

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER Buckner Westminster Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 Horseshoe LN Longview, TX 75605	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Record review of Resident #12's face sheet, dated 06/03/25, indicated reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included dysphagia (Difficulty swallowing foods or liquids).</p> <p>Record review of Resident #12's significant change MDS assessment, indicated she had a BIMS score of 06, which indicated severe cognitive impairment. She was prescribed a mechanically altered diet while a resident at the facility.</p> <p>Record review of Resident #12's physician's orders, dated 06/03/25, indicated an order for Diet: Thickened Liquids Nectar (Mildly Thick). The start date was 06/11/24.</p> <p>Record review of Resident #12's comprehensive care plan, dated 06/03/25, indicated a problem of Resident #12 receiving a mechanically altered diet. Interventions included record food intake at each meal; offer appropriate substitutes for uneaten food. The care plan did not address nectar thickened liquids.</p> <p>During an interview on 6/4/25 at 11:20 AM, LVN D said residents on thickened liquids should have that documented on their care plan. She said if the information was on the care plan everyone would know the resident was on thickened liquids. She said they also passed information from nurse to nurse in report. She said if a resident who was ordered thickened liquids was given thin liquids they could aspirate. She was not able to find that Resident #12 was care planned for thickened liquids.</p> <p>During an interview on 06/04/25 at 11:30 AM, the ADON said nectar liquids should have been on Resident #12's care plan. She said there was no risk to the resident because the nurses checked the orders and not the care plan. She said she was the one who updated the care plan, and she was responsible for ensuring the care plan was updated. She said the DON and the ADM checked the care plan from time to time.</p> <p>During an interview on 06/04/25 at 11:32 AM, the DON said, For comprehensive care plans, we refer to the RAI manual. She said they did not have a policy for comprehensive care plans.</p> <p>During an interview on 06/04/25 at 12:29 PM, the DON said she expected nectar thick liquids to be on the care plan for Resident #12. She said the risk was someone could not realize the resident was on nectar thick liquids and could cause injury.</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
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/04/25 at 12:38 PM, the Administrator said he expected Resident #12's care plan to address nectar thick liquids. He said the risk was someone may not know the resident was on thickened liquids and possibly give her thin liquids and cause her to aspirate.</p> <p>Record review of the RAI Manual, accessed on 06/05/25 and last revised October 2024, stated:</p> <p>.4.6 When is the RAI Not Enough? .</p> <p>.facilities are responsible for addressing all care issues that are relevant to individual residents, regardless of whether or not they are covered by the RAI .including monitoring each resident's condition and responding with appropriate interventions .</p> <p>.4.7 The RAI and Care Planning .</p> <p>.As required at 42 CFR 483.21(b), the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care .</p> <p>Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet each resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 8 residents (Resident #12 and Resident #16) reviewed for care plans.</p> <p>1.The facility failed to develop a person-centered care plan for Resident #16's planned weight loss of 8.35 % from 5/7/2025 to 6/1/2025 and implement recommendations for multivitamin with minerals daily and supplemental Ensure.</p> <p>2.The facility failed to ensure Resident #12's comprehensive care plan was developed to address nectar thickened liquids as prescribed by the physician .</p> <p>These failures could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services.</p> <p>Findings include:</p> <p>1. Record review of Resident #16's admission Record reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #16 had diagnoses which included wedge compression fracture of lumbar vertebra (a fracture where the front part of the vertebra collapses, creating a wedge shape), Dorsalgia (pain in the back, encompassing various areas of the spine), Hypertension (a medical condition where the force of blood against the artery walls is consistently too high) and falls.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #16's initial Care plan, dated 5/6/2025, reflected Resident #16 had altered/potential alteration in nutrition with a goal to maintain weight and meet nutritional needs at the highest practicable level. Interventions included to assess oral cavity, monitor appetite and meal intake, offer snacks, assist with meals as needed and provide a diet order regular, liquid consistency-regular and no liquid restrictions. The initial care plan indicated Resident #16 was at risk for infection/potential infection with goal to minimize risk of infection with goals to encourage nutrition and fluids.