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	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Harrison at Heritage	4600 Heritage Trace Parkway Fort Worth, TX 76244

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's right that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mentla and psychosocial needs that are identified in the comprehensive assessment for 1 of 4 residents (Resident #45) reviewed for care plans. The facility failed to revise and update Resident #45's comprehensive care plan with new diet orders. This failure could affect residents of the facility by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings included: Record review of the Admission Record dated 09/06/24 revealed Resident #45 was a [AGE] year-old male initially admitted on [DATE] and readmitted on [DATE] with diagnoses including vascular dementia, acute kidney failure, alcoholic cirrhosis of the liver, Type II diabetes mellitus, and epilepsy. Record review of the Quarterly MDS assessment dated [DATE] reflected Resident #45 had severe cognitive impairment with a BIMS score of 6. The MDS reflected the resident received a therapeutic diet. Record review of the undated physician's diet orders reflected Resident #45's diet order was a regular diet with no salt on tray, no orange juice, no oranges, no tomatoes, no bananas, and no potatoes. The order start date was 06/13/24. Record review of Resident #45's undated care plan reflected: [Resident #45] has a diet order of a mechanically altered diet. Resident will maintain existing weight over the next 90 days. Insert dentures/bridges prior to meals. Monitor and document weight; report a weight loss greater than 3 pounds to dietician. Record food intake at each meal; offer appropriate substitutes for uneaten food. The care plan did not reflect the current order for no salt on tray, no orange juice, no oranges, no tomatoes, no bananas, and no potatoes (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/06/24 at 12:10 PM of Resident #45 revealed resident was eating a regular tray with no salt on the tray. There also were no oranges, no tomatoes, no bananas, no potatoes, and no orange juice on the tray. Interview on 09/06/24 at 10:13 AM with LVN C revealed Resident #45 received a renal diet daily. LVN C acknowledged Resident #45's care plan and diet order did not match. LVN C also said he had not noticed the discrepancy between the diet order and the care plan. LVN C stated Resident #45 previously received a mechanical soft diet before it was changed to a renal diet. Then LVN C revealed that Resident #45's diet order changed to NSOT and a regular diet with no orangs, bananas, potatoes, tomatoes, or orange juice. In addition, LVN C stated it was the ADON's responsibility to update care plans. LVN C stated he did not remember the last in-service on care plans and diet orders matching. Interview on 09/06/24 at 11:30 AM with the MDS Coordinator revealed upon admission, Resident #45's initial care plan was initiated. The MDS Coordinator stated that clinical meetings were held daily to update care plans as needed. The MDS Coordinator said that Resident #45 was overlooked. The MDS Coordinator also said that the importance of the diet matching the care plan was that the floor staff know the resident's diet while providing care. The MDS Coordinator revealed that she was responsible for the updated the care plans and that if the care plan was not updated, Resident #45 could receive the wrong diet which was important since Resident #45 was on dialysis. The MDS Coordinator stated she would update the care plan to match the diet order immediately. Interview on 09/06/24 at 11:37 AM with ADON A revealed care plans were updated with acute changes in the nursing daily clinical meetings by the MDS nurse as well as the infection preventionist and wound treatment nurse. She stated it was a collaborative effort to update the care plan, it was the responsibility of the whole team to update care plans. ADON A also said that the importance of care plans matching the diet orders was to ensure that the resident was cared for properly. ADON A revealed that the diet was important because a resident could refuse to eat, could choke, etc. ADON A stated that their policy stated that the care plan must match the resident's order. ADON A did not remember the last in-service held on care plans and diet orders matching. Interview on 09/06/24 at 6:14 PM with the DON revealed diet orders were updated by the MDS Coordinator, and it was their responsibility to adjust care plans for long-term changes. The DON stated that management adjusted care plans for short-term orders such as antibiotic. But it was the DON's responsibility to ensure care plans and orders match. The DON stated that if there were a discrepancy in the care plan, there could be confusion in the plan of care. The DON said that clinical meetings were held daily to ensure that care plans and orders were updated by nursing management. Record review of the facility's Care Plans, Comprehensive