

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/09/2025
NAME OF PROVIDER OR SUPPLIER  Heritage House of Marshall Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  5915 Elysian Fields Road Marshall, TX 75672	

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 - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44933</p> <p>Based on interview 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 2 of 8 residents reviewed for resident rights. (Resident #1 and Resident #2)</p> <p>The facility failed to provide care to Resident #1 in a respectful manner on 4/4/25.</p> <p>The facility failed to provide care to Resident #2 in a respectful manner within the last three months.</p> <p>These failures could place residents at risk for decreased quality of life, decreased self-esteem and increased anxiety.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 4/8/25 indicated Resident #1 was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses including vascular dementia (is a type of dementia caused by impaired blood flow to the brain, leading to damage and eventual loss of brain cells), mild, with agitation (a state of being agitated, feeling restless, anxious, or worried, and can manifest in various behaviors like pacing, irritability, or even aggression) and major depressive disorder (is a mood disorder characterized by persistent sadness, loss of interest or pleasure in activities, and other symptoms like changes in sleep, appetite, and energy levels).</p> <p>Record review of Resident #1's annual MDS assessment dated [DATE] indicated Resident #1 was usually understood and had the ability to understand others. Resident #1 had adequate hearing, clear speech, and impaired vision. Resident #1 had a BIMS score of 10 which indicated moderately impaired cognition. Resident #1 required moderate assistance for oral hygiene, substantial assistance for upper body dressing and personal hygiene, and dependent for toileting hygiene, shower/bathe self, lower dressing, and putting on/taking off footwear. Resident #1 was always had incontinence for urine and frequently incontinence for bowel.</p> <p>Record review of Resident #1's care plan dated 4/3/25 indicated Resident #1 had an ADL self-care performance deficit related to dementia and impaired balance. Intervention included assist with personal hygiene.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a facility provided statement dated 4/4/25 at 11:15 a.m., indicated [Resident #1] reported to DON and [ADON E] that she [Resident #1] was afraid of [CNA B] .[Resident #1] stated that the [CNA B] is mean to her and doesn't like her .When we asked her why she feels that way, she stated that when [CNA B] was dressing her this morning, she put her head in through her shirt first and expected her to assist .Writer [DON and ADON E] asked her if she thought the [CNA B] was wanting her to get some exercise by assisting with putting on her shirt .The resident [Resident #1] stated 'no' .She said the other CNA always put her arms through her shirt first .When asked if [CNA B]has ever hit her, she stated 'No, darling.' .The resident [Resident #1] stated that she didn't want the [CNA B] back in her room .</p> <p>During an interview on 4/8/25 at 11:21 a.m., Resident #1 said CNA B had been verbally rough to her. She said CNA B told her to stand up, I'm [CNA B] not going to bend over and You [Resident #1] can do it! She said when CNA B spoke to her like that, it hurt her feelings and made her cry. She said she did not want to get up sometimes when CNA B worked the hall. She said CNA B did not talk rough to her all the time but often. She said CNA B had never grabbed her, just said words.</p> <p>Record review of Resident #2's face sheet dated 4/9/25 indicated Resident #2 was a [AGE] year-old male admitted on [DATE]. Resident #2 had diagnoses including muscle wasting and atrophy (shortening), vascular dementia (is a type of dementia caused by impaired blood flow to the brain, leading to damage and eventual loss of brain cells), cerebral infarction (is a condition where a part of the brain is damaged or dies due to a lack of blood supply) and hemiplegia (is a condition caused by brain damage or spinal cord injury that leads to paralysis on one side of the body) and hemiparesis (is one-sided muscle weakness) affecting right dominant side.</p> <p>Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated Resident #2 understood and had the ability to understand others. Resident #2 had adequate hearing, clear speech, and adequate vision with corrective lenses. Resident #2 had a BIMS score of 11 which indicated moderately impaired cognition. Resident #2 was dependent for toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear. Resident #2 required moderate assistance for upper body dressing and personal hygiene. Resident #2 was always incontinent for urine and bowel.</p> <p>Record review of Resident #2's care plan revised on 10/4/23 indicated Resident #2 had an ADL self-care performance deficit, dementia, and history of nontraumatic intracerebral hemorrhage (is a type of stroke where bleeding occurs inside the brain tissue itself, usually due to the rupture of a blood vessel). Intervention included bed mobility, the resident required assistance with turning and repositioning every 2 hours, as needed, and as necessary.