STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675553	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE HOUSE HEALTH CARE CENTRE	**1026 E GOODE ST QUITMAN, TX 75783**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident was treated with dignity and respect for 1 of 12 residents reviewed for resident rights. (Resident #7) CNA B did not provide Resident #7 with respect and dignity while providing incontinent care. This failure could place resident at risk of decreased dignity and quality of life. Findings included: An admission record dated 0[DATE] indicated Resident #7 was [AGE] years old, admitted [DATE] with [DIAGNOSES REDACTED]. A significant change MDS dated [DATE] indicated Resident #7 was moderately cognitively impaired, with clear speech, and was understood and could understand. The MDS indicated the resident's hearing was highly impaired but had a hearing aid. Resident #7's required extensive 1-person assistance with bed mobility and total dependence of 1-person for toileting. A care plan revised 01/02/20 indicated Resident #7 required extensive 2-person assistance with bed mobility and toileting. A Grievance/Complaint Report dated 03/04/20 noted Resident #7 complained of verbal abuse and rough treatment. Resident #7 reported CNA C told her she needed a shower and her [REDACTED] stunk and she and CNA C had words about what the CNA said. Resident #7 said CNA B told her to roll over and she informed the CNA the maintenance supervisor removed the enabler bar on her bed. The report indicated the resident told CNA B without the enabler bar she had nothing to grab hold of and that her left arm did not work. CNA B then pulled the pad under Resident #7 causing her to hit her head on the wall. The report noted Resident #7 asked CNA B her name and the CNA said she did not have one. Resident #7 told CNA B she would be reporting her because it was her room and CNA B would respect her and the CNA and should not be talking to her that way. The report indicated the resident said CNA B said it was the resident's word against hers and she walked out pushing the Hoyer lift. The Administrator's Summary to the 03/04/20 Provider Investigation Report noted CNA B said she informed the charge nurse for the evening of [DATE] about Resident #7's head bumping the wall. The administrator noted when he interviewed the charge nurse from the evening of [DATE] (when the incident allegedly occurred) and she denied CNA B reported anything. During an observation and interview on 03/09/20 at 2:15 p.m., Resident #7 had a scabbed abrasion to the left side of her forehead near the hair line.The resident had left side weakness. Resident #7 said CNA B and CNA C transferred her into her bed on the night of [DATE] at about 9:00 p.m. The resident said the CNAs said she needed to shower and CNA C said her (the resident's), [REDACTED] stunk. The resident said while CNA B provided her with incontinent care, she (CNA B) jerked the incontinent pad causing her (the resident) to roll toward the wall hitting her head on either the wood trim or the raised textured paint on the wall. Resident #7 said CNA B was spraying an air spray freshener and she asked the CNA not to spray it because it stinks. The resident said CNA B then sprayed the freshener 2 to 3 times in her (the resident's) face. Resident #7 said she asked CNA B her name and the CNA said she did not have one. During an interview on 0[DATE] at 12:40 p.m., CNA B said she and CNA C transferred Resident #7 into bed on [DATE] between 8:30 p.m. to 9:00 p.m. The CNA said Resident #7 was already upset that the Hoyer lift was not working. CNA B said Resident #7, was talking [REDACTED] calling us out of our name. CNA B said CNA C left to go obtain a brief to fit Resident #7. CNA B said the resident's bed was up against the wall in the room. She said she asked Resident #7 to roll over, but the resident was not cooperating so she used the incontinent pad to roll the resident toward the wall. CNA B said she did not jerk the pad but when she pulled it, the resident hit her forehead area on the wall. CNA B said it was an accident. CNA B said as an agency CNA, she carried a bag with items she purchased in it such as baby powder and a body spray. CNA B said she used the body spray to kill the odors of [REDACTED]. CNA B said she sprays the body spray up and down the hallways where ever she was assigned to work and in residents' rooms unless they tell her not to. The CNA said Resident #7 was [REDACTED] but she did not spray the body spray in Resident #7's face. CNA B said she applied some of the baby powder on Resident #7 upon providing incontinent care, sprayed some of the body spray on the inside of the resident's brief and some