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Form Approved OMB
No. 0938-0391

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	02/19/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 6 residents (Resident #32) reviewed for pharmacy services. The facility failed to administer the injectable Repatha (a prescription-strength, injectable used to significantly lower bad [LDL-low density lipoprotein] cholesterol and reduce the risk of heart attack and stroke) for Resident #32 on 01/26/2026. This failure could place residents at risk for not receiving the intended therapeutic benefit of their medications.Findings include: Record review of Resident #32's, undated, face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #32 had diagnoses which included CVA (stroke, occurs when blood flow to the brain is blocked or a vessel ruptures, causing brain tissue damage), hemiplegia (form of paralysis affecting one side of the body, caused by brain or spinal cord damage such as stroke, trauma, or congenital conditions), and hyperlipidemia (condition characterized by abnormally high levels of lipids [fats] in the blood). Record review of Resident #32's admission MDS assessment, dated 12/18/2025, revealed Resident #32 had a BIMS of 13, which indicated no cognitive impairment. She required substantial (helper does more than half the work) assistance with ADLs. Record review of care plan, dated 12/12/2025, revealed Resident #32 had interventions to administer medications as ordered. Monitor/document for side effects and effectiveness. Record review of Resident #32's MAR, dated January 2026, revealed Resident #32's Repatha 140mg/ml (1) syringe subcutaneous every 2 weeks was not administered on 01/26/2026 by LVN A. Record review of consolidated physician orders, dated February 2026, revealed Resident #32 had an order for an injection of Repatha 140mg/ml (1) syringe subcutaneous every 2 weeks for hyperlipidemia. During an interview on 02/19/2026 at 10:12 a.m., Resident #32 stated she missed her cholesterol medication injection at the end of January and no one called the MD to let her know. Resident #32 stated it was very important to get the injection because she had strokes in the past from having blockages in her arteries from cholesterol build up. She stated her family brought the medication to the facility the day after it was due. She stated she worried about it for two weeks until she got another injection. Resident #32 stated it had not caused her to miss sleep, miss meals, or be tearful to have missed the injection. During an interview on 02/19/2026 at 11:00 a.m., LVN A stated she missed giving Resident #32 the injection of Repatha which was due at 10:00 a.m. on 01/26/2026. She stated the family provided the medication and the weather would not permit the family member to bring it until 01/28/2026. LVN A stated she signed the medication out as not given but failed to make a note about the missed dose and did not contact the MD. LVN A stated she was unaware she needed to call the MD. LVN A stated she was counseled by the DON on the proper way to handle an available medication and in the future would call the MD if a medication was unavailable. She stated the next dose given to Resident #32 was on 02/09/2026, which was the next (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	date it was due. LVN A stated there were no adverse effects to the resident because a lipid panel was done when the MD was notified and her cholesterol was in normal limits. During an interview on 02/19/2026 at 2:30 p.m., the DON stated Resident #32 missed her injection of Repatha on 01/26/2026 because the family member could not make it to the facility to bring it because of the ice storm. She stated it was worked out prior to admission that the family would supply the medication because of the cost. She stated LVN A should have notified the MD that day that the medication was not administered and got an order to hold the medication or send the resident to the hospital if the MD felt the missed medication, was an urgent situation. The DON stated LVN A had not notified anyone that she held the medication, and it was brought to the facility's attention when the resident made a complaint about missing the medication on 02/09/2026. The DON stated she notified the MD on 02/09/2026 and the MD stated to have a lipid panel drawn to see if any adverse effects were present because of the missed medication. The DON stated she got a stat lipid panel and the results were normal. The MD ordered to resume the Repatha every 2 weeks as ordered, and the injection was given on 02/09/2026. She stated it was the responsibility of the floor nurses to ensure medications were reordered and available for administration. The DON stated the nurses were instructed to contact her immediately if they were having issues getting medications. During an interview on 02/19/2026 at 3:30 p.m., the ADM stated she expected the nurses to follow MD orders and contact the physician, the DON and the family if medications were missed. She stated not administering medications as ordered could lead to serious health problems for the residents. Record review of the facility's, undated, policy Medication Administration stated: .To provide practice standards for safe administration of medication for residents in the facility. XVII. Holding medications.A. Whenever a medication is held for any reason, the Licensed Nurse will initial the appropriate area on the MAR and circle his/her initials. The Licensed Nurse will document the reason the medication was held on the back of the MAR and notify the physician.