STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER The Harrison at Heritage		STREET ADDRESS, CITY, STATE, ZIP CODE 4600 Heritage Trace Parkway Fort Worth, TX 76244	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on interview and record review, the facility failed to notify the resident or the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for one of three residents (Resident #1) reviewed for discharge notices. The facility failed to notify Resident #1 in writing of his transfer/discharge to the hospital for altered mental status, the reason for the transfer, and the right to appeal and they failed to send a copy of the notice to the Ombudsman as soon as practicable. This failure could place residents at risk of being transferred or discharged , and not having access to available advocacy services, discharge/transfer options, and appeal processes. Findings included: Record review of Resident #1's face sheet, dated 01/23/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE], discharged [DATE] to an acute care hospital, and readmitted on [DATE]. Record review of Resident #1's quarterly MDS assessment, dated 01/10/25, reflected a BIMS score of 15, which indicated his cognition was intact. His diagnoses included metabolic encephalopathy (alteration in consciousness), opioid dependence, chronic pain syndrome, muscle weakness, diabetes mellitus (high glucose), heart failure, hypertension (high blood pressure), and need for assistance with personal care. Record review of Resident #1's Nurses Notes, dated 12/28/24, reflected the following: Patient continued with increased confusion, altered mental status, could not allow this writer to touch him, patient screaming and yelling in the room. Restless and hurting self by scratching to skin to face. Patient had very filthy smell from his mouth. Abdominal areas were bleeding due to existing skin condition, this writer contacted MD on call via [phone number] and MD gave an order to send patent back to the ER 911 was called and patient send out to the Hospital. DON made aware. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's clinical record reflected there was no documentation showing the resident and the Ombudsman were notified in writing of the resident's discharge or the reason for the resident's discharge. Interview on 01/23/25 a 12:00 PM with Resident #1 revealed he was doing well. Resident #1 stated about 2-3 weeks ago he was transferred to the hospital. Resident #1 stated he could not recall the exact date of when he went to the hospital, but it was the end of December 2024. He stated he was at the hospital for over a week even though he was ready to be discharged two days after he had admitted to the hospital. Resident #1 stated the facility did not want to take him back, he stated the hospital staff were involved and assisted with getting him back to the facility. Resident #1 stated he could not recall much of why he was transferred to the hospital. He stated he was his own responsible party. Resident #1 stated he was never provided with any transfer or discharged paperwork from the facility only his 30-day discharge notice upon return from the facility. Interview on 01/23/25 at 2:53 PM with Unit Manager B revealed when a resident would go out to the hospital the expectations were for nurses to provide a face sheet, copy of current medication list, and any recent lab results. She stated the POA and the residents were notified verbally of a hospital transfer. Unit Manager B stated she was unaware of any other transfer paperwork that were given to residents or POA's or Ombudsman. She stated she had not been told otherwise. Interview on 01/23/25 at 4:01 PM with Administrator revealed Resident #1 was transferred to the hospital for a change of condition. She stated Resident #1 refused to go the hospital several times; he had an altered mental status, and he finally agreed to go to the hospital. She stated Resident #1 was sent to the hospital the Saturday after Christmas (12/28/24), he tested positive for amphetamines while at the hospital. She stated they received report from the hospital, and she informed the hospital they could not take any referrals of patients who have a history of drug use. She stated they accepted the Resident #1 back to the facility and a 30 discharged notice was provided to him and Ombudsman. She stated nothing in writing had been sent with the resident or family explaining the reason for his transfer/discharge to the hospital. She stated she was unaware that written forms needed to be provided to anyone. She stated they only provide the resident face sheet, medication list, and provide report to the hospital. Review of the facility's current Transfer and Discharge, facility - Initiated policy, revised October 2022, reflected the following: Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy. Notice of Transfer or Discharge (Emergent or Therapeutic Leave) 1. When residents who are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfer, NOT discharges, because the resident's return is generally expected. 2. Residents who are sent emergently to an acute care setting, such as hospital, are permitted to return to the facility. Residents who are sent to the acute care setting for routine treatment/planned procedures are also allowed to return to the facility . (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.4. Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable. 5. Notice of facility bed-hold and return policies are provided to the resident and representative within 24 hours of emergency transfer. 