on the outside of the brief. The CNA said CNA C did not assist her with the incontinent care for Resident #7. CNA B said CNA C did not tell Resident #7 that her [REDACTED] stunk. CNA B said she told the resident she and CNA C could leave her [REDACTED] and leave her for the next shift. The CNA said Resident #7 said, you just going to leave my [REDACTED] wet. During an interview on 0[DATE] at 1:25 p.m., CNA C said she and CNA B transferred Resident #7 to bed on [DATE] around 9:00 p.m. She said the resident was kind of agitated because she had wanted to go to bed around 7:30 p.m. but since she was a 2-person transfer it was later before she was transferred to bed. CNA C said after the transfer, she left the resident's room and denied being present when CNA B provided incontinent care for Resident #7. The CNA said Resident #7 never cursed her or called her outside her name. She said when she returned to Resident #7's room CNA B was spraying the resident with perfume and said the resident stinks. CNA C said the resident said she did not want CNA B to spray her with the body spray. CNA C said she told CNA B to stop spraying the resident because she did not want to be sprayed. CNA C said CNA B said Resident #7 had called her a [REDACTED] and that the CNA kept saying she was not going to let anybody disrespect her. CNA B denied telling the resident that her [REDACTED] stunk and denied hearing the word [REDACTED] used to her knowledge. During an interview on 03/11/20 at 12:16 p.m., the administrator said CNAs should not bring in any personal baby powder, body spray, or deodorizers. He said when he interviewed CNA B, on 03/04/20 (the day he was informed of the alleged incident), regarding the allegation made by Resident #7, the CNA told him she did not spray any perfume but had sprayed peri-wash on Resident #7. He said CNA B admitted to accidently causing the resident to bump her head on the wall when she pulled the incontinent pad. The administrator said CNA C denied using inappropriate language toward Resident #7. The administrator said the facility was the residents' home and should not have been disrespected in any way.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe and clean homelike environment for 5 of 5 residents' [MED]gen equipment reviewed for clean environment. (Resident #s 13, 20, 9, 26, and 8) The facility did not clean the dust from the filters of [MED]gen concentrators used by Residents #20, #9, #26 and #8, and failed to ensure there was a filter on the [MED]gen concentrator used by Resident #13. This failure could place residents at risk of living in an unclean, un-homelike environment. Findings included: 1. An undated face sheet indicated Resident #13 was [AGE] years old, re-admitted on [DATE]. The resident's [DIAGNOSES REDACTED].#13 received [MED]gen therapy. The Physician order [REDACTED].#13, included an order to change [MED]gen and nebulizer tubing and clean concentrator filter every Sunday.

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

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.

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) During an observation on 03/09/20 at 10:48 a.m., Resident #13 was lying in bed with the [MED]gen concentrator providing [MED]gen via nasal canula. The [MED]gen concentrator did not have a filter in it. There was a layer of dust over the holes in the empty spot where the filter for the concentrator should have been. During an interview on 0[DATE] at 10:27 a.m., the DON said Resident #13's [MED]gen concentrator should have a filter and she noted the area where the filter should be was covered with dust. 2. An undated face sheet indicated Resident #20 was [AGE] years old, readmitted on [DATE]. The resident's [DIAGNOSES REDACTED]. The MDS dated [DATE] indicated Resident #20 received [MED]gen therapy. The Physician order [REDACTED].#20 contained an order to change out [MED]gen supplies and clean the concentrator filter every Saturday on the night shift. During an observation on 03/09/20 at 11:09 a.m., Resident #20 was resting in bed receiving [MED]gen via nasal canula connected to the [MED]gen concentrator. The [MED]gen concentrator's filter was covered with a thick layer of dust. During an interview on 0[DATE] at 10:28 a.m., the DON said the filter to Resident #20's [MED]gen concentrator looked like it needed to be washed. 3. An undated face sheet indicated Resident #9 was [AGE] years old, and was re-admitted on [DATE]. The resident's [DIAGNOSES REDACTED]. An MDS dated [DATE] indicated Resident #9 received [MED]gen therapy. The Physician order [REDACTED].