</p> <p>Record review of Nutritional Recommendations dated 5/8/2025-5/9/2025, reflected Resident #16's recommendations/interventions included the following: Ensure (a protein supplement) BID (twice daily) and between meals, start Multivitamin with minerals, Speech therapy evaluation due to reported problems swallowing food and liquids. The nutritional recommendation report was signed and undated by the ADON which indicated she received orders and added per MD.</p> <p>Record review of a paper copy of the weight concern care plan, initiation dated 5/12/2025, reflected a problem from member/guest was a weight concern as evidenced by Doctor recommendations to lose weight per Orthopedic surgeon. The Goal indicated to meet maximum nutritional potential with approaches to weigh weekly and registered dietician to evaluate and make recommendations as indicated, educate on healthy weight loss, and weight loss expected. The paper weight concern care plan was signed by the ADON and was undated.</p> <p>Record review of a progress note, dated 5/12/2025 at 1:49 PM, LVN D indicated she spoke with the nurse at the orthopedic surgeon office and was instructed Resident #16 to begin to lose weight.</p> <p>Record review of Resident #16's admission MDS, dated [DATE], reflected the resident was able to make self-understood and was able to understand others. Resident #16 had a BIMS score of 9, which indicated he had moderate cognitive impairment. Resident #16 was dependent with toileting, bathing, and dressing upper and lower body.</p> <p>Record review of vital sign notes, dated 5/19/2025 at 7:35 AM, the ADON indicated Resident #16 lost 4.6 lbs. in 2 weeks, and 2.8 lbs. x 1 week. The ADON indicated Resident #16 continued to do well with expected weight loss per doctor recommendations. The ADON documented she would continue to monitor and educate Resident #16 on nutritional choices to promote healthy weight loss.</p> <p>Record review of the weight log on 6/2/2025 at 11:44 AM, reflected Resident #16 weighed 256.4 lbs. on 5/7/2025 and last recorded weight on 6/1/2025 was 235 lbs. which was an 8.35 % weight loss in 26 days.</p> <p>Record review of a physician order, dated 6/2/2025, indicated Resident #16 was ordered to have a protein nutritional drink after meals.</p> <p>Record review of a progress note, dated 6/3/2025 at 8:44 AM, LVN D indicated Resident #16 began daily multivitamin with minerals and dietary supplements today.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/3/2025 at 12:15 PM, LVN D said Resident #16's orthopedic surgeon wanted him to lose weight. LVN D said Resident #16's incisional wounds had healed. She said Resident #16's last weight dated on 6/1/2025 was 235 lbs. and he weighed 256 lbs. upon admission 5/7/2025. LVN D said each resident was weighed the same way each time in his wheelchair. LVN D said Resident #16 did not receive large portion meals like he did at home. LVN D said there was not a verbal order written and said Resident #16 was care planned for weight loss.</p> <p>During an interview on 6/3/2025 at 1:41 PM, Resident #16 said he was trying to lose weight. He said he was choosing fruits, vegetables and was not snacking as much. Resident #16 said he was brought an Ensure (a protein supplement) today and that was the first one he had.</p> <p>During an interview on 6/3/2025 at 1:59 PM, the DON said Resident #16 was a planned weight loss. The DON said Medicare required weekly weight checks. The DON said she did not see a care plan for weight loss. The DON said the ADON would have a paper care plan separate from the EMR. The DON said she would expect the ADON to get orders when received. The DON said she did not see an order for Speech therapy. The DON reviewed the EMR and said the order for multivitamin with minerals was just put in the computer on 6/2/2025. The DON said the ADON was responsible for putting in weights and they both monitored. The DON said Resident #16 was a planned weight loss and it would be care planned. The DON said she guessed it would be important to care plan if there was a significant weight loss versus the planned weight loss so the facility staff would know the interventions and how to monitor.</p> <p>During an interview on 6/3/2025 at 2:35 PM, the ADON said LVN D spoke with the Doctor. The ADON said she personally completed the paper care plan. The ADON said bigger people lose weight faster. The ADON said she spoke with the primary doctor yesterday 6/2/2025 to let him know about the weight loss. The ADON said she wanted to make sure Resident #16's protein levels remained up and the doctor ordered a supplement. The ADON said she thought the dietician ordered Ensure (a protein supplement) after meals and vitamins. The ADON said she verbally spoke with the Speech therapist, and she informed her Resident #16 could swallow fine. The ADON could not verbalize why the care plan was not updated on the computer and why the orders were just placed in the computer for the multivitamin on 6/2/2025 when the recommendations were received on 5/9/2025.</p> <p>During an interview on 6/4/2025 at 11:02 AM, LVN D said she was responsible for the initial care plan when a resident was admitted to the facility. She said the DON and ADON were responsible for updating the care plans. LVN D said orders were placed in the computer by the nurse who received the orders. She said the ADON or DON would put in recommendations of orders from the dietician and supplements. LVN D said there could be harm to a resident if orders were not placed in the computer. LVN D said a resident could be at risk for weight loss if supplements or Ensure (a protein supplement) for nutrition was not ordered. LVN D said she followed the care plan but did not create them. She said the ADON was following the weight monitoring.