</p> <p>During an interview on 4/8/25 at 11:30 a.m., a family member of Resident #2, who also resided in the same room as Resident #2, said she had heard CNA B talking rough or mean to the residents. She said CNA B also spoke rough to Resident #2. She said it seemed CNA B was irritated she had to assist her bed bound family member, Resident #2. She said it seemed like CNA B was tired all the time and did not want to work. She said CNA B had acted that way within the past 3 months. She said CNA B acted that way every time she worked the 200 hall. She said she dreaded when CNA B worked and took care of Resident #2. She said she had never reported how CNA B treated Resident #2. She said she did know to report abuse to the nurse. Resident #2 nodded his head in agreement when asked if he agreed with the family member's statement.</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 - Few</p>	<p>During an interview on 4/8/25 at 1:45 p.m., LVN A said she had not personally heard CNA B speak to a resident in an unkind way. She said no residents had complained to her about CNA B. She said if a resident felt rushed, it could be upsetting to the resident. She said the residents should not feel like when they asked for assistance, the staff would get irritated. She said when staff rushed care of the residents, they could cause falls or skin tears. She said when worked with CNA B, CNA B had reported she was tired a lot. She said when staff were tired, it could affect their mood, performance level, patience, and job quality.</p> <p>Attempted interview on 4/8/25 at 2:44 p.m.; called CNA B and left a voicemail.</p> <p>During an interview, Confidential Staff C said CNA B spoke to residents in a rude and condescending ways. Confidential Staff C said CNA B talked about the residents in their presence. Confidential Staff C said it seemed like CNA B hated her job and the residents. Confidential Staff C said CNA B seemed overworked and took it out on the residents.</p> <p>Attempted interview on 4/9/25 at 8:59 a.m.; called CNA B and left a voicemail.</p> <p>During an interview on 4/9/25 at 9:15 a.m., the DON said Resident #1 had reported to her and ADON E that CNA B was rough with her during dressing. She said Resident #1 had explained it was not physically but verbally. She said Resident #1 had reported CNA B assisted her in dressing differently than another CNA. She said CNA B was suspended pending the investigation. She said the social worker had completed safe surveys on a different hall with no negative results after the incident. She said the social worker was going to complete a safe survey on the correct hall, where CNA B worked today (4/9/25). She said there had not been any complaints or grievances related to CNA B until 4/4/25. She said she expected staff to treat the residents with respect and to get to know the residents. She said the staff should make the resident feel comfortable, improve their quality of life, and look forward to seeing them. She said when the residents felt rushed or being a bother, they could feel bad. She said everyone deserved to be treated with dignity and respect. She said the facility tried to ensure the residents were being treated with dignity and respect by doing in-services and encouraging interaction with the residents to get to know them.</p> <p>During an interview on 4/9/25 at 9:45 p.m., the Administrator said CNA B had not been named in any other reported abuse allegations. He said CNA B had not been reported in any grievances or had any disciplinary action related to abuse and neglect. The administrator said he expected staff to be friendly, kind and caring to the residents. He said he wanted the residents to have the highest quality life and care. He said it depended on how it could affect the resident if they were not treated with dignity and respect. He said the facility tried to ensure residents were treated with dignity and respect by doing in-services, interviewing the residents, monitoring, and training the staff.</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 - Few</p>	<p>During an interview on 4/9/25 at 1:43 p.m., CNA B returned the surveyor's phone call after exit. CNA B said she worked with Resident #1 on 4/4/25. She said Resident #1 was hard to turn over and resisted. She said Resident #1 was resistive with cares. She said she had to brace herself against Resident #1. She said Resident #1 tried to help during care but she would push against her. She said Resident #1 always apologized afterwards because she was pushing against her (CNA B) during care. She said she always told Resident #1 it was okay, she knew Resident #1 was trying help. She said she took her time with each resident. She said the 200 hall was a heavier hall and had a lot of total care residents. She said she did get tired between taking care of the residents. She said she felt like she treated the resident with dignity and respect. She said the staff was there to take care of the residents and should be treated like family.</p> <p>Record review of an undated facility Resident Rights policy indicated, .the resident has a right to a dignified existence .the resident has a right to be treated with respect and dignity .</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</b></p> <p>Based on interview and record review, the facility failed to ensure each resident had the right to be free from misappropriation of property, and exploitation for 1 of 5 residents (Resident #3) reviewed for misappropriation of property.</p> <p>The facility failed to prevent the misappropriation of Resident #3's Promethazine-Dextromethorphan (is commonly used to reduce coughing and other symptoms from allergies or common cold) on 2/25/25.