#9 did not address the cleaning of the resident's [MED]gen concentrator. During an observation on 03/09/20 at 11:22 a.m., Resident #9 was up in her wheelchair in her room. She was receiving [MED]gen via nasal cannula from the [MED]gen concentrator in her room. The [MED]gen concentrator's filter was supposed to be black in color but was tan due to the dust covering the filter. 4. An undated face sheet indicated Resident #26 was [AGE] years old, with an admission date of [DATE]. The resident's [DIAGNOSES REDACTED]. An MDS dated [DATE] indicated Resident #26 received [MED]gen therapy. The Physician order [REDACTED].#26 contained an order to change the concentrator bottle, [MED]gen tubing, and clean concentrator filter each week on Sundays in the evening. During an observation on 03/09/20 at 11:30 a.m., Resident #26 was up in her wheelchair in her room. She was receiving [MED]gen via nasal canula. The filter on Resident #26's [MED]gen concentrator was covered with dust. During an observation and interview on 0[DATE] at 10:30 a.m., LVN A checked the [MED]gen filter on Resident #26's [MED]gen concentrator, and she said it was dirty. 5. An undated face sheet indicated Resident #9 was [AGE] years old, and was re-admitted on [DATE]. The resident's [DIAGNOSES REDACTED]. An MDS dated [DATE] indicated Resident #9 received [MED]gen therapy. The Physician order [REDACTED].#9 contained an order to change out [MED]gen supplies, and clean concentrator filter every Saturday night. During an observation on 03/09/20 at 11:41 a.m., Resident #8 was resting in bed, with the [MED]gen concentrator in use, receiving the [MED]gen via nasal canula. The filter on the [MED]gen concentrator was covered in dust. During an observation and interview on 0[DATE] at 10:30 a.m., LVNA checked the [MED]gen concentrator for Resident #8. She said the [MED]gen filter in Resident #8's room was even worse than the filter she saw earlier. (Resident #26's filter) During an interview on 0[DATE] at 10:42 a.m., the DON said she expected for the [MED]gen concentrator's filters to be present and free from dust. The DON said it was important for the filters to be clean and present to ensure the residents were receiving the full air flow. She said the concentrator's filter; humidifier bottle and [MED]gen tubing should be changed every Saturday night. The facility did not provide a policy and procedure for cleaning and/or maintaining the filter for the [MED]gen concentrators.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident had the right to be free from abuse for 1 of 12 residents reviewed for abuse. (Resident #7) The facility did not protect Resident #7 from verbal abuse when CNA B told the resident she stunk, sprayed a personal body spray on the resident when asked not to, and told the resident CNA B could leave her [REDACTED] because the resident was talking crazy to staff. This failure could place residents at risk for abuse. Findings included: An admission record dated 0[DATE] indicated Resident #7 was [AGE] years old, admitted [DATE] with [DIAGNOSES REDACTED]. A significant change MDS dated [DATE] indicated Resident #7 was moderately cognitively impaired, with clear speech, and was understood and could understand. The MDS indicated the resident's hearing was highly impaired but had a hearing aid. Resident #7's required extensive 1-person assistance with bed mobility and total dependence of 1-person for toileting. A care plan revised 01/02/20 indicated Resident #7 required extensive 2-person assistance with bed mobility and toileting. A Grievance/Complaint Report dated 03/04/20 noted Resident #7 complained of verbal abuse and rough treatment. Resident #7 reported CNA C told her she needed a shower and her [REDACTED] stunk and she and CNA C had words about what the CNA said. Resident #7 said CNA B told her to roll over and she informed the CNA the maintenance supervisor removed the enabler bar on her bed. The report indicated the resident told CNA B without the enabler bar she had nothing to grab hold of and that her left arm did not work. CNA B then pulled the pad under Resident #7 causing her to hit her head on the wall. The report noted Resident #7 asked CNA B her name and the CNA said she did not have one. Resident #7 told CNA B she would be reporting her because it was her room and CNA B would respect her and the CNA and should not be talking to her that way. The report indicated the resident said CNA B said it was the resident's word against hers and she walked out pushing the Hoyer lift. During an interview on 03/09/20 at 2:15 p.m., Resident #7 said CNA B and CNA C transferred her into her bed on the night of [DATE] at about 9:00 p.m. The resident said the CNAs said she needed to shower and CNA C said her (the resident's), [REDACTED] stunk. The resident said while CNA B provided her with incontinent