STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676317	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Harrison at Heritage	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on observations, interviews, and record reviews, the facility failed to ensure that the resident had the right to a dignified existence, self-determination, and communication with and access to persons and services outside the facility for 1 (Resident #1) of 5 residents reviewed for resident rights. -The facility failed to allow Resident #1 to exercise his right to choose his pain management provider after he expressed concerns for his pain management regimen and the facility's contracted provider. This failure could place residents at risk of decreased quality of care and treatment due to their lack of free choice for their care providers while in the facility. Findings included: Record review of Resident #1's face sheet, dated 7/16/24, revealed a [AGE] year-old male, who admitted to the facility on [DATE] with the following diagnoses: type II diabetes, morbid obesity, hypertension (high blood pressure), epilepsy (seizure disorder), cellulitis of lower legs (bacterial infection), toe amputations on both feet, major depressive disorder (mood disorder), chest pain, chronic pain syndrome, and opioid dependence. Record review of Resident #1's admission MDS Assessment, dated 07/03/24, revealed Resident #1 had a BIMS score of 14 which indicated cognition was intact. Further review reflected Resident #1 received a scheduled and PRN pain medication regimen with the resident experiencing frequent pain. Record review of Resident #1's care plan, dated 6/25/24, reflected the resident required pain management due to diagnoses of chronic pain and opioid dependence with interventions that included assessing level of comfort/discomfort, assessing that pain medications were adequately managing pain and signs/symptoms. Further review reflected Resident #1 required partial or moderate assistance with ADL s. Record review of Resident #1's medication profile, dated 7/2024, reflected in part the following orders: -Fentanyl transdermal patch 100mcg/hr. every 72 hours (for pain)- order date 07/04/24 (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dilaudid 2 mg (3 tablets) every 8 hours- order date 07/09/24 -acetaminophen 325mg (1-2 tablets) as needed every 6 hours (for pain)-order date 06/25/24 -naloxone 0.4 mg/ml injection as needed every one day (for opioid dependence)-order date 06/25/24 Record review of Resident #1's provider note by the Pain Management NP, dated 06/26/24, reflected the following: This is a subsequent visit for PM&R and Pain Management. Patient is in my care for complaints of chronic pain syndrome 2/2 [sic] lumbago (lower back), morbid obesity, wheelchair bound, debility, generalized weakness, gait abnormality, constipation. Pt refused to return to [facility] for pain management issues. Pt is observed in WC, agitated, conversant. Pt has a known history of physical and verbal aggression with staff. I have spoken to him about appropriate and safe use of narcotics multiple times in the past. Pt displays concerning narcotic seeking behaviors. Nurse reports pt stated since she won't give me what I want, I will find it somewhere else. At previous facility, pt was found with decreased LOC on many different occasions, with concerns guests may be bringing in medications from the outside. At time of my evaluation, pt demanding Norco 10/32 mg x 4 tabs. I again discussed this was not an appropriate or safe dosage. I will continue Fentanyl 100mcg q72h and Dilaudid 8mg 1 tab PO q8h RT [sic]. There will be no changes to regimen at this time. POC discussed with [MD] and nursing staff. In an interview on 07/16/24 at 9:30 AM, the Administrator stated Resident #1 was medication seeking and was upset about his Dilaudid medication recently being decreased by the Pain Management NP. The Administrator stated Resident #1 informed the Pain Management NP that he knew a doctor who would prescribe him the dosage of Dilaudid that he wanted; however, the resident never reported directly to the Administrator that he wanted a different doctor. In an interview on 07/16/24 at 12:25 PM, the Pain Management NP stated she had taken care of Resident #1 through 3 different facilities. The Pain Management NP stated Resident #1 had a history of being manipulative regarding his pain medication, where he would hoard medication to take larger doses at once, and have family bring in medication from outside. The Pain Management NP stated Resident #1 stated before that he knew how to get the medication he wanted. The Pain Management NP stated Resident #1 was refusing to get out of bed to receive therapy and care, and the nurses reported concerns to her about Resident #1 seeming to be overmedicated and out of it. The Pain Management NP stated she had spoken with Resident #1 about the concerns with his pain medication and he would become angry