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 2/25/25 and ended on 2/27/25. The facility had corrected the noncompliance before the investigation began on 4/8/25.</p> <p>This failure could place residents at risk for misappropriation of physician ordered medications which could result in residents not having medications/treatments available and a decline in health.</p> <p>Findings included:</p> <p>Record review of Resident #3's face sheet dated 4/8/25 indicated Resident #3 was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. Resident #3 had diagnoses including cerebral infarction (is a condition where a part of the brain is damaged or dies due to a lack of blood supply), hemiplegia (is a condition caused by brain damage or spinal cord injury that leads to paralysis on one side of the body) and hemiparesis (is one-sided muscle weakness) affecting left non-dominant side, type 2 diabetes (is a chronic condition that happens when you have persistently high blood sugar levels), epilepsy (s a brain disease where nerve cells don't signal properly, which causes seizures), and gastrostomy (is the placement of a feeding tube through the skin and the stomach wall) status.</p> <p>Record review of Resident #3's consolidated physician's order dated 2/1/25 indicated Promethazine-Dextromethorphan Syrup 6.25-15mg/5ml, give 5ml via gastrostomy every 6 hours as needed for nausea. Start date 5/18/23.</p> <p>Record review of Resident #3's significant change MDS assessment dated [DATE] indicated Resident #3 was sometimes understood and usually had the ability to understand others. Resident #3 had a BIMS score of 00 which indicated severely impaired cognition.</p> <p>Record review of Resident #3's care plan revised on 2/24/25 indicated Resident #3 had impaired cognitive function/dementia or impaired though processes. Intervention included administer medications as ordered. Resident #3's care plan did not address use of Promethazine-Dextromethorphan Syrup.</p> <p>Record review of the facility's Provider Investigation Report dated 2/25/25 indicated, .an officer with the . County sheriffs office contacted this administrator to inform me that during a traffic stop the officers found a bottle of liquid medication that had one of our residents name on it that LVN D had in her possession . investigation findings: confirmed .</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of an incident/offense report by a local county sheriff's office, dated 2/25/25 indicated, . evidence .drugs .exhibit 1: (1) 16 ounce bottle of suspected Promethazine, Hydrochloride, and Dextromethorphan Hydrobromide Oral Solution .suspected arrestee .LVN D .a vehicle search was conducted and in the front passenger seat .a black backpack .inside the backpack was an almost full Promethazine, Hydrochloride, and Dextromethorphan Hydrobromide Oral Solution Bottle, which the label showed to be prescribed to Resident #3 .LVN D stated the Promethazine bottle ended up in her work bag but could not provide any other information than that .</p> <p>Attempted interview on 4/8/25 at 2:48 p.m.; called LVN D and left a voicemail.</p> <p>During an interview on 4/8/25 at 4:23 p.m., the DON said LVN D worked at the facility as a LVN and MA. She said LVN D's background check was good upon hire. She said there had not been any reports of LVN D acting suspicious. She said the Administrator notified her about the incident involving LVN D on 2/25/25. She said the facility did not know where Resident #3's Promethazine bottle was stored prior to the incident on 2/25/25. She said Resident #3's liquid medication was stored either in the medication cart or room. She said she did not think Resident #3's Promethazine had been used in the last three months. She said LVN D called the facility, after the incident on 2/25/25 to explain why she had not come to work that week. LVN D did not mention having Resident #3's medication. She said the labeled bottle was in LVN D's possession when she was arrested. She said when another person had a resident's property it was called theft or a drug diversion. She said the facility had to reorder the missing medication and bill the facility. She said after the incident on 2/25/25, the facility in-serviced nursing staff on medication storage and narcotic counting. She said the facility implemented counting the narcotic blister package cards and bottles each shift. She said ADON F did weekly narcotic sheet monitoring.</p> <p>During an interview on 4/8/25 at 5:03 p.m., the Administrator said LVN D was found with Resident #3's bottle of Promethazine. He said the facility did not know how she got Resident #3's medication. He said LVN D possibly got Resident #3's medication from the medication room. He said he had not spoken to LVN D about the incident. He said LVN D had called saying she had gotten arrested for traffic tickets. He said LVN D got silent when he mentioned the county sheriff's department had notified the facility about Resident #3's medication being in her possession. He said when another person had a resident's property, unauthorized, it was considered theft. He said the facility had to reorder the medication and depending on the situation, pay for it.</p> <p>Attempted interview on 4/9/25 at 9:05 a.m.; called LVN D and left a voicemail. LVN D did not return the call prior to or after exit.</p> <p>The facility took the following actions to correct the non-compliance:</p> <p>Conducted an observation and record review on 4/8/25 at 10:44 a.m., of the 300 hall medication cart with RN G. All narcotic medications in the locked medication box were reviewed and accounted for.