care, she (CNA B) jerked the incontinent pad causing her (the resident) to roll toward the wall hitting her head on either the wood trim or the raised textured paint on the wall. Resident #7 said CNA B was spraying an air spray freshener and she asked the CNA not to spray it because it stinks. The resident said CNA B then sprayed the freshener 2 to 3 times in her (the resident's) face. Resident #7 said she asked CNA B her name and the CNA said she did not have one. During an observation on 03/09/20 at 2:15 p.m., Resident #7 was noted to have a scabbed abrasion to the left side of her forehead near the hair line. The resident had left side weakness. During an interview on 0[DATE] at 12:40 p.m., CNA B said she and CNA C transferred Resident #7 into bed on [DATE] between 8:30 p.m. to 9:00 p.m. The CNA said Resident #7 was already upset that the Hoyer lift was not working. CNA B said Resident #7, was talking [REDACTED] calling us out of our name. CNA B said CNA C left to obtain a brief to fit Resident #7. CNA B said the resident's bed was up against the wall in the room. She said she asked Resident #7 to roll over, but the resident was not cooperating so she used the incontinent pad to roll the resident toward the wall CNA B said she did not jerk the pad but when she pulled it, the resident hit her forehead area on the wall. CNA B said it was an accident. CNA B said as an agency CNA, she carried a bag with items she purchased in it such as baby powder and a body spray. CNA B said she used the body spray to kill the odors of [REDACTED]. CNA B said she sprays the body spray up and down the hallways where ever she was assigned to work and in residents' rooms unless they tell her not to. The CNA said Resident #7 was [REDACTED] but she did not spray the body spray in Resident #7's face CNA B said she applied some of the baby powder on Resident #7 upon providing incontinent care, sprayed some of the body spray on the inside of the resident's brief and some on the outside of the brief. The CNA said CNA C did not assist her with the incontinent care for Resident #7. CNA B said CNA C did not tell Resident #7 that her [REDACTED] stunk. CNA B said she told the resident she and CNA C could leave her [REDACTED] and leave her for the next shift. The CNA said Resident #7 said, you just going to leave my [REDACTED] wet. The Administrator's Summary to the 03/04/20 Provider Investigation Report noted CNA B said she informed the charge nurse for the evening of [DATE] about Resident #7's head bumping the wall. The administrator noted when he interviewed the charge nurse from the evening of [DATE] (when the incident allegedly occurred) and she denied CNA B reported anything. During an interview on 0[DATE] at 1:25 p.m., CNA C said she and CNA B transferred Resident #7 to bed on [DATE] around 9:00 p.m. She said the resident was kind of agitated because she had wanted to go to bed around 7:30 p.m. but since she was a 2-person transfer it was later before she was transferred to bed. CNA C said after the transfer, she left the resident's room and denied being present when CNA B provided incontinent care for Resident #7. The CNA said Resident #7 never cursed her or called her outside her name. She said when she returned to Resident #7's room CNA B was spraying the resident with perfume and said the resident stinks. CNA C said the resident said she did not want CNA B to spray her with the body spray. CNA C said she told CNA B to stop spraying the resident because she did not want to be sprayed. CNA C said CNA B said Resident #7 had called her a [REDACTED] and that the CNA kept saying she was not going to let anybody disrespect her. CNA B denied telling the resident that her [REDACTED] stunk and denied hearing the word [REDACTED] used to her knowledge. During an interview on 03/11/20 at 12:16 p.m., the administrator said CNAs should not bring in any personal baby powder, body spray, or deodorizers. He said when he interviewed CNA B, on 03/04/20 (the day he was informed of the alleged incident), regarding the allegation made by Resident #7, the CNA told him she did not spray any perfume but had sprayed peri-wash on Resident #7. He said CNA B admitted to accidently causing the resident to bump her

