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	04/28/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 4 residents (Resident #1) reviewed for quality of care. The facility failed to provide treatment to Resident #1's right elbow according to physician's orders. This failure placed residents of risk for not receiving appropriate care and treatment and a decreased quality of life.Findings included: Review of Resident #1's Admissions MDS Assessment, dated 04/14/26, reflected that she was admitted to the facility on [DATE]. Her MDS Assessment did not indicate her diagnoses, her cognitive abilities, or anything regarding her care. Review of Resident #1's face sheet, dated 04/27/26, reflected that she had diagnoses of repeated falls and rhabdomyolysis (a condition characterized by the rapid breakdown of skeletal muscle, leading to the release of muscle breakdown products into the bloodstream, which can be harmful to the kidneys and may result in acute kidney injury). Review of Resident #1's Order Summary Report, dated 04/27/26, reflected an order for the following: Wound Treatment- Dry Dressing everyday shiftCleanse wound to ___R elbow___ with Normal Saline or Skin Cleanser. Pat Dry. Cover with Dry Dressing with a start date of 04/16/26 Review of Resident #1's Wound Care Treatment Administration Record for April 2026 reflected she did not receive care on 04/18/26, 04/19/26, or 04/25/26 for the following treatment: Wound Treatment- Dry Dressing every day shift Cleanse [sic] wound to ___R elbow___ with Normal Saline or Skin Cleanser. Pat Dry. Cover with Dry Dressing Review of Resident #1's Care Plan, initiated on 04/16/26, reflected the following: Focus: [Resident #1] has current skin concerns:[R elbow] [sic] Open Lesions-Other [sic] than Stasis/venous Area.Interventions: Perform treatments per order, if no improvement x2 weeks report to MD. Treatment as ordered. Observation and interview on 04/27/26 at 2:50 PM, Resident #1 was observed lying in bed with a long sleeved shirt on. Resident #1 said she was not sure what her treatment orders were for her elbows. Resident #1 said she was not sure if the treatment order was supposed to be for every day or every other day. Resident #1 said the WCN completed her treatments during the week but she did not get any treatments during the weekends. Interview on 04/28/26 at 8:50 AM, the WCN said she was at the facility during the week (Monday through Friday) and completed all resident's treatments. The WCN said on the weekends when she was not there, the charge nurses were responsible for completing their own treatments. The WCN said the facility also had a weekend supervisor and she was not sure if the weekend supervisor assisted in completing resident's treatments or not on the weekends. The WCN said there was a meeting on Fridays to communicate with the weekend staff to be aware of treatments completed over the weekends. The WCN said she did not have any other communication with the weekend staff regarding residents' treatments. The WCN said sometimes when she came in to work on Mondays to complete a resident's treatment, she would notice a dressing was missing on a few residents. The WCN said she was not sure what happened to the dressing and did not address it with the staff from the weekend or previous shifts. The WCN said normally if a dressing was missing or fell off during care the nurse would reapply the dressing and provide treatment. The WCN said when anyone completed a resident's treatment it was (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented in the wound care treatment administration record. The WCN said all staff had access to the treatment cart to be able to complete a resident's treatment on the weekends. The WCN said all weekend nurses knew it was their responsibility to complete their assigned residents' treatments on the weekends. Interview on the phone on 04/28/26 at 10:46 AM, LVN A said he cared for Resident #1 this past Saturday (04/25/26) from 6:00 AM to 10:00 PM. LVN A said he did not provide any treatment for her elbow and the only interaction he recalled with her was when he provided her the requested pain medicine. LVN A said he worked double shifts on the weekends and sometimes the weekend supervisor completed residents' treatments on the weekends and sometimes he was responsible for them. LVN A said who was responsible for the residents' treatments on the weekends was dependent upon what the staff decided. LVN A said sometimes there was a conversation amongst the nurses about who was completing the treatments but not always. LVN A said he would normally look in the residents charts to see what treatments were due and if they were already completed he knew he did not need to do them, but if they were not completed yet then he would complete them himself. LVN A said he was not aware Resident #1 had treatment orders for her elbow that were due on Saturday (04/25/26). LVN A said since he was her assigned nurse he would have been responsible for completing her treatment. Attempted interview on the phone on 04/28/26 at 11:15 AM with RN B was unsuccessful as she did not answer or call back prior to exit; a message was left for a call back. RN B cared for Resident #1 on 04/19/26. Interview on the phone on 04/28/26 at 1:21 PM, the Previous DON said she recently left the faciity on Monday and no longer worked at the facility. The Previous DON said she was never made aware wound care was not completed on the weekends. The Previous DON said there was always enough staff on the weekends to ensure wound care was completed as ordered. The Previous DON said the nurses were responsible for completing their assigned residents' wound care unless there was an additional nurse who would then be delegated to completing wound care which would be shown on the schedule. The Previous DON said it should have been clear to the nurses that they would need to do their own wound care when a designated nurse was not scheduled to do the wound care over the weekend. Interview on 04/28/26 at 1:46 PM, the ADON said usually she would try to look at the resident's treatment administration records but had not done that recently. The ADON said she generally reviewed them to make sure residents were receiving their treatments as ordered. The ADON said the facility had an assigned Weekend Supervisor who managed the staff on the weekends. The ADON said she was never made aware residents treatments were not completed on the weekends. The ADON said the nurses were responsible for completing their assigned residents treatments on the weekends. The ADON said staff should document in the treatment administration record when they completed a residents' treatment. Interview on 04/28/26 at 2:14 PM, the Administrator said the charge nurses were responsible for completing wound care on the weekends. The Administrator said she had a sheet of paper that was provided to weekend staff that included instructions to complete their assigned residents' wound care. The Administrator said all staff on the weekends had access to the treatment cart to complete wound care for residents. The Administrator said staff also had access to each residents' wound care administration record to review which treatment orders were due. The Administrator said the purpose of completing wound care as ordered was to make sure wounds did not get worse. The Administrator said if residents did not receive ordered wound care the wound could deteriorate or worsen. The Administrator said she expected the weekend staff to complete the residents' ordered wound care treatments. The Administrator said all nurses were trained to complete an ordered residents' wound care treatments. Interview on 04/28/26 at 3:13 PM, the Weekend Supervisor said she had only been in the position for 3 weeks. The Weekend Supervisor said normally the charge nurses on the weekends were responsible for completing their assigned residents' wound care treatments. The Weekend Supervisor said she had not noticed or had been informed wound care treatments were not completed. The Weekend Supervisor said she did not check the residents' wound care treatment administration records to ensure wound care treatments were being completed. Review of the facility's Wound Treatment (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Management policy, dated 12/01/25, reflected the following: 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.7. Treatments will be documented on the Treatment Administration Record or in the electronic health record.