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/4/2025 at 11:09 AM, the ADON said the admitting nurse was responsible for initiating the care plans. The ADON said she updated the care plans most of the time. She said usually she completed the updates on the dietician recommendations. The ADON said there was no issues per the Speech Therapist. The ADON said the dietary recommendations were just recommendations, not orders. The ADON reviewed the note she wrote on the recommendations which indicated orders were received and added per MD with her initials. The ADON said the computer would say when the orders were put in. The ADON said the doctor told him he needed to lose weight. The ADON said she was not sure why the Dietitian recommended Ensure (a protein supplement), multivitamin and speech therapy evaluation. The ADON said weights were put in weekly and then the staff evaluated. She said when she signs off on it, it was done. The ADON said the Dietician did not know the resident needed to lose weight. The ADON said she did not feel there could have been a negative impact to Resident #16. She said the facility would monitor Resident #16 through weekly weight checks to determine that a resident was losing the weight at a healthy rate. The ADON said the resident selected menus and could choose what he wanted.</p> <p>During an interview on 6/4/2025 at 11:36 AM, the DON said she and the ADON were responsible for updating the initiating the care plan. The DON said the dietician only made recommendations. The DON said the doctor reviewed the recommendations and the nurse put in the order and updated the care plans. The DON said she did not know what date the ADON reviewed the dietician's recommendations. She said the Doctor would have come in and reviewed the following week. The DON said Resident #16 was not on a specific diet and there was not a risk to the resident. The DON said there should be education to Resident #16. The DON said she felt the Doctor would have intervened. The DON said Resident #16 could have a decline, skin issues, increased weakness or increased weight loss if not monitored. The DON said Speech therapy should have documentation about swallowing issues, and she would check the notes and get back with the state surveyor. The DON said she spoke with the Speech therapist and was told Resident #16 was observed eating and she did not have any concerns. The DON said the multivitamin and Ensure (a protein supplement) should have been on the care plan after the Doctor reviewed the recommendations.</p> <p>During an interview on 6/4/2025 at 12:39 PM, the ADM said recommendations were not orders. The ADM said the IDT discussed the issue. He said the orthopedic surgeon made recommendations for weight loss for Resident #16. He said it should be reflected on the care plan. He said the Doctor would have reviewed the dietary recommendations that next Thursday. The ADM said the ADON was responsible for updating the care plan. The ADM said he would expect the orders and care plan to be updated if the ADON noted the orders and care plan. He said it was a lack of communication. He said it could negatively impact the resident because he may not receive the best quality of care. The ADM said if the care plan were not updated or followed, it could lead to a decline, skin break down and other issues.</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>Based on interview and record review the facility failed to employ sufficient staff with the appropriate competencies and skills set to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for 3 of 20 kitchen staff (Cook A, Waitstaff B, and [NAME] C) reviewed for qualified dietary staff .</p> <p>The facility failed to ensure [NAME] A, Waitstaff B, and [NAME] C met the requirements for food handling by obtaining a current and valid Food Handler's Certificate.</p> <p>This failure could place residents at risk of not having their nutritional needs met and placing them at risk for food borne illnesses.</p> <p>Findings include:</p> <p>Record review of an undated dietary staff list revealed [NAME] A (hired 4/22/25), and Waitstaff B (hired 4/22/25) did not have a Food Handler's Certificate. [NAME] C's (hired 7/21/11) Food Handler's Certificate expired on 3/15/25.</p> <p>During an interview on 6/02/25 at 2:32 PM, the ADM said he knew some of the dietary staff did not have their Food Handler's Certificate. He said he knew at least one of the dietary staff was working on getting their Food Handler's Certificate today .</p> <p>During an interview on 6/02/25 at 3:23 PM, the Director of Culinary Services said he provided all the Food Handler's Certificates they had. He said dietary staff should get their Food Handler's Certificate immediately upon starting to work. He said he was responsible for making sure all dietary staff had their current Food Handler's Certificates. He said dietary staff not having a current Food Handler's Certificate could cause a risk to the residents of food born illness, improper food handling, or improper sanitation. He said dietary staff should have Food Handler's Training because the training covered all the things they would need to know for the kitchen and handling of food.