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) head on the wall when she pulled the incontinent pad. The administrator said CNA C denied using inappropriate language toward Resident #7. The administrator said the facility was the residents' home and should not have been disrespected in any way. During an interview and record review on 03/11/20 at 2:22 p.m., the ADON said the facility had a policy and procedure manual that agency staff should read and be in-serviced regarding the facility's abuse/neglect policy and procedure. She said the agency CNAs would not know the facility's policy and procedure for abuse/neglect without going through the policy and procedure manual. The manual provided from the back nurses' station was dated as last reviewed 03/01/12. The ADON said she did not believe the agency CNA B had been in-serviced by the facility over using personal powders and body sprays or abuse/neglect policy. The ADON said a resident could possibly have an allergic reaction to the powder or body spray and the facility would not have the proper [CONDITION]DS sheet to address the unknown powder or spray used. During an interview on 03/11/20 at 2:33 p.m., CNA B said CNA C was present in the room when she provided incontinent care to Resident #7. She said CNA C walked out after assisting with transferring the resident onto the bed to get a brief but returned to the room during care. CNA B said CNA C walked back in when she pulled the pad and Resident #7 hit her head. The CNA said CNA C did not assist with the actual incontinent care, but was there as a witness. CNA B said she told Resident #7, we just going to leave you [REDACTED] wet because you keep talking to us crazy. CNA B said she received abuse/neglect training from the agency that she worked through. The CNA said she had not been provided an abuse in-service through the facility. During an interview on 03/11/20 at 2:53 p.m., the DON and ADON said the facility did not have any check off proficiencies for CNA B. The DON and ADON said they were afraid the facility had dropped the ball in making sure agency staff had proper training. The DON said the facility had no paperwork to show CNA B received proper in-services from the facility. The ADON said they just assumed the agencies were handling the agency staffs' abuse/neglect in-services. The facility's Abuse and Neglect policy and procedure revised 07/17/19 indicated the following: Policy It is the policy of this facility to prohibit resident abuse or neglect in any form and to report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse or neglect caused by another person. Training: a. All new employees will receive in-service training pertaining to all aspects of abuse prohibition before working a shift.
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement writtenn policies and procedures to prevent abuse for 1 of 12 residents reviewed for abuse. (Resident #7) The facility did not protect Resident #7 from verbal abuse when CNA B told the resident she stunk, sprayed a personal body spray on the resident when asked not to, and told the resident CNA B could leave her [REDACTED] because the resident was talking crazy to staff. This failure could place residents at risk for abuse. Findings included: The facility's Abuse and Neglect policy and procedure revised 07/17/19 indicated the following: Policy It is the policy of this facility to prohibit resident abuse or neglect in any form and to report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse or neglect caused by another person. Training: a. All new employees will receive in-service training pertaining to all aspects of abuse prohibition before working a shift. An admission record dated 0[DATE] indicated Resident #7 was [AGE] years old, admitted [DATE] with [DIAGNOSES REDACTED]. A significant change MDS dated [DATE] indicated Resident #7 was moderately cognitively impaired, with clear speech, and was understood and could understand. The MDS indicated the resident's hearing was highly impaired but had a hearing aid. 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CNA B said as an agency CNA, she carried a bag with items she purchased in it such as baby powder and a body spray. CNA B said she used the body spray to kill the odors of [REDACTED]. CNA B said she sprays the body spray up and down the hallways where ever she was assigned to work and in residents' rooms unless they tell her not to. The CNA said Resident #7 was [REDACTED] but she did not spray the body spray in Resident #7's face CNA B said she applied some of the baby powder on Resident #7 upon providing incontinent care, sprayed some of the body spray on the inside of the resident's brief and some on the outside of the brief. The CNA said CNA C did not assist her with the incontinent care for Resident #7. CNA B said CNA C did not tell Resident #7 that her [REDACTED] stunk. CNA B said she told the resident she and CNA C could leave her [REDACTED] and leave her for the next shift. The CNA said Resident #7 said, you just going to leave my [REDACTED] wet. The Administrator's Summary to the 03/04/20 Provider Investigation Report noted CNA B said she informed the charge nurse for the