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	11/26/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 6 residents (Residents #1) reviewed for abuse and neglect. The facility failed to report an incident where Resident #1 was found with a call light around his neck on 08/26/25. This failure could place residents at risk of neglect, injury, and lack of timely reporting of incidents. Findings included:Record review of the facility's current Abuse Prohibition Protocol policy, dated 08/25, revealed the following: .5. The Abuse Prevention Coordinator will assure that all Facility staff is in-serviced on recognizing abuse, abuse prevention and abuse reporting upon employment, and as necessary to maintain an abuse free environment. 7. i. Adverse event. An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof.l. Neglect is the failure of the facility, it's employees or service providers to provide goods and services to a Patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.10. The Abuse Prevention Coordinator will:a. Immediately (within 2 hours) report to the State agency and other appropriate authorities incidents of Patient Abuse as required under applicable regulations and regulatory guidance. Report events that cause reasonable suspicion of serious bodily injury immediately (within 2 hours) after forming the suspicion to The State agency and other appropriate authorities as required under applicable regulations and regulatory guidance. Record review of Resident #1's MDS Five Day assessment, dated 07/28/25, reflected the resident was an [AGE] year-old male, admitted to the facility on [DATE]. The resident's diagnoses included anxiety disorder (a mood disorder characterized by excessive, persistent, and uncontrollable fear and worry about everyday situations), cerebral infarction unspecified, (occurs when there is a disrupted blood flow to the brain), and hemiplegia following cerebral infarction affecting left nondominant side). This MDS reflected Resident #1 had moderate cognitive impairment with a BIMS score of 10. The MDS Section D0150 Resident Mood Interview further reflected Resident # 1 did not exhibit symptoms of feeling down, depressed, or hopeless and had no symptoms of having little interest or pleasure in doing things. Record review of Resident #1's hospital records, dated 07/17/25, reflected no suicidal ideations while Resident #1 was in the hospital previous to admission to the facility. Record review of Resident #1's care plan, dated 07/22/25, reflected the resident used psychotropic medication related to depression. Interventions included the resident would remain free of psychotropic related complications including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment. Further review of Resident #1's care plan initiated on 10/09/25 did not reflect any history of having suicidal ideations/behaviors. Record review of Resident #1's clinical record did not reflect any suicidal ideations. Record review of Resident #1's progress notes dated 08/26/25 at 9:00 AM by LVN A reflected: Resident observed in bed. Patient alert and oriented x 2. Patient exhibited signs of agitation. Attempted to provide care to the resident. Resident refused care and proceeded to pull off the call light off the wall and wrap the cord around his neck. Patient then shouted out loud pull the cord I am better off dead than alive. Give me a bottle of sleeping pills. Resident become outrate [sic], unable to redirect. Notified MD, NP, and DON. New order received to send patient to . Hospital for psych evaluation. Family notified. Record review of Resident #1's progress notes, dated 08/26/25 at 9:02 AM, by DON reflected: Responded to the patient's room after being called by the nurse. The nurse reported that the patient had been attempting to wrap a cord around his neck. At the time of arrival, the nurse was holding the call light cord and was explaining to the patient that he could not use it in that manner. Upon speaking with the patient he expressed that he was upset about being placed in a nursing home. He shared that his daughter had told him he should just kill himself. He continued to ask for the cord, at which point I removed any objects from the room that could pose a risk of self-harm. The nurse manager and I remained in the room and performed a head to toe assessment to ensure that the patient had not caused himself any physical harm. I then assigned a staff member to stay in the room with the patient at all times, instructing them not to leave under any circumstances, as one-on-one monitoring was now required. Resident stated that he knows we love him just is sad because of his family. Resident assisted up to chair, resident barely has clothes, so staff went to laundry to get sweatpants for patient to wear. Resident in good spirits awaiting transportation. Record review of Resident #1's Head to Toe assessment, dated 08/26/25, completed by DON reflected: No markings around neck. No new skin concerns. Skin with no new areas Record review of

