

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/16/2024
NAME OF PROVIDER OR SUPPLIER  The Harrison at Heritage		STREET ADDRESS, CITY, STATE, ZIP CODE  4600 Heritage Trace Parkway Fort Worth, TX 76244	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32227</p> <p>Based on interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 4 residents reviewed for accidents.</p> <p>The facility failed to provide Resident #1, who had cognitive impairment and unsteady gait with a history of attempting to get up from her wheelchair unassisted, adequate supervision to prevent her falling. The resident was left alone in her room, and she fell sustaining lacerations to multiple sites on her scalp and neck and an injury to her wrist, which required the resident to be sent to the hospital where she received six staples to the back of her scalp, two staples on the left side of her scalp, and a brace to her wrist for a contusion.</p> <p>This failure could place residents at risk for serious injuries or harm, decline in health, and decreased quality of life.</p> <p>Findings included:</p> <p>Review of Resident #1's MDS dated [DATE] revealed the resident was an [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included cerebrovascular accident (stroke) and anxiety. The resident had long- and short-term memory and her daily decision making was severely impaired. Resident #1 used a wheelchair for mobility.</p> <p>Resident #1's most recent care plan printed on 04/16/24 reflected she was at risk for falls due to cognitive impairment and unsteady gait. Approaches included to anticipate needs and provide prompt assistance, encourage socialization, fall identifiers in place, keep bed in lowest position, move resident closer to the nurse's station, and keep Dycem (a sticky non-slip rubber that can be placed to stabilize objects) in the wheelchair. The care plan further indicated Resident #1 was on hospice services due to her diagnosis of dementia.</p> <p>Review of the facility's Provider Investigation Report dated 04/01/24 revealed Resident #1 was found on the floor and upon assessment was noted with open area to her head, so she was sent to the ER for evaluation and treatment. Resident #1 returned from the hospital with six staples to the back of the scalp, two staples on the left side of her scalp, and a brace to her wrist where she sustained a contusion.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/16/2024
NAME OF PROVIDER OR SUPPLIER  The Harrison at Heritage		STREET ADDRESS, CITY, STATE, ZIP CODE  4600 Heritage Trace Parkway Fort Worth, TX 76244	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's nurses notes dated 04/01/24 documented by LVN A revealed the following:</p> <p>CNA called nurse to patient room noticed patient on the floor on the side of the bed head to toe assessment done observed an open area on patient head DON, NP, and RP, notified call placed to 911 patient to sent to [hospital] for further evaluation hospice nurse notified.</p> <p>Review of Resident #1's hospital records dated 04/01/24 reflected the resident had a fall and was diagnosed with laceration of multiple sites of scalp and neck with stitches or staples.</p> <p>Resident #1 could not be observed as she had been discharged to another facility with a secure unit.</p> <p>Interview on 04/16/24 at 10:52 AM with LVN A revealed Resident #1 was on hospice services and a hospice aide would come in daily and provide care. LVN A said Resident #1 moved around in her wheelchair, and staff tried to keep her at the nurse's station because the resident would try to get up and walk. LVN A said the day of the incident, 04/01/24, the hospice aide had come in to provide the resident care and the hospice aide had left her in her room alone where the aide had later found her on the floor. The LVN was on her break and was not at the nurse's station while the hospice aide cared for the resident or when the hospice aide left. Once the LVN was alerted that Resident #1 was on the floor, she went to assess her and noticed an open area to the left side of her head, so she called 911. The resident was complaining of pain but was not able to verbalize what happened. LVN A further stated it was the same hospice aide that cared for the resident and the aide knew Resident #1 was a fall risk. She stated she should have taken the resident back to the nurse's station instead of leaving her in the room alone. LVN A also said because she was on her break, she was not able to tell the hospice aide to take the resident back to the nurse's station .