</p> <p>Conducted an observation and record review on 4/8/25 at 10:55 a.m., of the 400 hall medication cart with LVN A. All narcotic medications in the locked medication box were reviewed and accounted for.</p> <p>Conducted an observation on 4/8/25 at 11:05 a.m., of the facility's only medication room with LVN A. All liquid narcotics were stored in the refrigerator, in a locked, affixed box. The non-narcotic disposal box was locked with a padlock.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interviews of sampled residents during the course of investigation 4/8/25 to 4/9/25 revealed no residents complained of resident abuse/neglect or misappropriation. The sampled residents verified they had received pain medications on schedule and as needed and the medication relieved the pain.</p> <p>During interviews on 4/8/25, starting at 10:44 a.m., RN E, LVN A, ADON F, and LVN H had been in-serviced on narcotics sheets, medication destruction, storage, and notifying the DON and ADM if a staff was suspected of being under the influence. They said they were not aware of any abuse, neglect, or misappropriation of property and if so, would report it to the abuse coordinator, (Administrator).</p> <p>Record review of LVN D's undated employee disciplinary report indicated, .LVN D .date of infraction: 2/25 . type of disciplinary action: discharge .LVN D failed to adhere to the Corporate Code of Conduct .On 2/25, LVN D was in possession of resident medication outside of the facility .LVN D is aware of all policies and procedures via their signature on the employee handbook acknowledgement .LVN D meets criteria for immediate termination .LVN D will be terminated effective immediately .DON .Administrator .</p> <p>Record review of LVN D's employee disciplinary report action request dated 2/25/25 indicated, .LVN D . charge nurse LVN .hire date: 1/16/25 .date of infraction: 2/25/25 .request action: discharge .on 2/25/25 at around 10:00 pm .county sheriff's office contacted me to inform me that LVN D had been pulled over and was in possession of drugs that belonged to the facility .Administrator .2/26/25 .</p> <p>Record review of LVN D payroll input/personnel action form dated 2/26/25 indicated, .reason for submission: termination .LVN D .termination dated 2/26/25 .last day worked 2/25/25 .reason for separation: failed to adhere to the corporate code of conduct .eligible for rehire: no .possession of resident medications outside of the facility .Human Resource Clerk .</p> <p>Record review of LVN D license verification report dated 2/26/25 indicated, .LVN D .unencumbered .active .</p> <p>Record review of LVN D's verification of criminal history checks provided on 4/8/25 indicated, .date check was conducted: 1/16/15 .determined to be employable: Yes .Human Resource .</p> <p>Record review of the facility's Abuse/Neglect policy revised 9/9/24 indicated, the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation .misappropriation of resident property: means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings .</p> <p>Record review of a facility conducted in-service, Narcotic Count Sheets dated 2/26/25 reflected 14 of 22 nursing staff were provided education on the topic.</p> <p>Record review of a facility conducted in-service, Medication Destruction, Storage of Controlled Substance, and Medication Administration dated 2/26/25 reflected 12 of 22 nursing staff were provided education on the topic.</p> <p>Record review of a facility conducted in-service, If You Suspect that an Employee the Influence dated 2/27/25 reflected 19 staff members were provided education on the topic.</p> <p>(continued on next page)</p>		

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<p>F 0602</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 safe surveys dated 2/26/25 indicate 28 of 28 residents surveyed had received their medications and received as needed medication when asked.</p> <p>Record review of narcotic count sheets audit provided on 4/8/25 by the Administrator indicated no discrepancies for 12 residents who had been administered narcotics by LVN D.</p> <p>Record review of facility incident/accident reports for the past three (3) months revealed no concerns in the area(s) of Resident Abuse; Resident Neglect; Misappropriation of property. Appropriate facility responses and investigations were done as necessary. Incident report for Misappropriation of property was addressed with appropriate facility response and investigation. LVN D was terminated and referred to the Board of Nursing. Misappropriation cited.</p> <p>Record review of facility complaints for the past three (3) months revealed no concerns in the area(s) of Resident Abuse; Misappropriation of property; or Resident Neglect.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 2/25/25 and ended on 2/27/25. The facility had corrected the noncompliance before the investigation began on 4/8/25.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</b></p> <p>Based on interview and record review the facility failed to ensure that all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 8 (Resident #4) residents reviewed for abuse and neglect.</p> <p>Confidential Staff C failed to report to the Administrator CNA B allegedly called Resident #4 pissy and smelly. Confidential Staff C said the incident had happened within the last 3-6 months.