| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676317 | A. Building<br>B. Wing | 05/31/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Harrison at Heritage | 4600 Heritage Trace Parkway<br>Fort Worth, TX 76244 |

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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 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152<br><br>Based on observation, interview and record review, the facility failed to implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, and mental and psychosocial needs in order attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (Resident #1) of eleven residents reviewed for care plans.<br><br>The facility failed to ensure Resident #1 was attended and supervised while left in 96-degree heat for approximately 2 hours resulting in unresponsiveness, second degree skin burns, hospitalization , and heat stroke.<br><br>The facility failed to develop a comprehensive care plan to address Resident #1's behavior to ensure his safety while exercising his right to sit on the facility's patio during 96-degree heat, resulting in unresponsiveness, second degree skin burns, hospitalization , and heat stroke.<br><br>The facility failed to implement/document the interventions that were in the care plan when Resident #1 refused hydration and to come inside the facility, during 96-degree heat, to ensure he did not overheat while sitting on the facility's patio.<br><br>An Immediate Jeopardy (IJ) was identified on 05/30/2024. While the IJ was removed on 05/31/2024 at 2:50 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.<br><br>This failure could affect residents by placing them at risk for not receiving care and services to meet their needs.<br><br>Findings include:<br><br>(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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of Resident #1's Face Sheet dated 05/30/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Diagnoses included: vascular dementia (problems with reasoning, planning, judgement and memory), hemiplegia unspecified affecting left nondominant side (paralysis of the left side due to neurological injury), open-angle glaucoma - right eye (fluid in eye causing pressure on the optic nerve), cerebral infarction (disrupted blood flow to the brain), hyperlipidemia (elevated level of lipids like cholesterol in the blood), major depressive disorder (mood disorder causing persistent feelings of sadness and loss of interest), dysphagia (difficulty swallowing), muscle weakness, inflammatory liver disease (viral hepatitis), and chronic respiratory failure with hypoxia (respiratory failure).<br><br>Record review of Resident #1's quarterly MDS Assessment, dated 04/15/2024, reflected a BIMS score of 9 indicating a mild cognitive impairment. He exhibited not physical or verbal behavior directed toward others and did not refuse care. He used a manual wheelchair to ambulate, had functional limitations on left side and required supervision during use. Functional Status indicated he required total dependence for, transfers, toileting and lower body dressing, substantial assist for showers, and partial assist for hygiene.<br><br>Record review of Resident #1's Care Plan dated 09/01/2019 - Present, reflected, Problem: [Resident #1] is totally dependent on the staff with transfers - extensive (to/from: bed chair wheelchair, standing position). Intervention: [Resident #1] to be out-of-bed in chair at least two times daily. Interventions: Encourage PO and fluid intake. Problem: [Resident #1] is currently taking psychotropic medication as evidenced by, depression, cognitive impairment, and schizoaffective disorder. Interventions: Encourage appropriate behavior, discourage inappropriate behavior. Protect [Resident #1] from self-harm or harm to others. Monitor and record any displayed behavior or mood problems. Problem: [Resident #1] has cognitive impairment as evidenced by: Memory problems - short term, and impaired ability to make daily decisions r/t Dx Dementia. Interventions: assist with ADLs to the highest degree possible. Problem: [Resident #1] likes to go outside and sit in the courtyard. Intervention: Identify times/approaches/staff that result in least resistance. Communicate to all caregivers. Notify physician and Rp of noncompliance. When care is refused, remind [Resident #1] of potential risk. Coax but DO NOT FORCE compliance.<br><br>Record review of the Facility's Investigation Report reflected, On 05/26/2024 at an unknown time, [Resident #1] had requested to go to courtyard and aide assisted him. [Resident #1] advised and educated about heat, and to not stay long because of the heat. [Resident #1] had a change of condition, was put back into the facility and 911 called. Resident was unresponsive but breathing. Resident's vitals obtained and 911 called. EMT's advised nurses on cooling rags until their arrival. Investigation initiated. In-services on abuse and neglect, and outside protocol for residents. A statement signed by LVN V and dated 05/26/2024, reflected, During med pass around 4:30 PM [Resident #4] came to this nurse and said to check on [Resident #1] because he was sitting outside. This nurse went out to check on [Resident #1] and he was unresponsive and was burning up hot. This nurse brought the resident back in from sitting outside and started a sternum roll but was unsuccessful. This nurse told the other nurse to call 911. We started getting water and ice packs to cool him off. This nurse and [CNA D] put the resident on the floor flat on his back with his head tilted up faced to the left side. This nurse assisted in filling ice in the trash cans for the EMTs to give him ice and water.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of the EMT Record, dated 05/26/2026 at 4:53 PM, reflected, EMT arrived on scene to a nursing home with Fire Department. [Resident #1] was found lying supine on the floor inside the cafe area of the nursing home. Facility called EMS for heat exposure, not responsive. Facility reported he went outside to the courtyard, and then must have fallen asleep out there and was outside for a couple hours. Unknown how long pt was outside, heat was over 90 degrees at the time. Also, unknown if the pt fell outside or was laying on the concrete or a wheelchair. Upon EMS arrival to the pt, he was unresponsive. Skin was very hot and dry to the touch. Pt was tachycardic, hypotensive, and hypoxic. Pt had secretions in his mouth and had agonal snoring respirations. Began to ventilate the pt via BVM. Established an IO in the left humerus head. Started pt on a fluid bolus. Placed 2 NPA's in the pt. Administered 10 mcg of push-dose EPI. Picked up pt on ground and onto the cot to get HOB elevated 30 degrees and ETSN. On the cot had already placed bag for ice immersion with some ice. Placed in bag and covered with more ice to cool him. Pt has some second degree burns to his arms abdomen and neck with some of the top layer of skin peeling off.<br><br>Record review of the ER Hospital Record, dated 05/26/2026 at 8:31 PM, reflected, Chief Complaint: hyperthermia, unresponsive [Resident #1] was in his wheelchair outdoors for an unknown amount of time when he fell asleep and ended up falling from the wheelchair. On my exam he has a GCS of 3T, and physical exam is remarkable for second-degree burns to his chest, anterior neck and extremities. He was reported to be hyperthermic (106) on the scene and arrived surrounded by ice per EMS. In trauma bay found to be hypothermic requiring [NAME] and noted to have profound hypotensive shock requiring fluid resuscitation and vasopressors. CHIEF COMPLAINT: HEAT STROKE AND 13% TBSA PAVEMENT CONTACT BURNS HPI: 68M with PMH of a stroke, hemicraniectomy, and left sided hemiparesis who lives in a nursing home and was placed outside where he developed a heatstroke and fell on to the pavement and was on the pavement for quite some time. He presented with depressed mental status and hypotensive shock. He required intubation, fluid resuscitation, and vasopressors. He was found to have blistering of the skin and underwent debridement and was found to have at least 13% TBSA hot pavement contact burns which appear second degree at this point. Although at the scene he was apparently hyperthermic in heatstroke at 106F he then became hypothermic down to 92.3F in the ER.<br><br>Record review of Resident #1's Nursing Note dated 05/26/2024 at 10:44 PM, signed by LVN A, reflected, Resident went to the courtyard in the afternoon and was brought back into the building by staff. At the time, he was not responding to name calling, or painful stimulus. Cold towels were applied to his body to cool him down while this nurse called 911 for assistance. Paramedics on the line assisted and gave instructions on stabilizing resident until first responders were on the scene to stabilize resident using Vasopressors and ambu [resuscitation] bag. Resident was transferred to [hospital] for further treatment. RP, DON, and administrator notified.