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 03/06/2025

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** 32227 Based on observation, interview, and record review the facility failed to ensure each resident was treated with respect and dignity in a manner and in an environment which promotes maintenance of enhancement of his or her quality of life and recognizing each resident individually for 1 of 7 residents (Resident #21) reviewed for resident rights. LVN D failed to treat Resident #2 with dignity and respect when she raised her voice and scolded the resident. The noncompliance was identified as past noncompliance. The noncompliance began on 01/28/25 and ended on 01/28/25. The facility had corrected the noncompliance before the investigation began. This failure placed residents at risk for diminished quality of life, loss of dignity and self-worth. Finding included: Record review of Resident #2's quarterly MDS dated [DATE] reflected the resident was an [AGE] year-old female admitted to the facility 04/12/22. Her diagnoses included cancer, Alzheimer's disease, stroke, non-Alzheimer's dementia, seizure disorder, anxiety, depression, bipolar disorder, and schizophrenia. The resident had a BIMS of 3 which indicated her cognition was severely impaired. The MDS also reflected Resident #2 required partial to substantial assistance with ADL's and was dependent with transfers. Record review of Resident #2's care plan printed on 03/06/25 reflected she required extensive assistance with bed mobility, toileting, bathing, and transfers. Interventions included to assist with ADL's as needed. Record review of the facility's Provider Investigation Report dated 02/04/25 reflected the following: (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's family member sent a video to the Director of Nursing (DON) showing the alleged perpetrator answering the call light of this resident. While in the resident's room, the nurse raises her voice and appears to scold the resident for kicking of her covers and being restless in bed. The nurse states in a stern voice, 'I've already helped you .now why are you doing this .you've got to stop this.' The resident has a BIMS of a 3, has restless leg syndrome and unaware of her continuous actions/or behaviors. The nurse was interviewed and denied any 'wrong-doing' but also was defensive when questioned of the interactions. The nurse had been suspended pending investigation, and later termed on 01/31/25 for misconduct. The resident and family member were provided emotional support The employee was terminated. In-services continue on abuse/neglect and positive customer service. Satisfaction rounds continue with no issue noted Record review of Resident #2's video footage revealed LVN D entered the resident's room and with a raised voice said [Resident #2] stop playing with this call light. What do you want? I been here three times and you had your eyes closed. The resident was heard saying something but was not understood. LVN D continued to say, What do you want? Look for yourself. You got both of your covers on you already. Why do you keep on playing like this? What do you want? What else do you want? I fixed them up already. This is my third time you're not listening Observation and interview of Resident #2 on 03/05/25 at 11:17 AM revealed she was in bed watching TV with her headphones on. The resident stated the staff were treating her well but wanted a new roommate because the roommate would yell out at times. Resident #2 was asked about the incident where she was scolded by LVN D but she did not recall the incident. The resident reiterated all the staff were nice to her and she liked the facility. Interview on 03/07/25 at 9:33 AM with Resident #2's family revealed they had gone to visit the resident and the resident said they were mean and she did not like it there. The family said they had a camera in the room so that prompted them to look at it when she saw a staff member (LVN D) had been very ugly to the resident. The family further stated after the incident, Resident #2 did not say anything more and continued to say she loved the facility and got great care. Interview on 03/05/25 at 3:20 PM with RN E revealed Resident #2 was alert and oriented and able to make her needs known. RN E said the resident required total assistance with care and had never complained to her that she had been mistreated. Interview on 03/05/25 at 3:31 PM with CNA B revealed she worked with Resident #2 and said the resident was alert and oriented but had some moments of confusion. CNA B said Resident #2 there were time the resident would pull her call light repeatedly and then say she did not recall why she had pulled the call light or realized she had turned the light on. CNA B further stated Resident #2 had never mentioned she had been mistreated by staff. Interview on 03/06/25 at 9:50 AM with the Social Worker revealed she made daily rounds on Resident #2 and said the resident was alert and oriented but was forgetful at times. The Social Worker said the resident had never mentioned she had been mistreated by any staff member. (continued on next page)

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F 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Interview on 03/06/25 at 2:06 PM with the DON revealed Resident #2's family shared a video with her where it showed LVN D had been disrespectful to Resident #2. LVN D had entered the room and appeared to raise her voice at the resident and reprimand her for pushing the call light. The DON stated there were times Resident #2 would press her call light repeatedly but did not have any behaviors. The DON said once she saw the video, LVN D was sent home and during the investigation it was decided the LVN would be terminated for her actions. She further stated all staff were re-in-serviced on abuse/neglect and customer service.

Interview on 03/06/25 at 2:54 PM with the Administrator revealed Resident #2's family had sent a video to the DON where it appeared LVN D had reprimanded the resident for pressing the call light. Once they were made aware of the incident, LVN D was sent home pending the investigation and later terminated. The Administrator said she spoke with Resident #2 after the incident and she did not appear to recall the incident. The Administrator further stated all staff had been re-in-serviced on abuse/neglect and customer service. Satisfaction rounds were made with other residents and there were no concerns noted and the family and the resident was offered support.

Attempts to contact LVN D on 03/05/25 and 03/06/25 were unsuccessful.

Record review of the facility's policy titled Abuse Protocol dated April 2019 reflected the following:

1. The Patient has the right to be free from Abuse, neglect, mistreatment of resident property, and exploitation

.k. Mistreatment means inappropriate treatment or exploitation of a Patient

Interview on 03/05/25 from 11:17 AM to 1:23 PM with 14 alert and oriented residents revealed they did not have any concerns with abuse/neglect or mistreatment from the staff.

