STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676187	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House of Marshall Health & Rehabilitation	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to develop and implement comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident medical and nursing needs to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for 1 (Resident #1) of 1 resident reviewed for care plans in that: The facility failed to ensure CNA D followed the comprehensive person-centered care plan for a proper transfer on 11/10/25 with Resident #1. This failure could place residents in the facility at risk of injury, not receiving the necessary care and services and having personalized plans developed to address their needs.Based on interview, and record review the facility failed to develop and implement comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident medical and nursing needs to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for 1 (Resident #1) of 1 resident reviewed for care plans in that: The facility failed to ensure CNA D followed the comprehensive person-centered care plan for a proper transfer on 11/10/25 with Resident #1. This failure could place residents in the facility at risk of injury, not receiving the necessary care and services and having personalized plans developed to address their needs.Findings include: Record review of Resident #1's face sheet dated 12/01/25, revealed an admission on [DATE] and re-admission on [DATE] to the facility. Record review of Resident #1's facility history and physical dated 12/02/25, revealed, an [AGE] year-old female diagnosed with cerebral palsy (a group of neurological disorders that affect movement, balance, and posture), repeated falls, difficulty in walking, muscle wasting and atrophy, unsteadiness on feet, lack of coordination, symptomatic epilepsy (a type of epilepsy where seizures are caused by an identifiable, underlying issue in the brain) and osteoarthritis (the most common type of arthritis, characterized by the breakdown of joint cartilage, which causes bone-on-bone friction). Record review of Resident #1's quarterly MDS assessment dated [DATE], revealed moderate impaired cognition to be able to recall or make daily decision BIMS score of 9. Resident #1 was dependent and needed 2 or more helpers with toilet transfer, tub/shower transfer and chair/bed-to-chair transfer. Resident #1 was marked as a wheelchair for mobility device. Resident #1 was diagnosed with difficult in walking, lack of coordination, and Cerebral Palsy. Record review of Resident #1's Care Plan dated 11/7/25, revealed the resident has an ADL self-care performance deficit related to limited mobility, pain and fluctuations in cognition related to cerebral palsy. Bathing/ showering: The resident is totally dependent on staff x2 to provide shower. Bed mobility: The resident requires extensive staff assist x2 bed mobility. Toilet use: The resident requires extensive staff assist x2 for toileting. Transfer: The resident requires extensive staff assist x2 to move between surfaces. During an interview on 12/01/25 at 3:11 P.M., with CNA A she said she was coming from hall 300 and went through the shower door when she saw CNA D and she said Resident #1 was sliding down on 11/10/25. CNA A said Resident #1 had a shower and was fully dressed trying to transfer from the shower chair to her wheelchair. CNA A said Resident #1 was a 2-person assist, but CNA D was transferring her from the shower chair to her wheelchair by herself. CNA A said Resident #1 started sliding down to the floor and she told CNA D they were not going to put Resident #1 in the wheelchair; they lowered Resident #1 to the floor. CNA A said she went to get the charge nurse and explained to him what happened. CNA A said Resident #1 should be a 2-person assist. During an interview on 12/01/25 at 4:05 P.M., Resident #1 said she does not remember the incident in the bathroom when she was lowered to the floor by CNA D and CNA A. Resident #1 said when staff transferred her from her bed to her wheelchair it was usually 2 people. During an interview on 12/01/25 at 4:46 P.M., with the Regional Compliance Nurse she said the aide could go to the resident's plan of care in point click care (an electronic health record) and pull it up in the kardex (a genericized trademark for a nursing record-keeping system) to see what assistance a resident need for a transfer. She said if the aides were unsure how to transfer a resident, they could ask the charge nurse or the DON how the resident was supposed to be transferred. During an interview on 12/01/25 at 4:55 P.M., with LVN B said the aides could look up the resident's kardex in point click care to see how a resident was supposed to be transferred. During an interview on 12/01/25 at 4:57 P.M., with LVN C she said the aides know how to transfer a resident by the kardex and by word of mouth. During an interview on 12/01/25 at 5:01 P.M., with Regional Compliance Nurse she said the MDS Nurse said the care plan was generated on 2/17/25 and he documented Resident #1 was a 1-person assist. She said the MDS Nurse said he opened another care plan