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 05/30/2024 at 8:16 AM, the Executive Director stated, Resident #1 liked to sit outside and often did so after breakfast. She stated he always wore a hat and sunglasses and could get in / out of the patio on his own. She stated she was informed by staff on 05/26/2024 that Resident #1 was found outside unresponsive and sent to the hospital. She stated her investigation, thus far, concluded staff assisted him outside about 2:30 PM and was cautioned of the temperature and offered water. At about 4:30 PM Resident #4 asked LVN V to check on Resident #1 because he was unresponsive on the patio. She stated Resident #1's nurse, LVN A was on lunch break and LVN V was passing medications at the time. She stated LVN A called 911 and the dispatcher directed them on cooling Resident #1 down. She said they moved Resident #1 to the floor and covered with wet towels and ice packs. She stated EMS arrived quickly and took over then transported to the hospital. She said she was still working on her investigation but received the EMT transport record and they indicated Resident #1 was found on the ground outside. She stated said the EMT's reported Resident #1 fell asleep and fell from his wheelchair to the concrete and was on the floor for an unknown amount of time. She stated this was incorrect as he was found in his wheelchair. She said she had not received a medical update on Resident #1 from the hospital. She said the hospital reported 2nd degree burns and peeled skin to Resident #1's forehead and right side. She stated she spoke to the MD who said the burns likely occurred when the skin blistered when staff and EMTs attempted to cool Resident #1. She said it seemed that Resident #1 was not supervised as he could have been. When he refused water and warned of the temperature, staff still took him outside and the left him outside until the incident was brought to their attention. She said there was no documentation from staff that they did what they said they did.<br><br>In an interview on 05/30/2024 at 9:51 AM, Resident #3 stated she saw Resident #1 sitting on the patio in the afternoon of 05/26/24. She said he liked to sit outside, and she often would tell him to come inside, and he would tell her to go away. She said at about 4:30 PM she saw Resident #4 on the patio trying to wake Resident #1 up. She said Resident #1 was in his wheelchair and not responding to Resident #4. She stated Resident #4 told LVN V who immediately brought Resident #1 back into the facility. She said he did not have any burns that she could see but was unresponsive to the nurses. She said the nurses placed Resident #1 on the floor and used ice and wet towels to cool Resident #1 down. She said the EMTs came shortly after and put Resident #1 in a bag with ice then took him to the hospital.<br><br>In an interview on 05/30/2024 at 10:11 AM, LVN B said she worked on 100 Hall on 05/26/2024 but left the facility about 3:30 PM and did not notice if Resident #1 was outside or not. She said Resident #1 came to her about 1:45 PM and wanted to go outside but she told him to check with his nurse, LVN A. She stated she saw CNA D talk to Resident #1 but did not see them go outside. She stated she received a call from LVN A at 5:50 PM informing her that Resident #1 was taken to the hospital due to heat exposure.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In a telephone interview on 05/30/2024 at 12:11 PM, CNA D said Resident #1 wanted to go outside after lunch and he did assist Resident #1 to the patio at about 2:30 PM. He said he checked on Resident #1, but he did not want to come in. CNA D said he offered Resident #1 water and tried to get him to come into the facility but Resident #1 refused both as he always did. CNA D said Resident #1 told him he would let him know when he wanted to come in. CNA D said he was busy with other residents and did not follow up with Resident #1. He said he did not know the time, but he saw LVN V bring Resident #1 into the facility. He said LVN V told him to get ice and wet towels to cool Resident #1 down. He said Resident #1 did not respond to LVN V and LVN A was on the phone to 911. He said they moved Resident #1 to the floor and place wet towels and ice on him until EMTs arrived. He said he was not sure but thought Resident #1 was outside for about 2 hours.<br><br>In an interview on 05/28/2024 at 12:47 PM, LVN A stated she went for lunch and when she returned, as she walked down the hall, LVN V met her and told her that Resident #1 was not responding. She stated Resident #1 was in his wheelchair, hot to the touch, not really sweaty, and breathing heavily. She stated his eyes were closed and he was not moving. She said he did not respond to them calling his name. She stated she had staff get cold towels to wipe him down and to put on him to cool him down. She said she rubbed Resident #1's chest with her hand in a fist, palm on chest, but he did not respond, so she did it again with more pressure. She stated he still did not respond. She stated that was when she called 911. She said she told them Resident #1 was outside and was unresponsive. LVN A said they told her to lay Resident #1 on the floor. She said they laid him on the floor he started foaming at the mouth. She said they turned his head to the side and cleared his mouth. She stated just as they were done clearing his mouth, the EMTs arrived. She stated the EMTs checked his vitals and told staff to bring ice. She said Resident #1's temperature was 106.5 degrees F. She stated EMTs put a big plastic sheet under Resident #1 and poured all of the ice on and around him, lifted him on to the gurney, strapped him in and took him away in the ambulance. She stated she didn't not ask who found him or how long he had been outside.<br><br>In an interview on 05/30/2024 at 1:30 PM, Family Member X said Resident #1 was in ICU at the hospital. Family Member X said the attending physician at the hospital told her on 05/27/24 at 9:47 AM that Resident #1 came to the hospital with a temperature of 106.5 degrees F. She said the physician told her Resident #1 had heat stroke and was in cardiovascular shock, required fluid and medication for blood pressure, was on a mechanical ventilator, had lung and renal failure and remained unresponsive. She said the physician told her to prepare because he did not think Resident #1 would survive.<br><br>In an interview on 05/30/2024 at 2:32 PM, the Executive Director and DON, the DON stated there was no documentation indicating the CNA D or LVN A checked on Resident #1 of implemented any behavior interventions given that he often refused to come inside. The DON said the care plan should be specific when addressing behaviors because Resident #1 did have a right to stay on the patio as long as it did not pose a risk of harm to his wellbeing. She said that right needed to be balance with Resident #1's safety.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 05/30/2024 at 3:00 PM, Resident #4 stated he was going for supper at about 4:30 PM on 05/26/2024 but saw Resident #1 on the patio. He said he went to talk to Resident #1 but found him in his wheelchair and appeared to be asleep. Resident #4 said he poked Resident #1, and he did not respond. He stated he shook resident #1 and he was still unresponsive. Resident #4 said he called LVN V who came outside and brought Resident #1 into the facility. He said Resident #1 did not respond to LVN V either. He said the nurses called 911 and moved Resident #1 to the floor where they put ice and cold towels on him. He said the EMTs came quickly, and they took Resident #1 to the hospital. Resident #4 said Resident #1 liked it outside and often refused to come in even when it was hot. He said he could convince him to come in sometimes, but it depended on Resident #1's mood.<br><br>An observation, at the hospital ICU, on 5/31/24 at 9:15 AM, revealed Resident #1 unresponsive to hospital staff's verbal commands. Resident #1 was on dialysis and a ventilator. He was missing skin on his forehead, right cheek / throat, and right arm.<br><br>In an interview, at the hospital ICU, on 5/31/24 at 9:15 AM, the ICU RN and ICU Physician said although Resident #1 had been responding better to treatment, he still may not recover from his injuries. They said he was still non-responsive. The ICU Physician said EMTs brought Resident #1 to the hospital with a 106. 5-degree F temperature. He said that puts the body in sever shock. They said it was their understanding that Resident #1 was found on the pavement and had been there for an unknown amount of time. This survey informed them of eyewitness accounts that Resident #1 was not on the ground while outside. The ICU Physician stated the burns could be cause from blistering caused when they placed cold towels and ice on Resident #1 to cool him down. He said it would be similar to frost bite and skin would come off. The ICU Physician said Resident #1 had a lot of underlying comorbidities and this incident amplified them.