Person-Centered policy dated March 2022 reflected: .b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 8 residents (Resident #290) reviewed for ADL care. The facility failed to provide Resident #290 assistance with his personal hygiene by not providing scheduled showers. This failure could place the residents at risk for decreased feelings of self-worth, skin breakdown, and infection. Findings included: Record review of Resident #290's face sheet, dated 09/06/24, reflected the resident was an [AGE] year-old male, admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included hypertension (high blood pressure), hyperlipidemia (abnormally high levels of lipids in the blood), non-Alzheimer's dementia (loss of memory), and edema (fluid retention of the body). Record review of Resident #290's Admission MDS Assessment , dated 09/06/24, reflected Resident #290 had the ability to make himself understood and understood others, and his cognition was intact with a BIMS score of 13. Resident #290 had limited range of motion in both lower extremities, and he required partial/moderate assistance with shower/bathing, toileting, and personal hygiene. Record review of Resident #290's care plan, undated, reflected Resident #290 was admitted to the facility on [DATE]. The care plan reflected: Goal: Resident will participate in all activities of daily living and facility routines. Intervention included: Use cues to enhance participation in self-care. Observation and interview on 09/05/24 at 10:55 AM revealed Resident #290 in bed. The resident's bedding was soiled with stained dark amber circles (two the size of a [NAME]) and dark red smudges. Resident #290 had two pillows that were removed from bed and on nightstand with dark red smudges and small circles (the size of dimes) indicating evidence of blood stains. Resident #290 appeared disheveled with his hair greasy and facial hair grown out. According to Resident #290, he had not been showered due to having a PICC line in his left arm, but now that it had been removed, he hoped to get a shower. Resident #290 stated he would like to have a bath and shave. When asked about his sheets, Resident #290 revealed he could not recall the reason for the soiled sheets and bedding. Resident #290 could not recall the last time he showered. Observation and interivew on 09/06/24 at 10:09 AM revealed Resident #290 had a disheveled appearance, his hair was not combed but appeared wet/greasy. The resident had changed from a white shirt the day before to a black shirt. When asked if he received a shower, Resident #290 responded, No, but hoping to get one today. Resident #290's bedding was still soiled and discolored with dark red stains. Resident #290 stated he told an unknown staff person he would like to shower within the next hour. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/06/24 at 1:40 PM with CNA A aide revealed she was not working with Resident #290 and did not know who was responsible for his care. CNA A stated residents were showered according to the scheduled shower days. According to CNA A, not assisting Resident #290 with a shower would place him at risk of skin breakdown and not being cleaned. Interview and record review on 09/06/24 at 1:41 PM with CNA A of the shower sheets revealed Resident #290's shower days were Monday, Wednesday, and Friday on the 2:00 PM-10:00 PM shift. CNA A revealed she documented in the computer once showers were completed. CNA A reported she could not identify the last time Resident #290 had taken a shower or bed bath, as there was no documentation that indicated he was showered since his return to the facility on [DATE]. Observation and interview on 09/06/24 at 1:43 PM with LVN B of Resident #290 revealed the resident was lying in bed, and his bedsheets had stains. The resident had a disheveled appearance. LVN B stated residents were showered according to the shower sheet list. LVN B stated it appeared Resident #290 had not been showered, and she would address this concern with aides who were responsible. LVN B stated nurses were to be notified if aides required assistance with care or activities of daily living to ensure residents had proper care. LVN B stated not providing showers, bed bath, personal hygiene, or changing bed sheets could place Resident #290 at risk of infection. LVN B stated it was important for Resident #290 to receive proper hygiene because he was recently cleared from isolation due to being admitted to the facility for a urinary tract infection and COVID. Interview on 09/06/24 at 6:36 PM with the DON revealed Resident #290 was newly admitted to the facility. The DON stated the resident transferred to the facility from the hospital where they were addressing an acute diagnosis. The DON stated CNAs were responsible for offering a shower on admission and got the residents in rotation to provide showers three days a week. The DON stated nursing staff should document any time residents refused to shower and inform their charge nurse. The DON stated not doing so placed Resident #290 at risk