said on the day of the incident about the air freshener, Resident #1's room had an odor. CNA B said Resident #1 used all natural soaps and deodorant and sometimes there was an odor. CNA B said she had not been told Resident #1 did not want air fresheners used in her room. CNA B said she did not recall spraying any air freshener in Resident #1's room prior to the incident and Resident #1 asking her not to because it irritated her breathing. CNA B said she did not know why CNA C sprayed it the way she did. CNA B said there was no discussion with CNA B prior to entering Resident #1's room about the air freshener. CNA B said CNA C should not had said it stank up in here to Resident #1. CNA B said she did not feel CNA C spraying the air freshener above Resident #1's head was abusive. CNA B said Resident #1 started screaming right after the spray was sprayed and she assumed Resident #1 was screaming because of the spray. CNA B said it was not appropriate to tell Resident #1, I wish she would tell me that (but would not confirm that it was her on the video out of the camera's view). CNA B said it probably made the resident feel unwanted and that you did not want to take care of her. CNA B said it could possibly be a dignity issue also. CNA B said they now, have a different aides assigned to Resident #1 daily, but one aide feeds her breakfast, and a different aide feeds her lunch, or that was at least the way it was done on day shift and not sure about the other shifts.</p> <p>During an interview on 4/09/25 at 4:09 PM, ADON A said she had been the ADON on the 100/200 hall since February and was on the 300/400 prior to that. ADON A said Resident #1 was a 2 person assist except with feeding. ADON A said Resident #1 was very picky on how she wanted things, how she wanted her food, how her clothes fit, how she wanted her panties and sheets fixed, and ADON A said it was a lot. ADON A said she had not witnessed staff mistreat her. ADON A said she had received reports of staff mistreating Resident #1 from Resident #1 from her typing it on her device and then ADON A said she reported it to the ADM and the DON. ADON A said she had received emails from Resident #1, and she forwarded the emails to the ADM when she received them. ADON A said the main emails she received from Resident #1 that she remembered was related to the staff taking too long to put her on the bed pan. ADON A said she was sure it made Resident #1 feel some type of way and it affected her to be told she had ten minutes to use the bed pan. ADON A said Resident #1 probably feels like she was a burden and impacted her dignity.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/09/25 at 4:20 PM, the Regional Nurse reviewed the videos and said it was definitely poor customer service with the incident of spraying the air freshener. The Regional Nurse reviewed the video of CNA E and said the moving of the resident was not as bad as she had been told by the DON, but it was not how the staff should have treated the resident or how the staff should have positioned the resident. The Regional Nurse said the video of the male aide giving the resident 10 minutes to go to the bathroom was unacceptable and not how a resident should be treated. The Regional Nurse said she may need to do more education with the staff to educate them on Resident #1's disease and the need to be patient and provide her time to communicate her needs.</p> <p>During an interview on 4/09/25 at 4:31 PM, CNA D said he had worked at the facility this time for approximately 4 months. CNA D said abuse could be talking to residents bad or not changing them. CNA D said if a resident asked you to do something for them, you should do it. CNA D said he loved his job and had a kind heart. CNA D said he thinks he was overworked the day the video showed and was a little irritated that day. CNA D said he had been very good to Resident #1, and he thinks he was just trying to get his showers in that day. CNA D said he did not think it was fair to the other residents when he gets stuck in Resident #1's room providing care and his other residents suffer. CNA D said it was overwhelming at times. CNA D said he should have walked away for a few minutes because he was overwhelmed and not said the things he said to Resident #1. CNA D said it what he said probably made Resident #1 feel bad. CNA D said he felt he was one of the best aides working at the facility and he had one bad day.</p> <p>During an interview on 4/09/25 at 4:44 PM, the DON said CNA C was trying to hide some spray from the resident. The DON said she thought Resident #1 was into natural products and may have had an odor. The DON said she had not heard at any time that Resident #1 did not want sprays used in her room, until after the incident. The DON said CNA E had an attitude with Resident #1 and it was not great customer service. The DON said she could not answer for Resident #1 but knew how it would have made her feel and she would have been mad because of the attitude she had and how she positioned her up in the bed. The DON said CNA D was definitely rushing to care for Resident #1. The DON said she just thinks all of the staff had just terrible customer service, but the resident should never know that you are having a bad day. The DON said patience went a long. The DON said the resident should feel very comfortable while receiving care. The DON said it probably made her feel like a burden.