</p> <p>Interview on 04/16/24 at 3:43 PM with CNA B revealed she was on her way to her lunch break when she saw the Hospice Aide giving Resident #1 a shower. She stated when she was returned from lunch, she noticed the resident was on the floor of her room. CNA B called LVN A for assistance, and they noticed Resident #1 was bleeding. CNA B said Resident #1 was a fall risk and staff tried to keep her at the nurses' station, so they could keep an eye on her, but it appeared that the Hospice Aide left the resident unattended in the room. The CNA B said she did not know when the Hospice aide left after giving Resident #1 a shower. CNA B said there were some residents that had a red bracelet on the back of their wheelchairs and that meant those residents needed to be monitored more closely, as the bracelet indicated they were a fall risk, and Resident #1 had one on her chair.</p> <p>Attempts to contact the hospice aide on 04/16/24 were unsuccessful.</p> <p>Interview on 04/16/24 at 2:49 PM with LVN C revealed Resident #1 was very confused and required frequent redirection because she attempted to stand up from her wheelchair., Therefore the resident was kept at the nurse's station because she was a high fall risk. Resident #1 thought her wheelchair was a bicycle because she would move about with her feet and stated she was going to ride it home. LVN C further stated Resident #1 was on their high risk fall program and they kept a red bracelet on her wheelchair. This meant that resident had to be monitored more closely to ensure the residents were safe .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/16/2024
NAME OF PROVIDER OR SUPPLIER  The Harrison at Heritage		STREET ADDRESS, CITY, STATE, ZIP CODE  4600 Heritage Trace Parkway Fort Worth, TX 76244	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/16/24 at 2:23 PM with the ADON revealed Resident #1 was put on their high fall risk program because of her confusion but was easily redirected. There was a green leaf placed on her door and a red bracelet on the back of the wheelchair to remind staff the resident needed to be monitored more closely. They kept Resident #1 at the nurse's station most of the time to monitor her more closely. The ADON was made aware of Resident #1's fall and the resident was sent to the hospital and returned with some staples to the back of her head and a brace to her wrist .</p> <p>Interview on 04/16/24 at 3:49 PM with the hospice RN revealed they had been made aware of Resident #1's fall and injury. The RN stated when she visited Resident #1, she was usually in her wheelchair in the hallway. The RN would take her to her room to assess her and usually take her back to where she had found her. They were aware the resident was a high fall risk because of her poor safety awareness. The RN did not know the rest of the details regarding Resident #1's fall.</p> <p>Interview on 04/17/24 at 11:15 AM with the DON revealed Resident #1 had a history of being very independent and did not want anyone helping her. The DON stated they were doing everything they could to maintain her dignity and pride while trying to keep her safe at the same time. Resident #1 was very mobile in her wheelchair and always sat in the cafe across the nurse's station and would also wander the halls. The DON was never notified the hospice aide had been caring for Resident #1 prior to the resident's fall. The DON further stated they could not hold Resident #1 to a certain area because she was always moving around. Resident #1 required moderate supervision which meant staff should have been checking on the resident more often as the resident was a high fall risk .</p> <p>Interview on 04/16/24 at 6:04 PM with the Administrator revealed they could not say if Resident #1 had indeed been left in her room alone because the resident was able to self-propel her wheelchair and who was to know if she did not take herself back there after she had been cared for. The Administrator further stated she was not aware if the hospice aide had indeed taken care of the resident the day of the incident, 04/01/24. The Administrator said Resident #1 had been discharged to another facility with a secure unit so she could be monitored more closely in a smaller environment .</p> <p>Review of the facility's policy titled Fall Management Guidelines dated 11/2022 reflected the following:</p> <p>.2. A Fall Risk Assessment will be initiated for each Patient upon admission, re-admission, quarterly, upon significant change in a Patient's condition or after a fall. The Fall Risk Assessment score will be used in conjunction with clinical judgement and review of risk factors determining a Patient's risk for falls.</p> <p>.9. Staff assigned to the units will conduct rounds for residents at risk for falls or who have experienced a fall to ensure their fall prevention interventions are implemented.</p>		