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure all alleged violations involving neglect, which included injuries of unknown source, were reported immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials, which included the State Survey Agency, in accordance with State law through established procedures for 1 of 6 residents (Resident #1) reviewed for abuse and neglect.The facility failed to implement their policy on reporting an incident involving Resident #1 when he was found with a call light cord around his neck on 08/26/25. This failure could place residents at risk of and contribute to neglect. Findings included: Record review of Resident #1's MDS Five Day assessment, dated 07/28/25, reflected the resident was an [AGE] year-old male, admitted to the facility on [DATE]. The resident's diagnoses included anxiety disorder (a mood disorder characterized by excessive, persistent, and uncontrollable fear and worry about everyday situations), cerebral infarction unspecified, (occurs when there is a disrupted blood flow to the brain), and hemiplegia following cerebral infarction affecting left nondominant side). This MDS reflected Resident #1 had moderate cognitive impairment with a BIMS score of 10. The MDS Section D0150 Resident Mood Interview further reflected Resident # 1 did not exhibit symptoms of feeling down, depressed, or hopeless and had no symptoms of having little interest or pleasure in doing things. Record review of Resident #1's hospital records, dated 07/17/25, reflected no suicidal ideations while Resident #1 was in the hospital previous to admission to the facility. Record review of Resident #1's care plan, dated 07/22/25, reflected the resident used psychotropic medication related to depression. Interventions included the resident would remain free of psychotropic related complications including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment. Further review of Resident #1's care plan initiated on 10/09/25 did not reflect any history of having suicidal ideations/behaviors. Record review of Resident #1's clinical record did not reflect any suicidal ideations. Record review of Resident #1's progress notes dated 08/26/25 at 9:00 AM by LVN A reflected: Resident observed in bed. Patient alert and oriented x 2. Patient exhibited signs of agitation. Attempted to provide care to the resident. Resident refused care and proceeded to pull off the call light off the wall and wrap the cord around his neck. Patient then shouted out loud pull the cord I am better off dead than alive. Give me a bottle of sleeping pills. Resident become outrate [sic], unable to redirect. Notified MD, NP, and DON. New order received to send patient to . Hospital for psych evaluation. Family notified. Record review of Resident #1's progress notes, dated 08/26/25 at 9:02 AM, by DON reflected: Responded to the patient's room after being called by the nurse. The nurse reported that the patient had been attempting to wrap a cord around his neck. At the time of arrival, the nurse was holding the call light cord and was explaining to the patient that he could not use it in that manner. Upon speaking with the patient he expressed that he was upset about being placed in a nursing home. He shared that his daughter had told him he should just kill himself. He continued to ask for the cord, at which point I removed any objects from the room that could pose a risk of self-harm. The nurse manager and I remained in the room and performed a head to toe assessment to ensure that the patient had not caused himself any physical harm. I then assigned a staff member to stay in the room with the patient at all times, instructing them not to leave under any circumstances, as one-on-one monitoring was now required. Resident stated that he knows we love him just is sad because of his family. Resident assisted up to chair, resident barely has clothes, so staff went to laundry to get sweatpants for patient to wear. Resident in good spirits awaiting transportation. Record review of Resident #1's Head to Toe assessment, dated 08/26/25, completed by DON reflected: No markings around neck. No new skin concerns. Skin with no new areas. Record review of Resident #1's Change in Condition, dated 08/26/25 at 10:11 AM, by LVN A reflected: .Altered Mental Status on 08/26/25. This condition, symptom or sign has occurred before: No. Resident alert and oriented, knows what he is talking about. Appears distressed and agitated. Stated that he is better off dead than alive. Resident need psych eval. Mental status changes-Suicidal thoughts. Record review of a Situation Background Appearance Review and Notify Report for Resident #1, dated 08/26/25 by LVN A, reflected: The condition, symptom, or sign has occurred before: No. Altered level of consciousness. Danger to self or others. Sent to .Hospital. Interview on 10/09/25 at 11:54 AM, LVN A revealed he was Resident #1's 6:00 AM - 2:00 PM nurse. LVN A