</p> <p>During an interview on 4/09/25 at 5:16 PM, the ADM said the only video she had seen previously was the incident with CNA C spray the air freshener. The ADM said if she did not know about it then she could not fix it. The ADM said she expected her residents to be treated with dignity. The ADM said CNA B and CNA C should not have talked to the resident that way and she did write up CNA C for customer service. The ADM said CNA D talking to the resident that way probably made her feel bad and not good, but she could not fix everything if she did not know about it. The ADM said every month she preached about burnout and customer service to her staff. The ADM said she agreed CNA E was rough with the resident when position her and was rude to the resident. The ADM said CNA E was rushed and appeared to be on the rougher side. The ADM said CNA F was a good aide but should have taken the time to listen to the resident's communication about her needs. The ADM said she was ultimately responsible for everything in the facility because it was her license but did not feel it was fair to be cited when she had no prior knowledge of the incidents.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's policy titled Resident Rights dated revised February 2021 indicated . employees shall treat all residents with kindness, respect, and dignity . federal and state laws guarantee certain basic rights to all residents of this facility . these rights include the resident's right to . a dignified existence . be treated with respect, kindness, and dignity . self-determination . communication with and access to people and services, both inside and outside the facility . be supported by the facility in exercising his or her rights . exercise his or her without interference, coercion, discrimination or reprisal from the facility . voice grievances to the facility, or tother agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal . have the facility respond to his or her grievances .</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062</p> <p>Based on interview, observation and record review, the facility failed to file a grievance report and investigate the grievance reported by a resident's representative for 1 of 7 residents (Resident #1) reviewed for grievances.</p> <p>The facility failed to investigate Grievances/concerns when Resident #1 reported to ADON A by emails on 1/05/25, 2/03/25, and 2/06/25 related to the lack of care she was receiving and not answering her call light.</p> <p>The facility failed to document Resident #1's grievances/concerns on the Grievance/Concerns log forms for the reported dates of 1/05/25, 2/03/25, and 2/06/25.</p> <p>These deficient practices could place residents at risk for abuse, neglect, and not having their needs met.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 4/08/25 indicated she was [AGE] years old and was admitted to the facility on [DATE]. Resident #11 had diagnoses which included ALS (Amyotrophic Lateral Sclerosis-progressive neurodegenerative disease that affects nerve cells in the brain and spinal cord, which progressively leads to the loss of the ability to speak, eat, move and breathe), muscle weakness, lack of coordination, anxiety (feeling of worry, dread, and uneasiness), speech disturbances, and hypertension (high blood pressure).</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was sometimes understood but understood others. Resident #1 had had a BIMS score of 99 which indicated she was not able to complete the interview. Resident #1's short-term and long-term was okay and she was able to recall the location of her room, staff names and faces, and she was in a nursing home. Resident #1 did not have any behaviors and did not reject care. Resident #1 had impairment to upper and lower extremities. Resident #1 required substantial assistance in performing most ADLs. Resident #1 was occasionally incontinent of bowel and bladder. Resident #1 had shortness of breath or trouble breathing when lying flat. Resident #1 had coughing or choking during meals or when swallowing medications. Resident #1 received oxygen therapy.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's undated Care Plan indicated she had elected to use a camera/electronic monitoring device in her room with interventions to ensure staff and other residents were aware they were being recorded, ensure privacy was provided while providing personal care to resident; Resident #1 preferred not to be awakened to be checked on throughout the night and she would call for assistance when needed; Resident #1 had behavioral symptoms of exhibiting depressive/manipulative behaviors and agitation with staff with interventions if resident becomes agitated, exit and wait until a later time and reproach and staff to speak calmly, explain the procedure prior to providing care, give ample time for resident to respond, if she becomes upset, they will ensure her safety and allow her time to calm down before resuming care; Resident #1 had behavioral symptoms of resisting care with interventions to encourage resident to express feelings and fears, clarify misunderstandings, maintain a calm environment and approach to the resident, prepare and organize supplies before caring for resident, avoid delays and interruptions in care; Resident #1's ADL function stated she was maximum assist with all ADLs related to ALS, she used a bedpan for her bowel and bladder with staff assistance and would use her call light to alert staff; Resident #1 was on hospice services; Resident #1 had difficulty making herself understood related ALS with interventions to allow resident time to express herself, avoid interrupting, provide a quiet, non-hurried environment, free from distractions, and repeat what the resident had expressed to validate.