</p> <p>During an interview on 6/02/25 at 3:52 PM, the ADM looked at the list of dietary staff that did not have their Food Handler's Certificates. He said he would help the Director of Culinary Services look for them.</p> <p>During an interview on 6/03/25 at 7:57 AM, the ADM said [Food Company Name] was the Director of Culinary Services boss. He said they employed him and the Executive Chef. The ADM said the Director of Culinary Services should coordinate with him on a day-to-day basis. He said the Director of Culinary services told him all dietary staff had current Food Handler's Certificates and he took him at his word. The ADM said the Director of Culinary Services should have told him he did not have them all.</p> <p>During an interview on 6/03/25 at 12:37 PM, the ADM said dietary staff who did not have the food handler's certificate could be behind in the latest trainings or out of alignment with current standards that were set. He said the risk to the residents could be dietary staff not being aware of the best practices for food delivery.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/03/25 at 11:04 AM, The Director of Culinary Services said when he hired, about 3 months ago, someone (he did not remember who) had given him the binder containing the Food Handler's Certificates for the dietary staff and told him they were all up to date. He said he assumed they were all up to date but never opened the binder or checked them. He said all dietary staff should have a food handler's certificate when they started to work but must have it within 30 days of hire. He did not know if the new hires, [NAME] A and Waitstaff C, had a current Food Handler's Certificate. He said [NAME] B's Food Handler's Certificate expired 3/15/25.</p> <p>During a telephone interview on 6/04/25 at 8:40 AM, the Executive Chef said it was the responsibility of the Director of Culinary Services to make sure all dietary staff had their Food Handler's Certificate. She said when she was the Director of Culinary Services it was her responsibility. She said sometimes the HR Director would remind her a dietary staff's Food Handler's Certificate was about to expire but, it was ultimately her responsibility. She said dietary staff should be up to date on food handling procedures and safety. She said the risk to the residents was staff not keeping up with time and temperature control of food, that could cause bacterial growth and food born illnesses.</p> <p>During an interview on 6/04/25 at 8:50 AM, the HR Director said it was the responsibility of the Director of Culinary Services to make sure all dietary staff had their Food Handler's Certificate. She said she did not remind or have anything to do with Food Handler's Certificates. She said when the Executive Chef was the Director of Culinary Services, she did not remind her or check on any of the Food Handler's Certificates for dietary staff. She said it was not her responsibility.</p> <p>During an interview on 6/04/25 at 1:11 PM, the Regional Director of [food company] said it was the Director of Culinary Services job to make sure all dietary staff had their Food Handler's Certificates. She said she had not validated all dining team food staff did not have current Food Handler's Certificates, so she would not address the risks to residents of dietary staff not having the certificates.</p> <p>Record review of a Food Safety Policy, with a revised date of 1/23/25, indicated:</p> <p>1.All food handling and safety must comply with the Texas Food Establishment Rules (TFER) and the CMS (Centers for Medicare and Medicaid Services) and Texas Health and Human Services Commission (HHSC) regulations.</p> <p>Record review of the TFER accessed on 6/3/25 at 8:08 AM at https://www.dshs.texas.gov/licensing-foodhandler-training-programs, (Licensing of Food Handler Training Programs Texas DSHS) indicated:</p> <p>Licensing of Food Handler Training Programs</p> <p>Texas requires that many food service employees complete an accredited food handler training course within 30 days of getting a job. These courses train employees on food safety including good hygiene practices, how to avoid cross contamination, and more.</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>Based on interview and record review the facility failed to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement and volunteers, consistent with their expected roles for 1 of 15 employees (Director of Culinary Services) reviewed for training.</p> <p>The facility failed to ensure the Director of Culinary Services received training on the topics of HIV, restraint reduction, fall prevention, resident rights, behavioral health, and infection prevention and control.</p> <p>This failure could place residents at risk for unmet needs.</p> <p>Findings included:</p> <p>Record review of personnel records for the Director of Culinary Services indicated a hire date of 01/13/25. The file did not indicate training on the topics of HIV, restraint reduction, fall prevention, resident rights, behavioral health, or infection prevention and control for the Director of Culinary Services.