Record review of Resident #2's Psychosocial Well-being assessment dated [DATE] conducted by the Social Worker revealed the resident was in no distress or concerns noted.

Record review of the facility's in-services titled Abuse/Neglect and Customer Service and Sensitivity Training dated 01/28/25 reflected 50 staff members participated in the in-service.

Interview on 03/05/25 at 1:23 PM to 03/06/25 at 2:54 PM with staff from differnt shifts to include LVN A, CNA B, CNA C, LVN D, RN E, LVN F, CNA G, RN H RN I, CNA J, CNA K, LVN L, CNA M, LVN N, LVN O, RN P, and the Social Worker revealed they were all able to name the different types of abuse, reporting suspected abuse to the Administrator and providing the residents with good customer service.

Record review of LVN D's personnel file revealed she had been terminated after the incident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #1) observed for infection control. LVN A, CNA B and CNA C failed to wear a gown while providing care for Resident #1, who was on enhanced barrier precautions. This failure could lead to the resident being exposed to infections from other residents. Findings included: Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected the resident was a [AGE] year-old female, who admitted to the facility on [DATE]. The resident had severe cognitive impairment with a BIMS score of 0, and her diagnoses included dysphagia (swallowing difficulties), and the MDS reflected she had a feeding tube for nutrition. Record review of Resident #1's care plan dated 03/04/25 reflected: Focus: [Resident #1] Enhanced Barrier Precautions implemented rule out feeding tube. Goal: [Resident #1] The spread of an MDRO(is a germ that is resistant to many antibiotic) will be reduced over the next 90 days. Interventions: Implement enhanced barrier precaution: Offer emotional support as needed related to infection risk and use of EBP(Enhanced barrier precautions). Observation on 03/05/25 at 11:45AM on Resident #1's room revealed posting on the outside notifying staff and visitors the resident was on EBP, and it was required to wear a gown and gloves with all direct care of the resident. Observation on 03/05/25 at 11:50 AM revealed LVN A conducting a skin assessment for Resident #1. LVN A washed her hands, put on gloves, and performed the skin assessment. The gloves were the only PPE that LVN A wore while touching the resident to perform the skin assessment. Resident #1 was observed to have a gastronomy tube with a dressing dated 03/05/25. Observation on 03/06/25 at 10:04 AM revealed LVN A, CNA B and CNA C provideing Resident #1 with incontinence care. They washed their hands and gathered all the supplies they needed to provide the care. LVN A, who had only donned gloves as PPE, shut off the feeding pump and flushed the resident's the gastronomy tube. CNAs B and C washed their hands and put on gloves. The gloves were the only PPE they wore while providing Resident #1 with incontinence care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/06/25 at 11:50 AM with CNA B revealed she knew she was supposed to wear PPE when caring for residents on isolation. She stated Resident #1 was not on isolation. She stated she saw the sign but since she was not familiar with enhanced barrier precautions, she had no idea that she was supposed to wear a gown and gloves while providing Resident #1 with incontinence care. She stated she had not been putting on gloves and a gown while providing care for residents with g-tubes, Foley catheters, or who had wounds. She revealed she did not know the risk of not wearing the PPE, and she could not remember training on enhanced barrier precautions. Interview on 03/06/25 at 11:50 AM with CNA C revealed she knew she was supposed to wear PPE when caring for residents with an EBP sign on their doors. She stated she could not recall seeing one at Resident #1's room. She stated she knew she was only supposed to put on gloves and a gown when caring for residents with catheters. She stated she had done training on enhanced barrier precautions, but it was only for residents with Foley catheters to prevent contamination. She stated the risk of not wearing a gown and gloves was that it could lead to contamination. Interview on 03/06/25 at 12:25 PM with LVN A revealed she just forgot to wear her PPE. She stated she was aware she was supposed to wear gloves and a gown while coming into contact with Resident#1. She stated Resident #1 had signage by the door and a bin for PPE. She stated she knew all residents with g-tubes, Foley catheters, and chronic wounds were on enhanced barrier precautions. She stated failure to use enhanced barrier precautions was that it could put Resident #1 at risk of cross-contamination. She stated she had done training on enhanced barrier precautions. Interview on 03/06/25 at 1:38 PM with the DON revealed all residents on EBP required the staff to wear a gown and gloves when having direct contact with the resident such as turning, incontinence care, and providing medications via gastric tube. The DON stated the EBP were in place to protect the resident from exposure to infectious agents that might be on the provider's clothing, et cetera. The resident was on EBP precautions because the resident had gastric tube, that easily allowed the introduction of infections into the body. She stated she had done training on enhanced barrier precautions, and she was not sure whether the staff were in attendance since some were new to the facility. Record review of the facility's training records for EBP, dated 02/06/25, reflected LVN A, CNA B, and CNA C were not in attendance. Record review of the facility's Enhanced Barrier Precautions policy, dated March 2024, reflected: Enhanced Barrier Precautions is an infection control intervention to reduce transmission of multi-drug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. .EBP is indicated for residents with any of the following: .Infections or colonization with a CDC -targeted MDRO when contact precautions do not apply otherwise or, .Chronic wounds (pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and venous statis ulcers) and /or indwelling medical devices(devices fully embedded in the body,i.e. central lines, urinary catheters, feeding tubes, tracheostomy tubes) even if the resident is not known to be infected or colonized with a CDC Targeted MDRO)