6. Notices are provided in a form and manner that the resident can understand, taking into account the resident educational level, language, communication barriers, and physical or mental impairments.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, and record review, the facility failed to ensure that each resident received adequate supervision and assistive devices to prevent accidents for one of two residents (Residents #2) reviewed for accidents. CNA C failed to obtain assistance from another staff member when using a mechanical lift to transfer Resident #2 from his bed to his wheelchair and then left the resident unsupervised mid-transfer to obtain assistance in completing the transfer. This failure place residents at risk for accidents and injuries. Findings included: Record review of Resident #2's face sheet, dated 01/23/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #2's admission MDS assessment, dated 11/04/24, reflected a BIMS score of 14, which indicated his cognition was intact. His diagnosis included Type 2 diabetes mellitus without complication, pain, fluid overload, essential hypertension (high blood pressure), depression, and end state renal disease. The MDS further reflected the resident required substantial/maximal assistance to transfer to and from a bed to a chair (or wheelchair). Record review of Resident #2's care plan, revised date 12/24/24, reflected it did not address the resident's transfer needs. Observation on 01/23/25 from 10:15 AM to 10:20 AM revealed CNA C standing next to Resident #2's bed with a mechanical lift. Resident #2 was suspended above his bed approximately 3-5 inches in the lift sling. While Resident #2 was still in the sling, CNA C walked out of the room, leaving the resident alone, and walked to the nurses' station to ask for assistance to transfer resident from his bed to his wheelchair. The nurse's station was approximately 8-10 steps away from Resident #2's room. CNA C then returned to the room with CNA D, and they completed the transfer together. Interview on 01/23/25 at 1:08 PM with CNA C revealed she had been employed at the facility for seven years. She stated she was the CNA assigned to Resident #2. She stated she was getting Resident #2 ready for dialysis. She stated a mechanical lift was used to transfer Resident #2. She stated she lifted Resident #2 up with the mechanical lift alone and then she stepped out to get help. She stated there should be two staff when using the mechanical lift for transfers. She stated it was not okay to start the transfer and was not okay to leave the resident alone when the mechanical lift was in use. CNA C stated she should have asked for help from the beginning. She stated there was no risk to the resident because the mechanical lift was locked, and the bed was underneath him. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/23/25 at 1:40 PM with CNA D revealed she assisted CNA C complete Resident #2's transfer. She stated when she entered Resident #2's room she observed CNA C had already started the transfer by lifting the Resident #2 up with the mechanical lift. She stated two staff were required when using a mechanical lift for transfers. She stated there should be two staff in the room before a resident was placed in the sling and being lifted. She stated residents should never be left alone in the room while in a sling. She stated the potential risks were that the resident could fall or the mechanical lift could flip over causing the resident to fall. Interview on 01/23/25 at 1:56 PM with Unit Manager A revealed when a resident transfers via mechanical lift there should be two staff completing the transfer. She stated her expectation was for two staff to complete the transfer from beginning to end. She stated resident should never be left alone in the room while being lifted with the mechanical lift. She stated it was not okay to leave a resident hanging from the mechanical lift just because the bed was underneath. She stated it was a safety risk and mechanical lifts tipped over easily. Unit Manager A stated even if there were two people, there was still a risk when using a mechanical lift, but two staff would have more control. Interview on 01/23/25 at 2:16 PM with RN E revealed she was the nurse assigned to Resident #2. She stated Resident #2 was a two-person assist for transfers. She stated when using a mechanical lift to transfer a resident there should be two staff completing the transfer for safety. She stated there should be two staff in the room before hooking the sling to the Hoyer lift. She stated the potential risk would be the resident falling from the mechanical lift. Interview on 01/23/25 at 3:30 PM with the DON revealed her expectation was for two staff to complete mechanical lift transfers from beginning to end. She stated there should be two staff in the room before hooking the sling to the mechanical lift and lifting the resident. She stated if assistance was needed staff should use the call light for assistance and not leave the resident alone in the room. She stated it did not matter if the mechanical lift was locked or a bed was underneath the resident, for safety there should always be two staff completing the transfer. She stated the potential risk would be injury to the resident. Record review of the facility's Lifting Machine, using a Mechanical policy, revised July 2017, reflected the following: The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. General Guidelines 1. At least two (2) nursing assistants are needed to safety move a resident with mechanical lift