evening of [DATE] about Resident #7's head bumping the wall. The administrator noted when he interviewed the charge nurse from the evening of [DATE] (when the incident allegedly occurred) and she denied CNA B reported anything. During an interview on 0[DATE] at 1:25 p.m., CNA C said she and CNA B transferred Resident #7 to bed on [DATE] around 9:00 p.m. She said the resident was kind of agitated because she had wanted to go to bed around 7:30 p.m. but since she was a 2-person transfer it was later before she was transferred to bed. CNA C said after the transfer, she left the resident's room and denied being present when CNA B provided incontinent care for Resident #7. The CNA said Resident #7 never cursed her or called her outside her name. She said when she returned to Resident #7's room CNA B was spraying the resident with perfume and said the resident stinks. CNA C said the resident said she did not want CNA B to spray her with the body spray. CNA C said she told CNA B to stop spraying the resident because she did not want to be sprayed. CNA C said CNA B said Resident #7 had called her a [REDACTED] and that the CNA kept saying she was not going to let anybody disrespect her. CNA B denied telling the resident that her [REDACTED] stunk and denied hearing the word [REDACTED] used to her knowledge. During an interview on 03/11/20 at 12:16 p.m., the administrator said CNAs should not bring in any personal baby powder, body spray, or deodorizers. He said when he interviewed CNA B, on 03/04/20 (the day he was informed of the alleged incident), regarding the allegation made by Resident #7, the CNA told him she did not spray any perfume but had sprayed peri-wash on Resident #7. He said CNA B admitted to accidently causing the resident to bump her head on the wall when she pulled the incontinent pad. The administrator said CNA C denied using inappropriate language toward Resident #7. The administrator said the facility was the residents' home and should not have been disrespected in any way. During an interview and record review on 03/11/20 at 2:22 p.m., the ADON said the facility had a policy and procedure manual that agency staff should read and be in-serviced regarding the facility's abuse/neglect policy and procedure. She said the agency CNAs would not know the facility's policy and procedure for abuse/neglect without going through the policy and procedure manual. The manual provided from the back nurses' station was dated as last reviewed 03/01/12. The ADON said she did not believe the agency CNA B had been in-serviced by the facility over using personal powders and body sprays or abuse/neglect policy. The ADON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675553	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE HOUSE HEALTH CARE CENTRE	1026 E GOODE ST QUITMAN, TX 75783

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) said a resident could possibly have an allergic reaction to the powder or body spray and the facility would not have the proper [CONDITION]DS sheet to address the unknown powder or spray used. During an interview on 03/11/20 at 2:33 p.m., CNA B said CNA C was present in the room when she provided incontinent care to Resident #7. She said CNA C walked out after assisting with transferring the resident onto the bed to get a brief but returned to the room during care. CNA B said CNA C walked back in when she pulled the pad and Resident #7 hit her head. The CNA said CNA C did not assist with the actual incontinent care, but was there as a witness. CNA B said she told Resident #7, we just going to leave you [REDACTED] wet because you keep talking to us crazy. CNA B said she received abuse/neglect training from the agency that she worked through. The CNA said she had not been provided an abuse in-service through the facility. During an interview on 03/11/20 at 2:53 p.m., the DON and ADON said the facility did not have any check off proficiencies for CNA B. The DON and ADON said they were afraid the facility had dropped the ball in making sure agency staff had proper training. The DON said the facility had no paperwork to show CNA B received proper in-services from the facility. The ADON said they just assumed the agencies were handling the agency staffs' abuse/neglect in-services.