<br><br>A telephone call to LVN V on 05/31/2024 at 1:25 PM revealed no response.<br><br>A telephone call to LVN E on 05/31/2024 at 1:30 PM revealed no response.<br><br>In an interview on 05/31/2024 at 2:14 PM, the Medical Director said he was aware that Resident #1 was found unresponsive on the patio. He said the ED called to discuss the burn marks reported by the hospital. He said they were likely from blistering which occurred when staff and EMTs placed cold towels and ice on Resident #1 to cool him. He said he could have got the burns from being outside for an extended period of time, but that time period was different for everyone. He said Resident #1 has a right to go outside but the facility was responsible to ensure his choice to do so was safe. The MD said Resident #1's labs completed on 04/12/2024 were normal. He said a chest x-ray was completed on 04/09/2024 and had no issues noted.<br><br>In an interview on 05/31/2024 at 2:50 PM, the DON stated, she understood the failed to supervise and ensure Resident #1 was safe from hazards when he sat on the facility's patio in 92-degree heat for at approximately 1 3/4 - 2 hours. She stated there was no documentation that staff intervene in ensuring he came into the facility or that he was offered hydration. She stated the POR addressed the expectations on staff to ensure residents were safe in all weather conditions.<br><br>Record review of the Accuweather website: https://www.accuweather.com/en/us/[NAME]/76248/may-weather/340873?year=2024 reflected the actual high temperature on 05/26/2024 was 96 degrees F.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of the facility's policy, titled, Care plans - comprehensive person-centered, revised March 2022, reflected, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making .<br><br>The Executive Director, DON and Regional Director of Clinical Services were notified of an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 05/30/2024 at 6:16 PM, due to the above failures and the IJ template was provided.<br><br>The facility's Plan of Removal was accepted on 05/31/2024 at 2:50 PM and included: Assessment: The Executive Director notified the facility Medical Director of the Immediate Jeopardy on 05/30/2024 at 7:00 p.m. An emergency QAPI meeting was held on 5/26/2024. All residents will have an audit completed to determine if they are at risk of being outside alone during unfavorable weather conditions. This will include determination of the desire for the residents to go outside and the decision-making capacity to be alone outside if weather conditions are unfavorable. This will be completed by the Director of Nurses, Assistant Director of Nurses, Social Worker, and/or Patient Care Coordinators on 5/31/2024. This will be used to identify any current patients that are at imminent risk for heat stroke due to extended time outside and related to their medical conditions. After completion of the resident audits, no other residents were found to be at imminent risk of being alone outside in unfavorable weather conditions.<br><br>Who will be responsible: Nurse Managers.<br><br>Who Will monitor: Executive Director and Regional Director of Clinical Services (RDCS).<br><br>Beginning 5/31/2024, Resident audits will be completed upon admission, condition change, and quarterly by the charge nurse and/or nurse managers, and for any resident that is identified as wanting to be outside in unfavorable weather conditions. For any resident that identifies they would like to be outside, the weather conditions, their cognitive ability and physical ability will be reviewed by the charge nurse to determine the safety of the resident. If there is a safety concern and the weather conditions are unfavorable, Nursing is to assess if the weather conditions are safe for resident exposure a staff member or family member will remain with the resident while outside to ensure no adverse outcomes occur. Staff will be required to monitor with ongoing 15-minute checks for any resident who chooses to go outside in unfavorable weather conditions. The facility staff will progressively monitor the resident with 15-minute checks and if the resident is deemed in imminent danger the staff will also call 911. If a resident chooses to remain outside under unfavorable weather conditions despite attempts to coerce the resident to return inside, the staff will notify the DON and the ED and follow the plan of care including the following:<br><br>Explain/Educate resident/family when times and conditions are appropriate and safe for resident exposure<br><br>Staff to ensure that the resident is dressed appropriately for the weather<br><br>Staff to round frequently to offer/assist with hydration, nutrition<br><br>(continued on next page) |

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|---|---|
| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Staff to round frequently to offer/provide ADL assist (positioning, toileting .)<br><br>Confer with MD about a prn order for sunscreen<br><br>When weather not permitted, offer alternative activities of resident's preferences<br><br>Nursing to assess for any psychological, social, behavioral changes and document and follow up prn.<br><br>Staff to provide level of supervision appropriate for resident<br><br>The DON will monitor for compliance daily by receiving report from the charge nurses for any resident deemed unsafe to be outside alone that requests to be outside. Audits will be completed weekly for 3 months until 8/31/2024 and then monthly on an ongoing basis by the Executive Director.<br><br>Who will be responsible: Charge Nurses.<br><br>Who Will monitor: Director of Nursing and Executive Director.<br><br>All staff were educated to notify the Executive Director, Director of Nursing or nursing management immediately when any resident goes outside in unfavorable weather conditions and to remain with the resident until further notice or the resident agrees to return inside the facility. This education was provided on 5/31/2024. This education was provided by the Director of Nursing and Assistant Director of Nursing. Staff will not be allowed to begin their shift until the education has been completed.<br><br>Who will be responsible: Nurse Managers.<br><br>Who Will monitor: Executive Director and RDCS.<br><br>In-Services: All staff were in-serviced on residents going outside unsupervised during unfavorable weather conditions by the Director of Nursing and/or Nurse Managers. The ED and DON were educated by the RDCS on all in-service topics related to the IJ. All new clinical staff will receive the in services as part of the onboarding orientation process prior to being assigned and providing care to residents. All staff will be in-serviced on neglect, documenting behaviors, rounding and increased communication. No staff member will be allowed to work in the facility until the above required in-services are completed. The in-services with all staff will be completed by 5/31/2024. All staff were in-serviced by 8 am on 5/31/2024.<br><br>Who will be responsible: Nurse Managers.<br><br>Who Will monitor: Executive Director and RDCS.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 676317 | A. Building<br>B. Wing | 05/31/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Harrison at Heritage | 4600 Heritage Trace Parkway<br>Fort Worth, TX 76244 |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Monitoring: Starting 5/31/24 Director of nursing and/or Nurse Managers will review the 24-hour report for any incident of residents being outside during unfavorable weather conditions, each day for 4 weeks week, then weekly for 4 weeks. The Executive Director will review the documentation each week for compliance. Beginning 5/31/2024 no staff will be allowed to work until the required in servicing has been completed. Should Resident A return to the facility, he will not be allowed outside without supervision.<br><br>Quality: Starting 5/31/2024 and ongoing monthly all concerns regarding adequately supervising residents will be taken to the Quality Assurance Committee for analysis and recommendations with input from the Medical Director going forward. The Executive Director will monitor for compliance. Starting 5/31/2024 and ongoing monthly the Regional Director of Clinical Services and/or designee will monitor weekly to ensure compliance for four weeks and will review at the next Quality assurance meeting.<br><br>On 05/31/2024 at 2:50 PM the surveyor began monitoring the facility's Plan of Removal.<br><br>Interviews on 05/31/2024 between 3:00 PM and 4:00 PM with ADONs T and U, PTA H, OTA I, Housekeeper F and G, LVNs C and L, RNs O and P, and CNAs M, N, R, S, Maintenance Director, Social Worker, and Activities Director reflected staff representing 1st, 2nd, and 3rd shifts and all days of the week. Staff were able to convey appropriate knowledge of the POR inservice's including the identification of adverse weather exposure impacts on residents and care plans and interventions required address behavior changes and to ensure their safety in any weather conditions. They demonstrated knowledge of documenting behaviors, strategies to address behaviors and notifying the DON, MD, and family members, when residents were non-compliant with interventions meant to ensure their safety. All staff stated the DON and nurse managers would monitor these actions.