</p> <p>Record review of Resident #1's emails sent to ADON A indicated:</p> <p>* On 1/05/25 at 4:43 AM, email with a subject line of can not get care and reported they don't answer my light, just ignore me completely two hours, they can't do this, neglect, I know staff is out there, I need to go to the bathroom, they can't do this, please do something to stop this it's not right, they are supposed to be caring for me.</p> <p>* On 2/3/25 at 7:55 AM, email with a subject line of aides don't answer my call light and reported ADON A, I have been waiting on my light for forty-five minutes, there are at least three aides out at the desk . talking and laughing, I am being intentionally ignored, please forward this to somebody that will help, somebody who is a supervisor, this is every day not just today, I don't even know who my aide is.</p> <p>* On 2/6/25 at 11:53 AM, email with a subject line of help please call reported I have had my light on since she left me at breakfast at nine thirty because I need my head back, now I need the bed pan and breathing treatment and I have no way to call for help, she has not been in here . the nurse does not give my scheduled breathing treatments, . the aide won't come in here at lunch because they have someone else feeding me that can't do bed pan, this is ridiculous.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 4/08/25 at 2:10 PM, Resident #1 was sitting up in bed and used a communication tablet on a stand in front of her that she used by having a metal like dot on her forehead that acted like a wireless mouse, and she was able to use slight head movements to type her conversations. The communication table allowed for Resident #1 to turn the typed words to be read aloud by the device if she chose to. Resident #1 said she had little to no movement of her body but was able to push the touch pad call light for assistance when needed. Resident #1 said the staff did not take the time to let her explain what she needed due to it took her a while to type out her needs on the tablet. Resident #1 said the staff did not check on her every two hours and when she pushed her call light, they did not answer it timely. Resident #1 said she felt like the staff intentionally ignored her at times because they know she takes longer than the other residents. Resident #1 said often when staff do come in to assist her with the bed pan or other care, they are rough and talk rudely and made it very apparent they did not want to be providing her care. Resident #1 said staff would also come in and turn her light off and then tell her she would have to wait until they finished their rounds on the other residents before they could get her on the bedpan. Resident #1 said her bladder and bowels were one of the few things she had control over, and she felt that the staff should provide her care when she needed it, so it did not put her in a hardship to be holding it until they finished their rounds. Resident #1 said she felt a continent resident needing to be put on the bed pan should take precedent over an incontinent resident that had a brief. Resident #1 said it was emotionally and physically hard on her. Resident #1 said she often hollers or screams when staff would not give her time to communicate on her tablet and she knew once they left her room it would be a long time before they returned. Resident #1 said ADON A was the only staff member that gave her their email address. Resident #1 said it was easier for her to type an email and send her concerns and/or complaints to when she was not rushed and felt by sending an email to ADON A, she would ensure her concerns and/or complaints would be given to someone that could help resolve the issues.</p> <p>During an interview on 4/09/25 at 4:09 PM, ADON A said she had been the ADON on the 100/200 hall since sometime in February 2024 and had been on the 300/400 hall prior to that. ADON A said she had worked at the facility for three years. ADON A said Resident #1 resided on the 400 hall. ADON A said Resident #1 was very picky on how she wanted things, how she wanted her food, how her clothes fit, how she wanted her panties and sheets fixed, and ADON A said it was a lot. ADON A said she had not witnessed staff mistreat her. ADON A said she had received reports of staff mistreating Resident #1 from Resident #1 from her typing it on her device and then ADON A said she reported it to the ADM and the DON. ADON A said she had received emails from Resident #1, and she forwarded the emails to the ADM when she received them. ADON A confirmed the email address used by Resident #1 to send her grievances/concerns too. ADON A said she did not have access to her old emails since the facility was purchased by the new company and she received a new email address, and she did not recall the dates of the emails received from Resident #1. ADON A said the main emails she received from Resident #1 that she remembered was related to the staff taking too long to put her on the bed pan. ADON A said she was sure it made Resident #1 feel some type of way and probably feels like she was a burden and impacted her dignity. ADON A said residents grievances/concerns should be addressed timely.</p> <p>During an interview on 4/09/25 at 4:44 PM, the DON said when she received grievances/complaints from residents, she would address the grievance/concern and put them on the Grievance/Concern Form. The DON said usually the SW received the grievances/complaints and then they would discuss the grievances/complaints in the morning meetings and address them and go on. The DON said if the resident had a grievance/complaint, it should be addressed timely to ensure the needs of the resident were being met. The DON said not having her grievances/concerns addressed timely probably made Resident #1 feel bad.