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure adequate supervision and assistance was provided to prevent accidents for 1 of 12 residents reviewed for accidents. (Resident #7) The facility did not provide Resident #7 with a 2-person toileting/bed mobility assist during incontinent care as required according to the resident's plan of care. CNA B turned the resident onto her side and the resident bumped her forehead onto the wall causing an abrasion and bruising. This failure could place residents at risk for inadequate supervision, injury, and decreased quality of life. Findings included: An admission record dated 03/10/20 indicated Resident #7 was [AGE] years old, admitted [DATE] with [DIAGNOSES REDACTED]. A significant change MDS dated [DATE] indicated Resident #7 had clear speech, was understood and could understand. The MDS indicated the resident's hearing was highly impaired but had a hearing aid. Resident #7's cognition was moderately impaired, required extensive 1-person assistance with bed mobility, and total dependence of 1-person for toileting. A care plan revised 01/02/20 indicated Resident #7 required extensive 2-person assistance with bed mobility and toileting. A Grievance/Complaint Report dated 03/04/20 noted Resident #7 complained of verbal abuse and rough treatment. Resident #7 said CNA B told her to roll over and she told CNA B the maintenance supervisor removed the enabler bar on her bed and she had nothing to grab hold of and that her left arm did not work. CNA B then pulled the pad under Resident #7 causing her to hit her head on the wall. The report noted Resident #7 asked CNA B her name and the CNA said she did not have one. During an observation and interview on 03/09/20 at 2:15 p.m., Resident #7 was noted to have a scabbed abrasion to the left side of her forehead near the hair line. The resident had left side weakness. Resident #7 said CNA B and CNA C transferred her into her bed on the night of 03/03/20 at about 9:00 p.m. The resident said while CNA B was providing the incontinent care, she jerked the incontinent pad, causing her (the resident) to roll toward the wall hitting her head on either the wood trim or the raised textured paint on the wall. During an interview on 03/10/20 at 12:40 p.m., CNA B said Resident #7 was transferred into bed by she and CNA C on 03/03/20 between 8:30 p.m. to 9:00 p.m. The CNA said Resident #7 was already upset that the Hoyer lift was not working. CNA B said CNA C left to obtain a brief to fit Resident #7. CNA B said the resident's bed was up against the wall in the room. She said she asked Resident #7 to roll over, but the resident was not cooperating, so she used the incontinent pad to roll the resident toward the wall. CNA B said she did not jerk the pad but when she pulled it, the resident hit her forehead area on the wall. CNA B said it was an accident. During an interview on 03/10/20 at 1:25 p.m., CNA C said she and CNA B transferred Resident #7 to bed on 03/03/20 around 9:00 p.m. She said the resident was kind of agitated because she had wanted to go to bed around 7:30 p.m. but since she was a 2 person transfer it was later before she was transferred to bed. CNA C said after the transfer, she left the resident's room and denied being present when CNA B provided incontinent care for Resident #7. During an interview on 03/11/20 at 2:33 p.m., CNA B said CNA C was present in the room when she provided incontinent care to Resident #7. She said after CNA C assisted her with transferring Resident #7 into the bed, CNA C left to get a brief but returned to the room during care. CNA B said CNA C walked back in as she pulled the resident's incontinent pad that was under the resident and the resident rolled over hitting her head on the wall. The CNA said CNA C had not assisted but had been there as a witness. During an interview on 03/11/20 at 2:43 p.m., CNA C denied being present during Resident #7's peri care with CNA B. The CNA said, that's a lie, I was there to put Resident #7 down in the bed but the resident's gown and brief were already in there. CNA C said Resident #7 was a 2 person transfer and was a 1person assist with bed mobility and incontinent care. The CNA said she was trained on how to work with Resident #7 by the CNA who trained her when she started working at the facility. During an interview on 03/11/20 at 2:53 p.m., the DON and ADON said the facility did not have any check off proficiencies for CNA B. The DON and ADON said they were afraid the facility had dropped the ball in making sure agency staff had proper training. The DON said the facility had no paperwork to show CNA B received proper in-services from the facility. The ADON said we just assumed the agencies were handling the agency CNAs' in-services and proficiency training. The DON said if the care plan indicated resident #7 required 2persons with toileting then 2 people should have provided the incontinent care. During an interview on 03/11/20 at 12:16 p.m., the administrator said CNA B admitted to accidently causing Resident #7 to bump her head on the wall when she pulled the incontinent pad. He said the CNA said it had been an accident.