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	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House of Marshall Health & Rehabilitation	5915 Elysian Fields Road Marshall, TX 75672

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the notice to residents when changes in coverage were made to items and services covered by Medicare as soon as is reasonably possible was provided to 2 of 3 residents (Resident #15 and Resident #39) reviewed for Medicare services. 1. The facility failed to notify Resident #15 at least 2 days before the end of Medicare Part A coverage.2. The facility failed to notify Resident #15 with a complete Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) form before the end of Medicare Part A coverage.3. The facility failed to notify Resident #39 and/or his representative in writing of potential non-coverage due to the end of Medicare Part A coverage. These failures could affect residents who use skilled services and could place them at risk of not being aware of changes to provided services.Findings included: 1. Record Review of a face sheet, dated 07/29/22, revealed Resident #15 was admitted on [DATE] with diagnoses including history of falling, rhabdomyolysis (a serious condition where damaged muscle tissue releases its contents into the bloodstream, potentially harming the kidneys), and heart failure (occurs when the heart can't pump enough blood to meet the body's needs). The face sheet revealed the resident had not been discharged . Record Review of an admission MDS dated [DATE], revealed Resident #15 had a BIMS of 15 which indicated intact cognition. The MDS indicated Resident #15 was dependent on staff with most ADLs. Record review of a Notice of Medicare Non-Coverage form revealed Part A (Skilled) coverage for Resident #15 ended on 07/22/25. The form was signed by Resident #15 on 07/23/25. Record review of a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form indicated, “…Beginning on 07/23/25, you may have to pay out of pocket for this care…Physical Therapy…Occupational Therapy…Choose the option below about whether to get the care listed above…”. The “Options” section was not completed. The form was signed by Resident #15 on 07/22/25. 2. Record Review of a face sheet, dated 07/29/22, revealed Resident #39 was initially admitted on [DATE] with diagnoses including peripheral vascular disease (a circulatory problem where narrowed or blocked blood vessels restrict blood flow to limbs and organs, excluding the heart and brain), anxiety, and stroke. Record Review of quarterly MDS for Resident #39 dated 07/07/25, revealed a BIMS was not conducted due to Resident #39 being rarely to never understood. The MDS indicated Resident #39 was dependent on staff with most ADLs. Record review of a Notice of Medicare Non-Coverage form revealed Part A (Skilled) coverage for (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #39 ended on 06/04/25. The form was signed by Resident #39’s representative on 06/02/25. Record review of documentation provided by the facility between 07/27/25 – 07/29/25 for the Beneficiary Notice task did not reveal a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form for Resident #39. During an interview on 07/29/25 at 1:14 p.m., MDS Nurse C said the Social Worker was responsible for completing the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) forms. She said the MDS nurses did help when the Social Worker was not in the facility. She said she would have expected Resident #15 to have been notified at least 2 days before her coverage ended, and she would have expected for the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form to have been complete. She said Resident #39 was notified but she could not find the signed Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) forms. She said she felt Resident #37’s representative was notified by phone. During an interview on 07/29/25 at 1:29 p.m., the Social Worker said she was responsible for issuing the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) forms to the residents. She said she did not know why Resident #15 was not notified at least two days prior to the end of her Medicare Part A coverage. She said she let the resident fill out the form. She said she did not know why the form was not completed. She said she notified Resident 39's representative over the telephone. She said Resident #39 was nonverbal and unable to sign his own forms. She said a resident not being notified in time could affect their therapy services. During an interview on 07/29/25 at 1:41 p.m., the DON said the MDS Nurses, and the Social Worker were responsible for completing and issuing the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) forms. She said she would have expected Resident #15 to have notified in the correct time frame, and she would have expected for the form to have been completed. She said she would have expected a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form to have been completed for Resident #39. She said a resident not being notified correctly could affect their plan of care and possibly cause them to have to pay out of pocket for services. During an interview on 07/29/25 at 1:52 p.m., the Administrator said the Social Worker was responsible for completing the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) forms. She said she would have expected the Social Worker to have notified Resident #15 at least 2 days before her Part A coverage ended and the form to have been complete. She said she would have expected a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form to have been completed for Resident #39. She said the residents needed to have been notified that they were about to be without coverage. Record review of a Resident Rights facility policy last revised on 11/28/2016 indicated, “…The resident has the right to be informed of, and participate in, his or her treatment, including…The right to be fully informed in language that he or she can understand…The right to be informed, in advance, of changes to the plan of care…The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident…The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident’s personal funds…The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	charge will be…The facility must inform each resident before…and periodically during the resident’s stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid…Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan…”.