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/09/25 at 5:08 PM, the SW said when someone would tell her a resident had a grievance, she would go talk to the resident and document the resident's grievance on the Grievance/Concern Form, unless it was a simple fix then she would just get it fixed and did not put on the form. The SW said sometimes the ADM would address the grievances/complaints herself or the ADM would give her the information to follow up on the grievance/complaint. The SW said she did not recall receiving any grievances/complaints related to Resident #1. The SW said if it was related to the nursing department, then she usually did not receive those emails. The SW said it would be frustrating for the resident if the facility was not addressing their grievances/complaints.</p> <p>During an interview on 4/09/25 at 5:16 PM, the ADM said she had received some emails from ADON A related to Resident #1's complaints. The ADM said when she received a Grievance/concern, they talked to all staff members involved in the complaint and took statements from everyone involved. The ADM said she kept a separate file with Resident #1's grievances/concerns and investigated and addressed the situations as needed. The ADM said she did not recall getting the emails that were addressed to ADON A with the correlating dates and she could not fix something if she did not know about it. The ADM said maybe she needed to talk to Resident #1 and give Resident #1 her direct email, so things did not get missed. The ADM said she did not have any documentation of addressing the emails that were sent to ADON A related to Resident #1's care. The ADM said if she did not know about it then she could not fix it. The ADM said she expected her residents to be treated with dignity and to have their grievances/concerns addressed. The ADM said she was ultimately responsible for ensuring the residents grievances/concerns were addressed.</p> <p>Record review of the facility's Grievance/Complaint Log from 11/2024 through 4/2025 revealed there was only one grievance/complaint from Resident #1 on 11/12/24 of she did not like the way the CNA had fed her. There were no other complaints logged for Resident #1 for the months of 12/2024 through 4/2025.</p> <p>Record review of the facility's grievance policy titled Grievances/Complaints, Staff Responsibility dated revised October 2017 reflected . staff members were encouraged to guide residents about where and how to file a grievance and/or complaint when the resident believed that his/her rights had been violated . should a staff member overhear or be the recipient of a complaint voiced by a resident, a resident's representative, or another family member of a resident concerning the resident's medical care, treatment, food, clothing, or behavior of other residents, etc., the staff member was encouraged to guide the resident, or person acting on the resident's behalf, as to how to file a written complaint with the facility . staff members would inform the resident or the person acting on the resident's behalf that he or she could file a grievance or complaint with the administrator or other government agencies . without fear of threat or any other form of reprisal . staff members would inform the resident or the person acting on the resident's behalf as to where to obtain a Resident Grievance/Complaint Form and where to locate the procedures for filing a grievance or complaint . any alleged abuse, neglect, exploitation or mistreatment . must be reported to the administrator immediately .</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 1 of 7 residents (Resident #1) reviewed for resident abuse.</p> <p>1. The facility failed to ensure Resident # 1 was free from abuse when CNA C hid a can of air freshener and sprayed the top of Resident #1's top of bed, pillow, and her head on 12/26/24.</p> <p>2. The facility failed to ensure Resident #1 was free from abuse when CNA E abruptly grabbed Resident #1 by both shoulders and roughly positioned her more upright in bed and spoke to her in a loud rude tone on 12/27/24.</p> <p>These failures could place residents at risk of physical harm, mental anguish, and/or emotional distress.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet dated 4/08/25 indicated she was [AGE] years old and was admitted to the facility on [DATE]. Resident #11 had diagnoses which included ALS (Amyotrophic Lateral Sclerosis-progressive neurodegenerative disease that affects nerve cells in the brain and spinal cord, which progressively leads to the loss of the ability to speak, eat, move and breathe), muscle weakness, lack of coordination, anxiety (feeling of worry, dread, and uneasiness), speech disturbances, and hypertension (high blood pressure).</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was sometimes understood but understood others. Resident #1 had had a BIMS score of 99 which indicated she was not able to complete the interview. Resident #1's short-term and long-term was okay and she was able to recall the location of her room, staff names and faces, and she was in a nursing home. Resident #1 did not have any behaviors and did not reject care. Resident #1 had impairment to upper and lower extremities. Resident #1 required substantial assistance in performing most ADLs. Resident #1 was occasionally incontinent of bowel and bladder. Resident #1 had shortness of breath or trouble breathing when lying flat. Resident #1 had coughing or choking during meals or when swallowing medications. Resident #1 received oxygen therapy.