<br><br>In an interview on 05/31/2024 at 2:50 PM, the DON stated, she understood the failed to supervise and ensure Resident #1 was safe from hazards when he sat on the facility's patio in 92-degree heat for at approximately 1 3/4 - 2 hours. She stated there was no documentation that staff intervene in ensuring he came into the facility or that he was offered hydration. She said she was also interview in writing comprehensive care plans that addressed specific resident behaviors, interventions, and tracking them. She stated the in-services were done by the Regional Director of Clinical Services and she, in turn in-serviced facility staff in all departments. She stated in-servicing would be ongoing until all facility staff had completed training.<br><br>In an interview on 05/31/2024 at 2:40 PM, the Executive Director stated she and the DON, had been in-serviced on weather condition safety for all residents, by the Regional Director of Clinical Services. She stated all facility staff were educated on communication and notification of nursing staff regarding resident behaviors that may pose a risk of harm to them. She said she completed an audit of residents who were at risk of harm based on their behaviors and propensity to be outside. She said in-services were provided to nursing staff on comprehensive care planning to address specific behaviors in residents and provide specific strategies to ensure their safety. She said these will be monitored by the DON through assessment reports and nursing communication records. She said she would monitor this through the IDT and QUPI process. She stated in-servicing would be ongoing until all facility staff had completed training.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of the facility's in-service record addressed to nurses, dated 05/30/2024, and titled, Documentation of Behaviors, included the following topics. All services provided to the resident, or any changes in the resident's medical or mental condition, and behaviors shall be documented in the resident's medical record. A behavior is the way a person acts in response to a particular situation or event. Behaviors include but are not limited to: Going outside daily, yelling, repeating themselves, etc.6. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: a. The date and time the procedure/treatment was provided. b. The name and title of the individual(s) who provided the care. c. The assessment data and/or any unusual findings obtained during the procedure/treatment. d. How the resident tolerated the procedure/treatment. e. Whether the resident refused the procedure/treatment. f. Notification of family, physician, or other staff, if indicated. g. The signature and title of the individual documenting.<br><br>Record review of the facility's in-service record addressed to CNAs, dated 05/30/2024, and titled, Documentation of Behaviors, included the following topics. All services provided to the resident, or any changes in the resident's medical or mental condition, and behaviors shall be documented in the resident's medical record. A behavior is the way a person acts in response to a particular situation or event. Behaviors include but are not limited to going outside daily, yelling, repeating themselves, etc. C.N.A. documentation should include factual documentation, needs and conditions of the resident, on-going, and all observations made by care staff. What should be documented: 1. Documenting Activities of Daily Living (ADL's) that are outlined in each resident's care plan. 2. Any other activities in which assistance is provided. 3. Useful information that the family provides about the resident. 4: Any refusal of assistance by the resident. Observations that are made regarding the resident (examples: chilling, sweating, pain, heat, redness, swelling, coughing, skin changes, change in color of lips or nails, and mental status, etc). The C.N.A. is to communicate any observations regarding the resident to their nurse, and the nurse is to document and assess the resident. The nurse then notifies the appropriate individuals such as the responsible party, physician, etc<br><br>Record review of the facility's resident risk audit addressing the following criteria: Behavior of seeking to go outside; physical ability to go outside without assistance; and poor judgement or safety awareness identified 27 residents. Care plans were updated for these residents.<br><br>An Immediate Jeopardy (IJ) was identified on 05/30/2024. While the IJ was removed on 05/31/2024 at 2:50 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152<br><br>Based on observation, interview, and record review, the facility failed to ensure the resident received adequate supervision and assistance devices to prevent accidents for one (Resident #1) eleven residents reviewed for accidents and hazards.<br><br>The facility failed to ensure Resident #1 was attended and supervised while left in 96-degree heat for approximately 2 hours resulting in unresponsiveness, second degree skin burns, hospitalization , and heat stroke.<br><br>The facility failed to ensure Resident #1 was safe from hazards when he sat on the facility's patio in 96-degree heat for at approximately 2 hours resulting in unresponsiveness, second degree skin burns, hospitalization , and heat stroke.<br><br>An Immediate Jeopardy (IJ) was identified on 05/30/2024. While the IJ was removed on 05/31/2024 at 2:50 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.<br><br>This failure could place the residents at risk of adverse health reactions and / or death.<br><br>Findings include:<br><br>Record review of Resident #1's Face Sheet dated 05/30/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Diagnoses included: vascular dementia (problems with reasoning, planning, judgement and memory), hemiplegia unspecified affecting left nondominant side (paralysis of the left side due to neurological injury), open-angle glaucoma - right eye (fluid in eye causing pressure on the optic nerve), cerebral infarction (disrupted blood flow to the brain), hyperlipidemia (elevated level of lipids like cholesterol in the blood), major depressive disorder (mood disorder causing persistent feelings of sadness and loss of interest), dysphagia (difficulty swallowing), muscle weakness, inflammatory liver disease (viral hepatitis), and chronic respiratory failure with hypoxia (respiratory failure).<br><br>Record review of Resident #1's quarterly MDS Assessment, dated 04/15/2024, reflected a BIMS score of 9 indicating a mild cognitive impairment. He exhibited not physical or verbal behavior directed toward others and did not refuse care. He used a manual wheelchair to ambulate, had functional limitations on left side and required supervision during use. Functional Status indicated he required total dependence for, transfers, toileting and lower body dressing, substantial assist for showers, and partial assist for hygiene.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of Resident #1's Care Plan dated 09/01/2019 - Present, reflected, Problem: [Resident #1] is totally dependent on the staff with transfers - extensive (to/from: bed chair wheelchair, standing position). Intervention: [Resident #1] to be out-of-bed in chair at least two times daily. Interventions: Encourage PO and fluid intake. Problem: [Resident #1] is currently taking psychotropic medication as evidenced by, depression, cognitive impairment, and schizoaffective disorder. Interventions: Encourage appropriate behavior, discourage inappropriate behavior. Protect [Resident #1] from self-harm or harm to others. Monitor and record any displayed behavior or mood problems. Problem: [Resident #1] has cognitive impairment as evidenced by: Memory problems - short term, and impaired ability to make daily decisions r/t Dx Dementia. Interventions: assist with ADLs to the highest degree possible. Problem: [Resident #1] likes to go outside and sit in the courtyard. Intervention: Identify times/approaches/staff that result in least resistance. Communicate to all caregivers. Notify physician and Rp of noncompliance. When care is refused, remind [Resident #1] of potential risk. Coax but DO NOT FORCE compliance.