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure parenteral fluids was maintained consistent with professional standards of practice for 1 of 1 residents (Resident #76) reviewed for parenteral fluids central venous lines (a thin, flexible tube that's inserted into a large vein to provide access to the circulatory system. The facility failed to change a midline catheter (a type of central venous line) dressing according to facility protocol for Resident #76. Resident #76 midline catheter dressing change was due on 7/25/25 and was not changed until 7/27/25. This failure could place residents with central venous lines at risk of an infection and hospitalization. Findings included: Record review of Resident #76’s face sheet dated 7/27/25 indicated a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Resident #76 had diagnoses including cellulitis (is a bacterial infection of the skin and underlying tissues) of right and left lower limb, extended spectrum beta lactamase resistance (is an enzyme produced by certain bacteria that makes them resistant to many commonly used antibiotics) and displaced fracture media malleolus of left tibia (the bony bump on the inside of the left ankle (the medial malleolus) has broken and moved out of its normal position). Record review of Resident #76’s quarterly MDS assessment dated [DATE] indicated Resident #76 was usually understood and usually had the ability to understand others. Resident #76 had a BIMS score of 05 which indicated severe cognitive impairment. Resident #76 required substantial assistance for oral and toilet hygiene, shower/bathe self, and dressing. Resident #76 required partial assistance for eating and personal hygiene. Record review of Resident #76’s care plan dated 7/21/25 indicated Resident #76 had osteomyelitis (is a bone infection, most often caused by bacteria). Interventions included contact isolation, assist to turn and reposition, treatment as ordered, and follow up appointment with surgeon. Record review of Resident #76’s order summary report dated 7/27/25 indicated PICC line dressing change every 7 days one time a day every Friday, right upper arm. Start date 7/25/25. Record review of Resident #76’s Treatment Administration Record dated 7/1/25-7/31/25 indicated: * PICC line dressing change every 7 days one time a day every Friday, right upper arm. Start date 7/25/25. Resident #76’s TAR did not indicate the dressing change was completed on 7/25/25. * PICC line dressing change every 7 days one time a day every Sunday dressing change. Discontinued 7/27/25 at 6:39 p.m. Resident #76’s TAR indicated RN D completed the dressing change on 7/27/25. During an observation on 7/28/25 at 9:15 a.m., RN A administered an intravenous (is a medical process that administers fluids, medications and nutrients directly into a person's vein) antibiotic medication in Resident #76’s PICC line. Resident #76’s PICC line dressing was intact and dated 7/27/25. Resident #76’s PICC line site did not have redness or drainage noted. During an interview on 7/29/25 at 12:55 p.m., RN A said she was assigned Resident #76 last Friday (7/25/25). She said Resident #76’s PICC line dressing change was due last Friday (7/25/25). She said the nurses documented on the resident’s MAR/TAR when the dressing change was (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed. She said Resident #76’s PICC line dressing was the last thing on her to do list, and she did not get to it. She said she did not let the DON, or the oncoming shift know, Resident #76’s dressing did not get changed on her shift. She said she totally forgot that Resident #76’s PICC line dressing did not get done on 7/25/25. She said she normally told the oncoming shift if she did not get to something so it could be completed. She said the DON called her on Sunday (7/27/25) and asked about Resident #76’s PICC line dressing change. She said it was important to do the scheduled PICC line dressing change to not mess up the scheduled timeframe of the dressing changes. She said when the PICC line dressing changes were not done as scheduled, it placed the resident at risk for an infection. She said the resident could then need more antibiotics. During an interview on 7/29/25 at 1:00 p.m., the DON said the nurses were responsible for the PICC line dressing changes. She said the nurse documented on the resident’s MAR/TAR when the PICC line dressing change was completed. She said she contacted RN A on 7/27/25 about Resident #76’s PICC line dressing change. She said the PICC line dressing change was not signed off on Resident #76’s TAR for 7/25/25. She said she contacted RN A to see if she forgot to document the dressing change on 7/25/25 or if it was not done. She said when they found out Resident #76’s PICC line dressing change was not done, they called and notified the MD. She said Resident #76’s PICC line site looked good and there were no signs of infection. She said it was important to do a resident’s scheduled PICC line dressing changes to make sure there was no infection. She said not doing a resident’s dressing change could place them at risk for an infection. She said the ADONs was responsible for ensuring the nurses completed the scheduled PICC line dressing changes. During an interview on 7/29/25 at 1:10 p.m., ADON B said she was responsible for Hall 300 and 400. She said Resident #76 resided on Hall 300. She said the LVNs, and RNs were responsible for the PICC line dressing changes. She said the LVNs had to be checked off to do the PICC line dressing changes. She said the PICC line dressing changes should be completed as ordered which was normally every 7 days. She said Resident #76 was admitted on [DATE] so the PICC line dressing change was due on 7/25/25. She said she wrote it on her calendar and reminded RN A it was due on 7/25/25. She said after reviewing Resident #76’s chart on 7/27/25, she noticed the PICC line dressing was not done. She said she notified the DON, and the DON contacted RN A to see why the dressing change was not done. She said after the DON spoke with RN A and confirmed it was not done on 7/25/25, she rescheduled it for 7/27/25. She said another nurse completed the PICC line dressing change on 7/27/25. She said the PICC line dressing change flags on the resident’s MAR/TAR for the nurse to complete it. She said it was important to complete the scheduled dressing change because the PICC line was a central line and went into the body. She said when the PICC line dressing changes were not done as scheduled, it placed the resident at risk for infection. She said the ADONs were responsible for ensuring the nurses completed the scheduled PICC line dressing changes. She said she also felt the RNs should not need to be reminded to complete a PICC line dressing change. During an interview on 7/29/25 at 2:04 p.m., the ADM said the nurses were responsible for completing the resident’s scheduled PICC line dressing changes. She said she expected the nurses to complete the PICC line dressing changes on the scheduled day. She said it was important to complete the scheduled PICC line dressing change to make certain there was no infection, everything was attached, and to follow the facility’s policy and procedure. She said when the PICC line dressing change was not done it placed the resident at risk for an infection. She said if the resident developed an infection, they could need hospitalization or more antibiotics. She said the Infection Control Preventionist, ADON, and/or DON should ensure the nurses were completing the PICC line dressing changes. She said they should be monitoring this process by chart audits and looking at the (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident’s PICC line sites. Record review of a facility’s “Central Venous Catheters” policy dated 2003 indicated, “…a central line…is a temporary or long-term intravenous catheter inserted into one of the major veins of the neck, chest, or…peripherally through the brachial or cephalic vein…central lines are used for administration of intravenous (IV) fluids, antibiotics…PICC lines…dressing…24hr after insertion, then transparent dressing every 7 days and prn…central line dressing should be changed according to facility protocol and when the dressing is damp, loose, or soiled…dressings minimize the buildup of skin microorganisms, provide protection against external contamination, and keep the exit site dry…”