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's undated Care Plan indicated she had elected to use a camera/electronic monitoring device in her room with interventions to ensure staff and other residents were aware they were being recorded, ensure privacy was provided while providing personal care to resident; Resident #1 preferred not to be awakened to be checked on throughout the night and she would call for assistance when needed; Resident #1 had behavioral symptoms of exhibiting depressive/manipulative behaviors and agitation with staff with interventions if resident becomes agitated, exit and wait until a later time and reproach and staff to speak calmly, explain the procedure prior to providing care, give ample time for resident to respond, if she becomes upset, they will ensure her safety and allow her time to calm down before resuming care; Resident #1 had behavioral symptoms of resisting care with interventions to encourage resident to express feelings and fears, clarify misunderstandings, maintain a calm environment and approach to the resident, prepare and organize supplies before caring for resident, avoid delays and interruptions in care; Resident #1's ADL function stated she was maximum assist with all ADLs related to ALS, she used a bedpan for her bowel and bladder with staff assistance and would use her call light to alert staff; Resident #1 was on hospice services; Resident #1 had difficulty making herself understood related ALS with interventions to allow resident time to express herself, avoid interrupting, provide a quiet, non-hurried environment, free from distractions, and repeat what the resident had expressed to validate.</p> <p>Record review of Resident #1's Order Summary Report dated 4/08/25 revealed an order for Albuterol (medication works by opening the airways to make breathing easier) 0.083 % inhale the contents of 1 vial by nebulizer (turns liquid medication into an aerosol that can be inhaled) three times a day before meals, with an order date of 7/31/24; Albuterol 0.083 % updraft 1 vial every four hours as needed, with an order date of 6/28/24.</p> <p>Record review of Resident #1's email sent to ADON A on 12/26/24 at 8:09 AM titled {CNA C's name} sprayed air freshener on me stated to please get video 12/26 7:30-7:50 AM . CNA B sprayed a air freshener in here . telling her not to, that it irritates my breathing and she had CNA C come in here and stand over my bed and spray it right on me and then laughed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of video footage dated 12/26/24 beginning at 07:48 AM, began with Resident #1 sitting up in bed, with oxygen tubing in her nose, in her room with her communication device on a stand in front of her. CNA B entered the room first and went to the head of Resident #1's right side (door side) and CNA C closely followed and went around the bed to Resident #1's left side (wall side). CNA C was holding an aerosol can down by her right side with the can held behind her upper leg/thigh area. Resident #1's attention was on CNA B as CNA B leaned over the top back of Resident #1's bed to look at the communication device screen and said, I can't read this. CNA C also leaned forward as if looking at the communication device and then took her right arm with the aerosol can in her hand and took her arm around the top of the bed and then with her pointer finger on the top of the aerosol can appeared to have sprayed the top of Resident #1's bed, pillow, and top of her head and then suddenly jerked her hand behind Resident #1's bed. Resident #1 then began to make noises that sounded between a cry and holler, and she had facial grimacing. CNA B had left the view of the camera. CNA C then walked to the end of Resident #1's bed and she said what {Resident #1's name}, what is wrong, it was stank up in here, it was stank up in here. Resident #1 begun to holler louder and had increased facial grimacing and moving her legs. CNA C left the view of the camera but could be heard saying you don't won't me up in here and then returned and went to the head of Resident #1's bed and asked, you don't won't me up in your room and Resident #1 shook her head no and CNA C said alright and walked toward the door and off camera. CNA B could be heard saying out of the camera's view I wished you'd tell me that, well I don't guess I will come back in here today, I don't know. Then there was some other un-understandable conversation between CNA B and CNA C as they were apparently leaving Resident #1's room. End of video clip.</p> <p>Record review of video footage dated 12/27/24 beginning at 12:22 PM, started with Resident #1 sitting up in bed with her communication device on a stand in front of her and CNA E standing at the side of the bed with linen in her right hand. Resident #1 was making moan-like noises. CNA E quickly put the linen down on top of Resident #1's leg area of bed and abruptly reached up and grabbed Resident #1 by both shoulders and roughly moved her to a more upright position. CNA E then said, anything else you need before you eat and then said in a louder voice anything else you need before you eat, don't do all that hollering, cause, cause, I can't do it. End of video clip.