<br><br>Record review of the Facility's Investigation Report reflected, On 05/26/2024 at an unknown time, [Resident #1] had requested to go to courtyard and aide assisted him. [Resident #1] advised and educated about heat, and to not stay long because of the heat. [Resident #1] had a change of condition, was put back into the facility and 911 called. Resident was unresponsive but breathing. Resident's vitals obtained and 911 called. EMT's advised nurses on cooling rags until their arrival. Investigation initiated. In-services on abuse and neglect, and outside protocol for residents. A statement signed by LVN V and dated 05/26/2024, reflected, During med pass around 4:30 PM [Resident #4] came to this nurse and said to check on [Resident #1] because he was sitting outside. This nurse went out to check on [Resident #1] and he was unresponsive and was burning up hot. This nurse brought the resident back in from sitting outside and started a sternum roll but was unsuccessful. This nurse told the other nurse to call 911. We started getting water and ice packs to cool him off. This nurse and [CNA D] put the resident on the floor flat on his back with his head tilted up faced to the left side. This nurse assisted in filling ice in the trash cans for the EMTs to give him ice and water.<br><br>Record review of the EMT Record, dated 05/26/2026 at 4:53 PM, reflected, EMT arrived on scene to a nursing home with Fire Department. [Resident #1] was found lying supine on the floor inside the cafe area of the nursing home. Facility called EMS for heat exposure, not responsive. Facility reported he went outside to the courtyard, and then must have fallen asleep out there and was outside for a couple hours. Unknown how long pt was outside, heat was over 90 degrees at the time. Also, unknown if the pt fell outside or was laying on the concrete or a wheelchair. Upon EMS arrival to the pt, he was unresponsive. Skin was very hot and dry to the touch. Pt was tachycardic, hypotensive, and hypoxic. Pt had secretions in his mouth and had agonal snoring respirations. Began to ventilate the pt via BVM. Established an IO in the left humerus head. Started pt on a fluid bolus. Placed 2 NPA's in the pt. Administered 10 mcg of push-dose EPI. Picked up pt on ground and onto the cot to get HOB elevated 30 degrees and ETSN. On the cot had already placed bag for ice immersion with some ice. Placed in bag and covered with more ice to cool him. Pt has some second degree burns to his arms abdomen and neck with some of the top layer of skin peeling off.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of the ER Hospital Record, dated 05/26/2026 at 8:31 PM, reflected, Chief Complaint: hyperthermia, unresponsive [Resident #1] was in his wheelchair outdoors for an unknown amount of time when he fell asleep and ended up falling from the wheelchair. On my exam he has a GCS of 3T, and physical exam is remarkable for second-degree burns to his chest, anterior neck and extremities. He was reported to be hyperthermic (106) on the scene and arrived surrounded by ice per EMS. In trauma bay found to be hypothermic requiring [NAME] and noted to have profound hypotensive shock requiring fluid resuscitation and vasopressors. CHIEF COMPLAINT: HEAT STROKE AND 13% TBSA PAVEMENT CONTACT BURNS HPI: 68M with PMH of a stroke, hemicraniectomy, and left sided hemiparesis who lives in a nursing home and was placed outside where he developed a heatstroke and fell on to the pavement and was on the pavement for quite some time. He presented with depressed mental status and hypotensive shock. He required intubation, fluid resuscitation, and vasopressors. He was found to have blistering of the skin and underwent debridement and was found to have at least 13% TBSA hot pavement contact burns which appear second degree at this point. Although at the scene he was apparently hyperthermic in heatstroke at 106F he then became hypothermic down to 92.3F in the ER.<br><br>Record review of Resident #1's Nursing Note dated 05/26/2024 at 10:44 PM, signed by LVN A, reflected, Resident went to the courtyard in the afternoon and was brought back into the building by staff. At the time, he was not responding to name calling, or painful stimulus. Cold towels were applied to his body to cool him down while this nurse called 911 for assistance. Paramedics on the line assisted and gave instructions on stabilizing resident until first responders were on the scene to stabilize resident using Vasopressors and ambu [resuscitation] bag. Resident was transferred to [hospital] for further treatment. RP, DON, and administrator notified.<br><br>In an interview on 05/30/2024 at 8:16 AM, the Executive Director stated, Resident #1 liked to sit outside and often did so after breakfast. She stated he always wore a hat and sunglasses and could get in / out of the patio on his own. She stated she was informed by staff on 05/26/2024 that Resident #1 was found outside unresponsive and sent to the hospital. She stated her investigation, thus far, concluded staff assisted him outside about 2:30 PM and was cautioned of the temperature and offered water. At about 4:30 PM Resident #4 asked LVN V to check on Resident #1 because he was unresponsive on the patio. She stated Resident #1's nurse, LVN A was on lunch break and LVN V was passing medications at the time. She stated LVN A called 911 and the dispatcher directed them on cooling Resident #1 down. She said they moved Resident #1 to the floor and covered with wet towels and ice packs. She stated EMS arrived quickly and took over then transported to the hospital. She said she was still working on her investigation but received the EMT transport record and they indicated Resident #1 was found on the ground outside. She stated said the EMT's reported Resident #1 fell asleep and fell from his wheelchair to the concrete and was on the floor for an unknown amount of time. She stated this was incorrect as he was found in his wheelchair. She said she had not received a medical update on Resident #1 from the hospital. She said the hospital reported 2nd degree burns and peeled skin to Resident #1's forehead and right side. She stated she spoke to the MD who said the burns likely occurred when the skin blistered when staff and EMTs attempted to cool Resident #1. She said it seemed that Resident #1 was not supervised as he could have been. When he refused water and warned of the temperature, staff still took him outside and the left him outside until the incident was brought to their attention. She said there was no documentation from staff that they did what they said they did.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 05/30/2024 at 9:51 AM, Resident #3 stated she saw Resident #1 sitting on the patio in the afternoon of 05/26/24. She said he liked to sit outside, and she often would tell him to come inside, and he would tell her to go away. She said at about 4:30 PM she saw Resident #4 on the patio trying to wake Resident #1 up. She said Resident #1 was in his wheelchair and not responding to Resident #4. She stated Resident #4 told LVN V who immediately brought Resident #1 back into the facility. She said he did not have any burns that she could see but was unresponsive to the nurses. She said the nurses placed Resident #1 on the floor and used ice and wet towels to cool Resident #1 down. She said the EMTs came shortly after and put Resident #1 in a bag with ice then took him to the hospital.<br><br>In an interview on 05/30/2024 at 10:11 AM, LVN B said she worked on 100 Hall on 05/26/2024 but left the facility about 3:30 PM and did not notice if Resident #1 was outside or not. She said Resident #1 came to her about 1:45 PM and wanted to go outside but she told him to check with his nurse, LVN A. She stated she saw CNA D talk to Resident #1 but did not see them go outside. She stated she received a call from LVN A at 5:50 PM informing her that Resident #1 was taken to the hospital due to heat exposure.<br><br>In a telephone interview on 05/30/2024 at 12:11 PM, CNA D said Resident #1 wanted to go outside after lunch and he did assist Resident #1 to the patio at about 2:30 PM. He said he checked on Resident #1, but he did not want to come in. CNA D said he offered Resident #1 water and tried to get him to come into the facility but Resident #1 refused both as he always did. CNA D said Resident #1 told him he would let him know when he wanted to come in. CNA D said he was busy with other residents and did not follow up with Resident #1. He said he did not know the time, but he saw LVN V bring Resident #1 into the facility. He said LVN V told him to get ice and wet towels to cool Resident #1 down. He said Resident #1 did not respond to LVN V and LVN A was on the phone to 911. He said they moved Resident #1 to the floor and place wet towels and ice on him until EMTs arrived. He said he was not sure but thought Resident #1 was outside for about 2 hours.