</p> <p>This failure to report could place the residents at risk for further abuse which could result in psychosocial harm and a diminished quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #4's face sheet dated 4/9/25 indicated Resident #4 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #4 had diagnoses including dementia (is a general term for a decline in mental ability, including memory, thinking, and reasoning, severe enough to interfere with daily life, and is not a specific disease, but rather a group of symptoms), hypertension (is when the force of blood pushing against your artery walls is consistently too high), and chronic obstruction pulmonary disease (is a group of lung diseases that cause airflow obstruction, making it difficult to breathe and worsen over time).</p> <p>Record review of Resident #4's quarterly MDS assessment dated [DATE] indicated Resident #4 was usually understood and usually had the ability to understand others. Resident #4 had a BIMS score of 15 which indicated intact cognition. Resident #4 required moderate assistance for toileting hygiene. Resident #4 was frequently incontinent of urine and bowel.</p> <p>Record review of Resident #4's care plan dated 2/23/25 indicated:</p> <p>*Resident #4 has potential impairment to skin integrity of related to incontinence of bowel and bladder. Resident #4 was resistive to incontinence care. Resident #4 refused to allow staff to change her briefs on a routine basis. Intervention included report resident incidents of refusal of care to charge nurse for intervention.</p> <p>*Resident #4 had a behavior problem resistive to care. Resident #4 verbalizes she did not want to be disturbed during the night to receive toileting or incontinence care. Intervention included caregivers to provide opportunity for positive interaction and attention.</p> <p>*Resident #4 had an ADL self-care performance deficit related to activity intolerance, dementia, and impaired balance. Intervention included Resident #4 request to only be checked once per night after being assisted to bed. Check Resident #4 for incontinence in early morning per resident request.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/09/2025
NAME OF PROVIDER OR SUPPLIER  Heritage House of Marshall Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  5915 Elysian Fields Road Marshall, TX 75672	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview Confidential Staff C said CNA B spoke to residents in a rude and condescending ways. Confidential Staff C said CNA B talked about the residents in their presence. Confidential Staff C said it seemed like CNA B hated her job and the residents. Confidential Staff C said CNA B seemed overworked and took it out on the residents. Confidential Staff C said CNA B told Resident #4 she was pissy and smelly. Confidential Staff C said CNA B and Resident #4 were having a heated argument. Confidential Staff C said she/he did not report CNA B. Confidential Staff C said because previous administration had not done anything when she/he had reported CNA B for another incident. Confidential Staff C said it was important to report verbal abuse because it could become physical. Confidential Staff C said if abuse or neglect was not report then it could continue. Confidential Staff C said abuse or neglect should be reported to the Abuse Coordinator immediately.</p> <p>During an interview on 4/9/25 at 9:21 a.m., the DON said abuse and neglect should be reported immediately. She said abuse and neglect should be reported to the nursing administration and the Abuse Coordinator, which was the Administrator. She said using words like pissy or smelly could be considered verbal abuse or belittling. She said the allegations had never been reported to her by any staff or residents. She said it was important to report abuse or neglect to protect the residents. She said the facility provided in-services to staff to prevent abuse and neglect. She said the facility also provided in-services on reporting abuse.</p> <p>During an interview on 4/9/25 at 9:45 a.m., the Administrator said he expected staff to report abuse and neglect to the Abuse Coordinator/Administrator. He said when abuse and neglect were not reported, the resident could not be protected. He said he was never made aware of CNA B saying pissy or smelly to a resident. He said the facility provided many in-services on abuse, neglect, and reporting. He said it was frustrating that the facility hounded into the staff about reporting and the staff still did not report.</p> <p>During an interview and observation on 4/9/25 at 10:19 a.m., Resident #4 was lying in bed. Resident #4's room had a strong urine smell. Resident #4 said no one had said any means words towards her. She said she could not recall any CNAs telling her she was smelly.</p> <p>During an interview on 4/9/25 at 1:43 p.m., CNA B returned the surveyor's phone call after exit. CNA B said she took care of Resident #4. She said Resident #4 got made about being asked to shower and would cuss at the staff. She said Resident #4 threw her wet briefs on the floor or in the trash and her room would smell like pee. She said she had told Resident #4 her room or sheets smelled like pee but never told Resident #4 she did. She said telling a resident they were smelly or pissy would make them feel bad. She said she would never do that.</p> <p>Record review of a facility's Abuse/Neglect policy revised 9/9/24 indicated, .the resident has the right to be free from abuse, neglect .when suspected abused, neglected, exploited, mistreated .comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee .facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents .to the facility administrator .</p>		