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 4/08/25 at 2:10 PM, Resident #1 was sitting up in bed and used a communication tablet on a stand in front of her that she used by having a metal like dot on her forehead that acted like a wireless mouse, and she was able to use slight head movements to type her conversations. The communication tablet allowed for Resident #1 to turn the typed words to be read aloud by the device if she chose to. Resident #1 said she had little to no movement of her body but was able to push the touch pad call light for assistance when needed. Resident #1 said on the day of the air freshener incident on 12/26/24, CNA B had previously sprayed air freshener in her room, and she had asked CNA B then to not spray air freshener in her room because it irritated her breathing, and she had no way to cover her nose or mouth. Resident #1 said then later, CNA C snuck air freshener into her room and sprayed it right on her and then laughed. Resident #1 said when she realized CNA C had sprayed air freshener, she became very upset and felt it was done intentionally to hurt her because she had already told CNA B it irritated her breathing. Resident #1 said with her disease she was unable to effectively cough to clear secretions in her lungs. Resident #1 said CNA C did not work at the facility any longer. Resident #1 said she sent an email to ADON A reporting the incident. The resident said the air freshener had to stop because she had compromised breathing, used oxygen, was in an enclosed space with no outside ventilation, and she no way to cover her mouth or eyes. Resident #1 said the staff did not take the time to let her explain what she needed due to it took her a while to type out her needs on the tablet. Resident #1 said the staff did not check on her every two hours and when she pushed her call light, they did not answer it timely. Resident #1 said she felt like the staff intentionally ignored her at times because they knew she takes longer than the other residents. Resident #1 said often when staff do come in to assist her with the bed pan or other care, they are rough and talk rudely and made it very apparent they did not want to be providing her care. She said there was one time she pushed her call light because she could not move her head, could not type her needs, was having difficulty breathing, and the only thing she could do was scream trying to get help and instead of trying to help her or try to figure out what was wrong, the nurse treated her like a kid and told her to calm down and she would be back when she calmed down. Resident #1 said it was a scary situation to not be able to breathe and no one would help her. Resident #1 said she often hollers or screams when staff would not give her time to communicate on her tablet and she knew once they left her room it would be a long time before they returned. Resident #1 said in the video where CNA E was rough with her when she positioned her more upright in bed and then hollered at her anything else before I leave, anything else before I leave and CNA E told her do not do all that hollering and would not even give her time to respond. Resident #1 said she felt CNA E was trying to harm her and she knew the aide was irritated at her. Resident #1 said CNA E no longer worked at the facility. Resident #1 said when she was not given time to respond on her tablet, the only thing she could do was make hollering type noises and it was very frustrating to her and caused her a lot of anxiety when the staff would not take the time to listen to her needs.</p> <p>During an interview on 4/08/25 at 5:46 PM, Resident #1's RP said there was a camera in Resident #1's room. Resident #1's RP said she took the video of the aide spraying something over Resident #1's head to the ADM the day after it happened and told the ADM it was abuse and she wanted something done about it and nothing was done. Resident #1's RP said when they had her last care plan meeting in March, she got with the OMB and showed them several videos of how staff were treating Resident #1 during the meeting. Resident #1's RP said it was very sad how the staff treated Resident #1 when she was totally dependent on staff for all her care and ADLs.</p> <p>During an interview on 4/09/25 at 10:45 AM, the DON said the only video she had seen was when CNA C sprayed the air freshener behind Resident #1's head. The DON viewed the other videos and identified the staff member in the turquoise uniform as CNA E, and CNA B as the other aide with CNA C.</p> <p>(continued on next page)</p>		

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 04/09/2025
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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/09/25 at 11:29 AM, called CNA C but it was not a working number and requested another number if available from the ADM. On 4/09/25 at 11:39 AM, an email was sent to the email listed in her employment application documents. On 4/09/25 at 11:52 AM, called the other number provided by the ADM and it was also not a working number. On 4/09/24 at 12:36 PM, the DON also messaged CNA C on Facebook Messenger requesting a return call. The DON said CNA C no longer worked at the facility and she did not have any other way to contact her. CNA C did not return any of the messages prior to exiting the facility.</p> <p>On 4/09/25 at 12:04 PM and at 4:30 PM, called CNA E but there was no answer and was unable to leave a message because the mailbox had not been set up. The DON said CNA E no longer worked at the facility and she did not have another phone number for her. CNA E did not return call prior to exiting the facility.