<br><br>In an interview on 05/28/2024 at 12:47 PM, LVN A stated she went for lunch and when she returned, as she walked down the hall, LVN V met her and told her that Resident #1 was not responding. She stated Resident #1 was in his wheelchair, hot to the touch, not really sweaty, and breathing heavily. She stated his eyes were closed and he was not moving. She said he did not respond to them calling his name. She stated she had staff get cold towels to wipe him down and to put on him to cool him down. She said she rubbed Resident #1's chest with her hand in a fist, palm on chest, but he did not respond, so she did it again with more pressure. She stated he still did not respond. She stated that was when she called 911. She said she told them Resident #1 was outside and was unresponsive. LVN A said they told her to lay Resident #1 on the floor. She said they laid him on the floor he started foaming at the mouth. She said they turned his head to the side and cleared his mouth. She stated just as they were done clearing his mouth, the EMTs arrived. She stated the EMTs checked his vitals and told staff to bring ice. She said Resident #1's temperature was 106.5 degrees F. She stated EMTs put a big plastic sheet under Resident #1 and poured all of the ice on and around him, lifted him on to the gurney, strapped him in and took him away in the ambulance. She stated she didn't not ask who found him or how long he had been outside.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 05/30/2024 at 1:30 PM, Family Member X said Resident #1 was in ICU at the hospital. Family Member X said the attending physician at the hospital told her on 05/27/24 at 9:47 AM that Resident #1 came to the hospital with a temperature of 106.5 degrees F. She said the physician told her Resident #1 had heat stroke and was in cardiovascular shock, required fluid and medication for blood pressure, was on a mechanical ventilator, had lung and renal failure and remained unresponsive. She said the physician told her to prepare because he did not think Resident #1 would survive.<br><br>In an interview on 05/30/2024 at 2:32 PM, the Executive Director and DON stated they had started in-services on heat related risks and resident supervision. They said they did an audit if at risk residents who go outside. The ED said she ordered coolers and cups to place on the patio for hydration and made posters for all the patio entrances warning staff and residents of the dangers of sitting out in extreme weather. The DON stated there was no documentation indicating the CNA D or LVN A checked on Resident #1 of implemented any behavior interventions given that he often refused to come inside. The DON said the care plan should be specific when addressing behaviors because Resident #1 did have a right to stay on the patio as long as it did not pose a risk of harm to his wellbeing. She said that right needed to be balance with Resident #1's safety.<br><br>In an interview on 05/30/2024 at 3:00 PM, Resident #4 stated he was going for supper at about 4:30 PM on 05/26/2024 but saw Resident #1 on the patio. He said he went to talk to Resident #1 but found him in his wheelchair and appeared to be asleep. Resident #4 said he poked Resident #1, and he did not respond. He stated he shook resident #1 and he was still unresponsive. Resident #4 said he called LVN V who came outside and brought Resident #1 into the facility. He said Resident #1 did not respond to LVN V either. He said the nurses called 911 and moved Resident #1 to the floor where they put ice and cold towels on him. He said the EMTs came quickly, and they took Resident #1 to the hospital. Resident #4 said Resident #1 liked it outside and often refused to come in even when it was hot. He said he could convince him to come in sometimes, but it depended on Resident #1's mood.<br><br>An observation, at the hospital ICU, on 5/31/24 at 9:15 AM, revealed Resident #1 unresponsive to hospital staff's verbal commands. Resident #1 was on dialysis and a ventilator. He was missing skin on his forehead, right cheek / throat, and right arm.<br><br>In an interview, at the hospital ICU, on 5/31/24 at 9:15 AM, the ICU RN and ICU Physician said although Resident #1 had been responding better to treatment, he still may not recover from his injuries. They said he was still non-responsive. The ICU Physician said EMTs brought Resident #1 to the hospital with a 106. 5-degree F temperature. He said that puts the body in sever shock. They said it was their understanding that Resident #1 was found on the pavement and had been there for an unknown amount of time. This survey informed them of eyewitness accounts that Resident #1 was not on the ground while outside. The ICU Physician stated the burns could be cause from blistering caused when they placed cold towels and ice on Resident #1 to cool him down. He said it would be similar to frost bite and skin would come off. The ICU Physician said Resident #1 had a lot of underlying comorbidities and this incident amplified them.<br><br>A telephone call to LVN V on 05/31/2024 at 1:25 PM revealed no response.<br><br>A telephone call to LVN E on 05/31/2024 at 1:30 PM revealed no response.<br><br>(continued on next page) |

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| | 676317 | A. Building<br>B. Wing | 05/31/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Harrison at Heritage | 4600 Heritage Trace Parkway<br>Fort Worth, TX 76244 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 05/31/2024 at 2:14 PM, the Medical Director said he was aware that Resident #1 was found unresponsive on the patio. He said the ED called to discuss the burn marks reported by the hospital. He said they were likely from blistering which occurred when staff and EMTs placed cold towels and ice on Resident #1 to cool him. He said he could have got the burns from being outside for an extended period of time, but that time period was different for everyone. He said Resident #1 has a right to go outside but the facility was responsible to ensure his choice to do so was safe. The MD said Resident #1's labs completed on 04/12/2024 were normal. He said a chest x-ray was completed on 04/09/2024 and had no issues noted.<br><br>In an interview on 05/31/2024 at 2:50 PM, the DON stated, she understood the failed to supervise and ensure Resident #1 was safe from hazards when he sat on the facility's patio in 92-degree heat for at approximately 1 3/4 - 2 hours. She stated there was no documentation that staff intervene in ensuring he came into the facility or that he was offered hydration. She stated the POR addressed the expectations on staff to ensure residents were safe in all weather conditions.<br><br>Record review of the National Institute on Aging Website: https://www.nia.nih.gov/health/safety/hot-weather-safety-older-adults#:~:text=Get%20out%20of%20the%20sun,Lie%20down%20and%20rest, reflected Heat stroke is a medical emergency in which the body's temperature rises above 104 F. Signs of heat stroke are fainting; confusion or acting strangely; not sweating even when it's hot; dry, flushed skin; strong, rapid pulse; or a slow, weak pulse. When a person has any of these symptoms, they should seek medical help right away and immediately move to a cooler place, such as under shade or indoors. They should also take action to lower their body temperature with cool clothes, a cool bath or shower, and fans.<br><br>Record review of the Accuweather website: https://www.accuweather.com/en/us/[NAME]/76248/may-weather/340873?year=2024 revealed the actual high temperature on 05/26/2024 was 96 degrees F.<br><br>Record review of the facility's policy, titled, Care plans - comprehensive person-centered, revised March 2022, reflected, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of the facility's policy, titled, Charting and Documentation, revised April 2008, reflected, Policy Statement: All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. Policy Interpretation and Implementation: 1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records. 2. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified Nursing Assistants may only make entries in the resident's medical chart as permitted by facility policy. 3. All incidents, accidents, or changes in the resident's condition must be recorded. 4. Information documented in the resident's clinical record is confidential and may only be released in accordance with state law and facility policy. Refer all requests for information to the Director of Nursing Services, Nurse Supervisor/Charge Nurse or to the business office. 5. To ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries in the resident's clinical records. 6. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: a. The date and time the procedure/treatment was provided. b. The name and title of the individual(s) who provided the care. c. The assessment data and/or any unusual findings obtained during the procedure/treatment. d. How the resident tolerated the procedure/treatment. e. Whether the resident refused the procedure/treatment. f. Notification of family, physician, or other staff, if indicated. g. The signature and title of the individual documenting.<br><br>In an interview on 05/31/2024 at 1:02 PM, the Executive Director was asked for the facility's policy on accidents and hazards and only an undated procedure guide was provided, titled, Accidents / Hazards.