and verbally abuse her and accuse her of calling him an addict. She stated she recently reduced Resident #1's Dilaudid after the nurses expressed their concerns. The Pain Management NP stated Resident #1 stated he was going to get a new pain management doctor, but when she would ask the resident if he was firing her, he would say no. The Pain Management NP stated she informed Resident #1 that he was welcome to find an outside pain management provider. The Pain Management NP stated it was her responsibility to ensure the safety of the residents she cared for, and it was not safe for Resident #1 to take the amount of pain medication he was requesting. She stated Resident #1 would also try to get muscle relaxers from the primary care MD, which would be a danger to take along with the high doses of pain medication Resident #1 was already on. She stated Resident #1 did not have metastatic cancer or any diagnoses that would require the amount of pain medication he wanted. The Pain Management NP stated she was concerned that Resident #1 was at risk of aspirating due to lethargy. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 07/16/24 at 12:30 PM, Resident #1 was observed lying in bed talking on his phone. Resident #1 was lying on an air mattress that he stated he had just received on this day. Resident #1 was alert and able to be interviewed. Resident #1 stated he had only been at the facility for about a month and was unhappy with his pain management provider. He stated he had never seen the MD but was visited by the Pain Management NP who he had worked with at 3 or 4 previous facilities and did not have a good rapport with because she had labeled him as an addict and did not believe that he was in the amount of pain that he was in. Resident #1 stated the Pain Management NP had him on 8mg of Dilaudid every 6 hours at a previous facility; however, when he first admitted to the current facility, she placed him on 8mg of Dilaudid every 8 hours. Resident #1 stated about a week ago the Pain Management NP reduced his Dilaudid again to 6mg every 8 hours and informed him that it was because he was taking too much medication that was causing him to be lethargic. Resident #1 stated he was not lethargic; he would just rather sleep than to be awake in pain. Resident #1 stated the Pain Management NP was reducing his pain medication because she was accusing him of being an addict and would not listen to him when he told her that he was in pain. Resident #1 stated he received multiple fractures, injuries, and amputation of toes on both feet over the years, with the most recent injury being a fractured coccyx (tailbone) about 2 months ago. Resident #1 stated he reported to LVN A one day last week that he wanted a new pain management MD, and she told him that she would report it to management. Resident #1 stated LVN A later came back and told him that the facility's policy stated he had to use the MD/NP that was contracted with the facility, and he would have to leave the facility if he wanted a different MD/NP. Resident #1 stated he did not want to leave the facility because he liked the staff and all other services. Resident #1 stated he was afraid to say that the Pain Management NP was fired because he was not sure that he could continue getting his pain medication and he could not do without it. Resident #1 stated the Administrator or DON had not come to speak with him about his rights or the process of getting a new MD. He stated he was not even sure who the DON was. In an interview on 07/16/24 at 2:02 PM, LVN A stated she worked at the facility for 1.5 years. LVN A stated she worked with Resident #1 and had a good rapport with him. She stated Resident #1 laid in bed often, but she was able to get him to at least sit up on the edge of the bed for meals. LVN A stated Resident #1 presented very lethargic and over-medicated last week, and she reported concerns to the Pain Management NP. LVN A stated after the Pain Management NP visited with Resident #1 last week, he became very upset and told LVN A that he wanted a new pain management doctor. LVN A stated she brought it up the following day during morning meeting. LVN A could not recall who all was at the meeting, but stated someone in management had to be there and heard her state that Resident #1 wanted a new doctor. LVN A stated she had also spoken to the interim DON previously and informed her that Resident #1 was not satisfied with his pain management, and she was told to inform Resident #1 that he could go to the hospital if he felt the facility was not managing his pain properly. LVN A stated she also asked Resident #1 if he had another pain management doctor in mind and he could never provide anyone. LVN A stated it was her responsibility to report Resident #1's concerns to the DON but she was not sure if it was being followed up on. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/16/24 at 2:18 PM, the SW stated she worked at the facility for over 4 years. She stated yesterday was the first time it was brought to her attention that Resident #1 was upset about his pain management and wanted a new doctor. The SW stated LVN A sent her a text message stating that Resident #1 was going to call the state. The SW stated she went to Resident #1's room to see how she could help him and found he was already on the phone with the state agency. She stated she asked Resident #1 how she could help, and he informed her he was not happy about his Dilaudid being decreased by the Pain Management NP and he wanted a different doctor. The SW stated she told Resident #1 that she would talk to the team about his concerns. The SW stated she went to inform the Administrator; however, the Administrator was in a meeting, and they were not able to reach a solution then. The SW could not recall LVN A bringing Resident #1's concerns up during a morning meeting last week. The SW stated she typically only pays attention during the meetings when something is brought up in her area. The SW stated she typically only deals with ancillary services and had never been involved with finding new attending physicians for residents, but she would be willing to help Resident #1 find one. She stated it was her responsibility to be an advocate for all residents; however, she was only recently made aware of Resident #1's concerns. In an interview on 07/16/24 at 2:46 PM, the interim DON stated she was the regional traveling nurse and had been helping at the facility for 3-4 weeks. She stated she was at the facility when Resident #1 admitted . The interim DON stated she was informed by the SW yesterday that Resident #1 was upset about his pain management and wanted a new provider. The DON stated this information was given at the end of the day and she had not spoken to Resident #1 yet but was going to. The interim DON stated she recalled LVN A reporting to her shortly after Resident #1 admitted that he did not feel his pain was being managed and she informed that the resident could go to the hospital to be assessed if the facility was not managing his pain. The interim DON stated she did not talk to Resident #1 at that time. The interim DON stated the process of assisting a resident with getting a new provider would be for the resident to state that the current provider was fired, then the resident would have to choose a new provider or let the facility assist them with choosing someone. The interim DON stated the new provider would have to agree to accept the resident before the previous provider was removed from the case to prevent any gaps in treatment. The interim DON stated the attending primary physician would not manage Resident #1's pain regimen due to the high amount of medication the resident required. In an interview on 07/16/24 at 3:17 PM, CNA B stated she worked at the facility for 6 years. She stated she worked with Resident #1, and he would always complain about being in pain and demand his pain medications right away. CNA B stated Resident #1 would become very angry and say terrible things to staff if it was not time for his pain medication. CNA B stated she would notify the nurse when Resident #1 reported being in pain and do what she could to keep him calm. CNA B stated the nurses would check on Resident #1 and give him pain medication as scheduled. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a further interview on 07/16/24 at 4:45 PM, the Administrator stated when Resident #1 first admitted to the facility the Pain Management NP informed her that she worked with Resident #1 at previous facilities and he had medication-seeking behaviors, and that the resident did not like her. The Administrator also stated the Pain Management NP told her that she offered to give Resident #1 a list of facilities that she did not work at if he did not want to have her as his provider. The Administrator stated she did not speak to Resident #1 about his reasons for not liking the Pain Management NP or his right to remain at the facility and choose a different provider because she did not initially see it as a problem; however, she corrected the Pain Management NP about offering Resident #1 a list of facilities that she did not work at. The Administrator stated if a resident had bad rapport with a provider, the resident might not be seen as often or there could be miscommunication between the two. The Administrator stated that miscommunication could lead to inadequate care and/or bias. The Administrator stated she and the interim DON were in the process of helping Resident #1 find a new pain management provider. The facility's policy on resident rights was requested from the Administrator on 07/16/24 at 09:48 AM, and the Code of Federal Regulations was provided. Review of Code of Federal Regulations on 07/16/24 reflected in part the following: Resident rights- The resident has the right to a dignified, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. .