</p> <p>During an interview on 4/09/25 at 1:57 PM, CNA B said she had worked at the facility for almost a year and normally worked the 6AM-2PM on the 300/400 halls. CNA B said she had not witnessed any abuse or neglect in the facility, and she would report to the ADM if she did. CNA B said Resident #1 was at times very needy, but they do the best of their ability to meet her needs and do what she wants. CNA B said she had not witnessed any staff talk to Resident #1 in a mean manner, but sometimes you have to be stern with her. CNA B said sometimes Resident #1 just did not seem to understand why they were able to come right to her, if they had other things going on with other patients at the time. CNA B said sometimes Resident #1 probably waited longer than she wanted because she may have to find help because Resident #1 required two staff for assistance and Resident #1 would start screaming and she also had an alarm on her device that she would set off. CNA B said on the day of the incident about the air freshener, Resident #1's room had an odor. CNA B said Resident #1 used all natural soaps and deodorant and sometimes there was an odor. CNA B said she had not been told Resident #1 did not want air fresheners used in her room. CNA B said she did not recall spraying any air freshener in Resident #1's room prior to the incident and Resident #1 asking her not to because it irritated her breathing. CNA B said she did not know why CNA C sprayed it the way she did. CNA B said there was no discussion with CNA B prior to entering Resident #1's room about the air freshener. CNA B said CNA C should not had said it stank up in here to Resident #1. CNA B said she did not feel CNA C spraying the air freshener above Resident #1's head was abusive. CNA B said Resident #1 started screaming right after the spray was sprayed and she assumed Resident #1 was screaming because of the spray. CNA B said it was not appropriate to tell Resident #1, I wish she would tell me that (but would not confirm that it was her on the video out of the camera's view). CNA B said it probably made the resident feel unwanted and that you did not want to take care of her. CNA B said it could possibly be a dignity issue also. CNA B said she did not think the incident was abusive to Resident #1.</p> <p>During an interview on 4/09/25 at 4:20 PM, the Regional Nurse reviewed the videos and said it was definitely poor customer service with the incident of spraying the air freshener. The Regional Nurse reviewed the video of CNA E and said the moving of the resident was not as bad as she had been told by the DON, but it was not how the staff should have treated the resident or how the staff should have positioned the resident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/09/25 at 4:44 PM, the DON said CNA C was trying to hide some spray from the resident. The DON said she thought Resident #1 was into natural products and may had an odor. The DON said she had not heard at any time that Resident #1 did not want sprays used in her room, until after the incident. The DON said CNA E had an attitude with Resident #1 and it was not great customer service. The DON said she could not answer for Resident #1 but knew how it would have made her feel and she would have been mad because of the attitude CNA E had and how she positioned her up in the bed. The DON said she just thinks all of the staff had just terrible customer service, but the resident should never know that you were having a bad day. The DON said patience went a long way. The DON said the resident should feel very comfortable while receiving care. The DON said it probably made her feel like a burden.</p> <p>During an interview on 4/09/25 at 5:16 PM, the ADM said the only video she had seen previously was the incident with CNA C spray the air freshener and had investigated it and did not feel it was abuse. The ADM said she expected her residents to be treated with dignity and not be abused. The ADM said CNA B and CNA C should not have talked to the resident that way and she did write up CNA C for customer service. The ADM said every month she preached about burnout and customer service to her staff. The ADM said she agreed CNA E was rough with the resident when she positioned her and was rude to the resident. The ADM said CNA E was rushed and appeared to be on the rougher side. The ADM said she was ultimately responsible for everything in the facility because it was her license but did not feel it was fair to be cited when she had no prior knowledge of the incidents.</p> <p>Record review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated revised April 2021, . residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation . this includes but is not limited to freedom from corporal punishment . verbal, mental, sexual or physical abuse . resident abuse, neglect and exploitation prevention program consisted of facility wide commitment and resource allocation to support the following objectives . protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including . staff . ensure adequate staffing and oversight/support to prevent burnout, stressful working situations . establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems . implement measures to address factors that may lead to abusive situations, for example . adequately prepare staff for caregiving responsibilities . identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property .</p> <p>Review of the facility's policy titled Resident Rights dated revised February 2021 indicated . federal and state laws guarantee certain basic rights to all residents of this facility . these rights include the resident's right to . be free from abuse, neglect, misappropriation of property, and exploitation . be supported by the facility in exercising his or her rights . exercise his or her without interference, coercion, discrimination or reprisal from the facility .</p>		