<br><br>Record review of the facility's Accident and Hazards Guide, dated May 2016, outlined the steps to be taken in the event of an accident and did not reflect the facility's role in preventing accidents or hazards.<br><br>The Administrator, DON and Regional Director of Clinical Services were notified of an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 05/30/2024 at 6:16 PM, due to the above failures and the IJ template was provided.<br><br>The facility's Plan of Removal was accepted on 05/31/2024 at 2:50 PM and included: Assessment: The Executive Director notified the facility Medical Director of the Immediate Jeopardy on 05/30/2024 at 7:00 p.m. An emergency QAPI meeting was held on 5/26/2024. All residents be audited to determine if they are at risk of being outside alone during unfavorable weather conditions. This will include determination of the desire for the residents to go outside and the decision-making capacity to be alone outside if weather conditions are unfavorable. This will be completed by the Director of Nurses, Assistant Director of Nurses, Social Worker, and/or Patient Care Coordinators on 5/31/2024. This will be used to identify any current patients that are at imminent risk for heat stroke due to extended time outside and related to their medical conditions. After completion of the resident audits, no other residents were found to be at imminent risk of being alone outside in unfavorable weather conditions.<br><br>Who will be responsible: Nurse Managers.<br><br>Who Will monitor: Executive Director and Regional Director of Clinical Services (RDCS).<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -Beginning 5/31/2024, Resident audits will be completed upon admission, condition change, and quarterly by the charge nurse and/or nurse managers, and for any resident that is identified as wanting to be outside in unfavorable weather conditions. For any resident that identifies they would like to be outside, the weather conditions, their cognitive ability and physical ability will be reviewed by the charge nurse to determine the safety of the resident. If there is a safety concern and the weather conditions are unfavorable, a staff member or family member will remain with the resident while outside to ensure no adverse outcomes occur. Staff will be required to monitor with ongoing 15-minute checks for any resident who chooses to go outside in unfavorable weather conditions. The facility staff will progressively monitor the resident with 15-minute checks and if the resident is deemed in imminent danger the staff will also call 911. If a resident chooses to remain outside under unfavorable weather conditions despite attempts to coerce the resident to return inside, the staff will notify the DON and the ED and follow the plan of care including the following:<br><br>Explain/Educate resident/family when times and conditions are appropriate and safe for resident exposure.<br><br>Staff to ensure that the resident is dressed appropriately for the weather.<br><br>Staff to round frequently to offer/assist with hydration, nutrition.<br><br>Staff to round frequently to offer/provide ADL assist (positioning, toileting .)<br><br>Confer with MD about a prn order for sunscreen.<br><br>When weather not permitted, offer alternative activities of resident's preferences.<br><br>Nursing to assess for any psychological, social, behavioral changes and document and follow up prn.<br><br>Staff to provide level of supervision appropriate for resident.<br><br>The DON will monitor for compliance daily by receiving report from the charge nurses for any resident deemed unsafe to be outside alone that requests to be outside. Audits will be completed weekly for 3 months until 8/31/2024 and then monthly on an ongoing basis by the Executive Director.<br><br>Who will be responsible: Charge Nurses.<br><br>Who Will monitor: Director of Nursing and Executive Director.<br><br>All staff were educated to notify the Executive Director, Director of Nursing, or nursing management immediately when any resident goes outside in unfavorable weather conditions and to remain with the resident until further notice or the resident agrees to return inside the facility. This education was provided on 5/31/2024. This education was provided by the<br><br>Director of Nursing and Assistant Director of Nursing. Staff will not be allowed to begin their shift until the education has been completed.<br><br>Who will be responsible: Nurse Managers.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Who Will monitor: Executive Director and RDCS.<br><br>In-Services: All staff were in-serviced on residents going outside unsupervised during unfavorable weather conditions by the Director of Nursing and/or Nurse Managers. The ED and DON were educated by the RDCS on all in-service topics related to the IJ. All new clinical staff will receive the in services as part of the onboarding orientation process prior to being assigned and providing care to residents. All staff will be in-serviced on neglect, documenting behaviors, rounding and increased communication. No staff member will be allowed to work in the facility until the above required in-services are completed. The in-services with all staff will be completed by 5/31/2024. All staff were in-serviced by 8 am on 5/31/2024.<br><br>Who will be responsible: Nurse Managers.<br><br>Who Will monitor: Executive Director and RDCS.<br><br>Monitoring: Starting 5/31/24 Director of nursing and/or Nurse Managers will review the 24-hour report for any incident of residents being outside during unfavorable weather conditions, each day for 4 weeks week, then weekly for 4 weeks. The Executive Director will review the documentation each week for compliance. Beginning 5/31/2024 no staff will be allowed to work until the required in servicing has been completed. Should Resident A return to the facility, he will not be allowed outside without supervision.<br><br>Quality: Starting 5/31/2024 and ongoing monthly all concerns regarding adequately supervising residents will be taken to the Quality Assurance Committee for analysis and recommendations with input from the Medical Director going forward. The Executive Director will monitor for compliance. Starting 5/31/2024 and ongoing monthly the Regional Director of Clinical Services and/or designee will monitor weekly to ensure compliance for four weeks and will review at the next Quality assurance meeting.<br><br>On 05/31/2024 at 2:50 PM the surveyor began monitoring the facility's Plan of Removal.<br><br>Interviews on 05/31/2024 between 3:00 PM and 4:00 PM with ADONs T and U, PTA H, OTA I, Housekeeper F and G, LVNs C and L, RNs O and P, and CNAs M, N, R, S, Maintenance Director, Social Worker, and Activities Director reflected staff representing 1st, 2nd, and 3rd shifts and all days of the week. Staff were able to convey appropriate knowledge of the POR inservice's including the identification of adverse weather exposure impacts on residents, care plans and interventions required to ensure resident's safety in any weather conditions. They demonstrated knowledge of documenting behaviors, strategies to address behaviors and notifying the DON, MD, and family members, when residents were non-compliant with interventions meant to ensure their safety. All staff stated the DON and nurse managers would monitor these actions.<br><br>In an interview on 05/31/2024 at 2:50 PM, the DON stated, she was in-serviced regarding nursing staff communications and documenting efforts to ensure resident safety. She said she was also interview in writing comprehensive care plans that addressed specific resident behaviors, interventions, and tracking them. She stated the in-services were done by the Regional Director of Clinical Services and she, in turn in-serviced facility staff in all departments. She stated in-servicing would be ongoing until all facility staff had completed training.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 05/31/2024 at 2:40 PM, the Executive Director stated she and the DON, had been in-serviced on weather condition safety for all residents, by the Regional Director of Clinical Services. She stated all facility staff were educated on communication and notification of nursing staff regarding resident behaviors that may pose a risk of harm to them. She said she completed an audit of residents who were at risk of harm based on their behaviors and propensity to be outside. She said in-services were provided to nursing staff on comprehensive care planning to address specific behaviors in residents and provide specific strategies to ensure their safety. She said these will be monitored by the DON through assessment reports and nursing communication records. She said she would monitor this through the IDT and QUPI process. She stated in-servicing would be ongoing until all facility staff had completed training.