</p> <p>During an interview on 06/04/25 at 11:41 AM, the HR Director said the Director of Culinary Services was responsible for taking care of his required trainings. She said the managers receive emails about their trainings and they were responsible for taking their own trainings. She said he had not completed any of his required trainings.</p> <p>During an interview on 06/04/25 at 12:10 PM, the Director of Culinary Services said he was not aware the trainings were not completed. He said he and HR were responsible for ensuring the trainings were completed. He said he may not know what HIV is or restraints. He said he may not know the resident rights. He said he may not know behavioral health. He said he may not know infection prevention.</p> <p>During an interview on 06/04/25 at 12:38 PM, the Administrator said he expected the Director of Culinary Services to complete his required training. He said the managers receive emails that included the training they were required to complete. He said the risk was the Director of Culinary Service may not be properly trained on the topics. He said his boss at the contract company should be responsible for ensuring his trainings were completed. He said the main breakdown was the director of culinary services did not complete his trainings and his boss did not ensure the trainings were completed.</p> <p>During an interview on 06/04/25 at 01:09 PM, the Regional Director of [Contract Food Company] said she was not aware of the timelines of the training requirements for the Director of Culinary Services. She said both corporate entities (the facility and the contract company) had the oversight for the Director of Culinary services' trainings.</p> <p>Record review of the facility's undated policy, Staff Development, stated:</p> <p>(continued on next page)</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>Based on interview and record review the facility failed to provide training to their staff that at a minimum educated staff on activities that constituted abuse, neglect, exploitation, and misappropriation of resident property and procedures for 1 of 15 employees (Director of Culinary Services) reviewed for staff training.</p> <p>The facility failed to ensure the Director of Culinary Services received abuse training.</p> <p>This failure could place residents at risk of abuse, neglect, and exploitation and a poor quality of care.</p> <p>Findings included:</p> <p>Record review of personnel records for the Director of Culinary Services indicated a hire date of 01/13/25. The file did not indicate any abuse training for the Director of Culinary Services.</p> <p>During an interview on 06/04/25 at 11:41 AM, the HR Director said the Director of Culinary Services was responsible for taking care of his trainings that were required. She said the managers got emails about their trainings and they were responsible for taking their own trainings. She said he had not completed any of his required trainings.</p> <p>During an interview on 06/04/25 at 12:10 PM, the Director of Culinary Services said he was not aware the trainings were not completed. He said he and HR were responsible for ensuring that the trainings were completed. He said he may not know what abuse was or how to prevent it.</p> <p>During an interview on 06/04/25 at 12:38 PM, the Administrator said he expected the Director of Culinary Services to complete his required training. He said the managers received emails that included the training they were required to complete. He said the risk was the Director of Culinary Service may not be properly trained on the topics. He said his boss at the contract company should be responsible for ensuring his trainings were completed. He said the main breakdown was the director of culinary services did not complete his trainings and his boss did not ensure the trainings were completed.</p> <p>During an interview on 06/04/25 at 01:09 PM, the Regional Director of [Contract Food Company] said she was not aware of the timelines of the training requirements for the Director of Culinary Services. She said both corporate entities (the facility and the contract company) had the oversight for the Director of Culinary services' trainings.</p> <p>Record review of the facility's abuse policy, last revised 10/23/24, stated:</p> <p>.In-service training for abuse prevention</p> <p>1. All associates are required to complete resident rights and abuse prevention program in-service training sessions prior to having any resident contact AND on an annual basis</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER Buckner Westminster Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 Horseshoe LN Longview, TX 75605	

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's undated policy, Staff Development, stated:</p> <p>.To ensure employees are kept up to date on important procedures and in accordance with all local, state, and federal laws, as well as regulatory agency guidelines, [Facility name] requires associates to complete a certain amount of training courses each year, dependent upon the employee's role. Courses may be offered in BOLD, [Facility name]'s online learning management system, in person, or through another learning avenue. Compliance with mandatory assigned trainings is a must. Failure to complete the required number of training hours may result in corrective action, up to and including termination of employment</p>