<br><br>Record review of the facility's in-service record addressed to nurses, dated 05/30/2024, and titled, Documentation of Behaviors, included the following topics. All services provided to the resident, or any changes in the resident's medical or mental condition, and behaviors shall be documented in the resident's medical record. A behavior is the way a person acts in response to a particular situation or event. Behaviors include but are not limited to: Going outside daily, yelling, repeating themselves, etc. 1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records. 2. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified Nursing Assistants may only make entries in the resident's medical chart as permitted by facility policy. 3. All incidents, accidents, or changes in the resident's condition must be recorded. 4. Information documented in the resident's clinical record is confidential a [TRUNCATED] |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152<br><br>Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles in locked compartments and permit only authorized personnel to have access to the keys for one (Resident #2) of eleven residents reviewed for storage of drugs.<br><br>LVN C left Resident #2's morning IV medication and injection medication on top of the 600 Hall Nurse Medication Cart unattended.<br><br>This deficient practice could place residents at risk of medication misuse and diversion.<br><br>The findings include:<br><br>Record review of Resident #2's face sheet, dated 05/31/2024, reflected Resident #2 was admitted to the facility on [DATE] with diagnoses, which included: cellulitis of left lower limb (a skin infection caused by bacteria), type 2 diabetes with diabetic polyneuropathy (a problem with the way the body regulates and uses sugar as fuel, can lead to significant nerve damage), and chronic arterial fibrillation (arrythmia that causes the top chambers of the heart to beat irregularly).<br><br>Record review of Resident #2's MDS Assessment, dated 05/30/2024, reflected Resident #2 had a BIMS score of 15, signifying no cognitive impairment. She requires partial assistance with personal hygiene and dressing, substantial assistance with toileting and transfers. She was incontinent of bowel and bladder and used a walker to ambulate. Resident #2 had an infected diabetic foot ulcer. Resident #2 required insulin injections and IV antibiotics.<br><br>Record review of Resident #2's care plan, 05/13/2024, reflected Problem: [Resident #2] has current skin concerns: Other: LEFT 3RD TOE-DIABETIC, Left Heel, and Right calf. Interventions: Perform treatments per order, if no improvement x2 week's report to MD. Monitor areas for increase breakdown, s/s of infection-report to MD. Monitor for pain, give med per order, monitor for relief. Problem: [Resident #2] is on Antibiotic(s) and is at risk for Adverse Infection will be resolved or resolving at the Reactions. Med. cefepime 2g q12. Interventions: Give meds per order-monitor labs, cultures-report abn's to MD. Problem: [Resident #2] is on Antibiotic(s) and is at risk for Adverse Reactions. Med. Daptomycin 500mg qd. Interventions: Give meds per order-monitor labs, cultures-report abn's to MD.<br><br>Record review of Resident #2's physician orders, dated 05/31/2024, included the following medications:<br><br>Intravenous - cefepime 2-gram solution for injection (2 grams/100ml) VIAL (EA) twice daily at 8:00 AM and 8:00 PM - start date 05/13/2024.<br><br>Lantus Solostar U-100 Insulin 100 unit/ml (3 ml) subcutaneous pen (15 Units) INSULIN PEN (ml) Subcutaneous, twice daily at 8:00 AM and 8:00 PM - start date 05/13/2024.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Intravenous daptomycin 500 mg intravenous solution (500mg) VIAL (EA) - one time daily for thirty-four days starting on 05/14/2024.<br><br>An observation on 05/30/2024 at 8:00 AM revealed the 600 Hall Nurse Medication Cart parked outside Resident #2's room, with enough room for anyone to walk behind the cart and into Resident #2's room. There were no staff in the hall and two residents walked past the cart toward the Nurses' Station. LVN C was observed in Resident #2's room assisting her. The room door was open, and LVN C had her back to the doorway. The medication's lock was open and in the unlocked position. Two bags of liquid labeled cefepime fluid 2 mg and daptomycin 5 mg were observed on top LVN C's medication cart. A 2.5 ml vile of insulin was also on top of the cart.<br><br>In an interview on 05/30/2024 at 8:05 AM, LVN C said she had placed the medications on her cart and was going to administer them to Resident #2. She stated she should have locked the cart and taken the medications with her when she went into Resident #2's room. She said medications of any kind should never be left unattended and should be secured in the cart. She said she was only in Resident #2's room for a short time but was not able to see the medication on the top of the cart from where she was in the room. She stated Resident #2's name was also on the medication and visible to anyone who walked past the cart. She stated she had received in servicing on medication security but did not recall when the last time was.<br><br>In an interview on 05/30/2024 at 8:12 AM, the DON stated she expected that medications be secured in the medication carts and the carts be locked at all times. She stated Nurses knew this and were responsible to ensure they followed the facility's policy. She said residents could get into medications left unsecured. She said they could have an adverse reaction to unprescribed medication.<br><br>In an interview on 05/30/2024 at 8:17 AM, the ED stated she expected staff to follow the facility's medication security policy. She said leaving medications unsecured placed residents at risk of harm because they could consume medications not prescribed to them and have an adverse reaction.<br><br>In an interview on 05/30/2024 at 10:56 AM, Resident #2 said LVN C was in her room to give her antibiotics and insulin. She said she had an infection on her left heal.<br><br>Record review of the facility's policy titled, Medications, dated November 2017, reflected, Monthly Quality Assurance & Performance Improvement Meeting must include . the appropriate administration of medications by licensed staff and/or medication aide .<br><br>In an interview on 05/31/2024 at 1:02 PM, the Executive Director was asked for the facility's policy regarding Medication Administration was requested and none was provided prior to exit. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>35152<br><br>Based on observation, interview, and record review, the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys for one (600 Hall Medication Cart) of four Medications Carts reviewed for security.<br><br>LVN C failed to ensure the 600 Hall Medication Cart was locked when unattended.<br><br>This failure could place residents at risk of having access to unauthorized medications and/or lead to possible harm or drug diversions.<br><br>Findings included:<br><br>An observation on 05/30/2024 at 8:00 AM revealed the 600 Hall Nurse Medication Cart parked outside Resident #2's room, with enough room for anyone to walk behind the cart and into Resident #2's room. There were no staff in the hall and two residents walked past the cart toward the Nurses' Station. LVN C was observed in Resident #2's room assisting her. The room door was open, and LVN C had her back to the doorway. The medication's lock was open and in the unlocked position.<br><br>In an interview on 05/30/2024 at 8:05 AM, LVN C said she stated she should have locked the cart when she went into Resident #2's room. She said the medication cart should be locked to ensure no one could get into medications that were not prescribed to them. She said she was in Resident #2's room for a short time. She said it was the nurse's responsibility to ensure their medication carts were secured. She stated she had received in servicing on medication security but did not recall when the last time was.<br><br>In an interview on 05/30/2024 at 8:12 AM, the DON stated she expected that medications be secured in the medication carts and the carts be locked at all times. She stated Nurses knew this and were responsible to ensure they followed the facility's policy. She said residents could get into medications left unsecured. She said they could have an adverse reaction to unprescribed medication.<br><br>In an interview on 05/30/2024 at 8:17 AM, the ED stated she expected staff to follow the facility's medication security policy. She said leaving medications unsecured placed residents at risk of harm because they could consume medications not prescribed to them and have an adverse reaction.<br><br>Record review of the facility's policy titled, Medications, dated November 2017, reflected, Monthly Quality Assurance & Performance Improvement Meeting must include .the appropriate administration of medications by licensed staff and/or medication aide .<br><br>In an interview on 05/31/2024 at 1:02 PM, the Executive Director was asked for the facility's policy regarding Medication Security was requested and none was provided prior to exit. |