of him not thriving as well and could result in illness. The DON stated CNAs were responsible for ensuring residents were showered according to their schedule, and charge nurses were responsible for ensuring CNAs were doing their job. Review of the facility's current, undated Activities of Daily Living policy reflected: .every effort must be made to assure that assignments of the nurses and nurse aides to patients are as consistent as possible. A daily care guide must be prepared from the electronic medical record to assist direct care staff in providing assistance to patients in their activities of daily living. Certified Nurse Aide Activity of Daily Living Tracking Record must be maintained in accordance with the Minimum Date Set coding guidelines and specific to the Patient's individual needs. Certified Nurse Aide Activity of Daily Living Tracking Record must be regularly monitored by the DON or designee to ensure that task are being performed as scheduled.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goal and preferences for 1 of 1 resident (Resident #242) reviewed for pharmacy services. The facility failed to ensure Resident #242's intravenous medication bag and tubing were labeled with dates time and initials. These failures could place residents at risk for medication error, and delay in medication administration. Findings included: Review of Resident #242's entry MDS assessment, dated 09/04/24, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. The resident had diagnoses including which included: sepsis, unspecified organism (a life-threatening medical emergency caused by body's overwhelming response to an infection. Resident #242 had intact cognition with a BIMS score of 15. Review of Resident #242's face sheet, dated 09/06/24, revealed the resident was a [AGE] year-old female with an admitted [DATE]. Review of Resident #242's physician's orders dated 08/29/24 reflected: (meropenem 1-gram intravenous solution (1) vial every eight hours for nineteen days starting 08/30/2024) and (change intravenous tubing every 24 hours). Observation and interview on 09/04/24 at 2:02 PM revealed Resident #242 in her room, lying in bed. She was observed to have a PICC line dated 09/04/24. The intravenous medication bottle was hanging on the pole. The IV bag and the tubing were not labeled with the date, time, and initials to indicate when it was hung, and another empty bag and tubing were also hanging not dated or labeled. Interview on 09/04/24 at 2:15 PM with LVN F revealed she hung the bag that was currently infusing. She stated she saw the unlabeled empty bag hanging on the pole. LVN F said the IV bag was supposed to have the correct resident's name, date, time and initial of the nurse administering the medications. She stated she was aware she was supposed to label the bag and the tubing, so other staff were aware when the bag was hung, to prevent omission of a dose or overdose but she did not. She stated she did not get why it was an issue not labeling, putting a date, and initialing the bag and the tubing. She stated failure to label the bag and the tubing could lead to overdose, omission of a dose and infection control. She stated the bag was changed as scheduled and the tubing could be changed every 24 hours as per the orders. LVN A stated she had done training on IV administration. Interview on 09/06/24 at 6:01 PM with the DON revealed she expected staff to date and initial intravenous bags and tubing when administering intravenous medications to prevent infection and medication error. She stated the tubing should be changed every 24 hours. She stated she had done training with staff on labeling and putting initials on bags and tubing. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility training record reflected an in-service training regarding IV/PICC Lines on 08/12/24. The training reflected: remember to date, initial and time all tubing's and medication. Review of the facility's current Intermittent IV Via Secondary Line (IV Piggyback) policy, dated July 2014, reflected the following: A Label system shall be established to indicate time and date of the tubing change and initials of nurse performing the procedure. Apply appropriate label to tubing. Include: Date Time Nurses' initials ."

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident on two of three medication carts (600 Hall and split hall) one medication room(central supply cabinent) and 4 of 4 (Residents #8, #21, #66 and #126) reviewed for pharmacy services. 1. The facility failed to ensure the 600 Hall nurses' medication cart contained accurate narcotic logs for Resident #126. 2. The facility failed to ensure the split hall nurses' medication cart contained accurate narcotic logs for Residents #8, #21, and #66. 3. The facility failed to ensure expired medications in Central Supply were removed and destroyed. These failures could place residents at risk for medication error, drug diversion,residnet reciving medications that were ineffective and delay in medication administration. Findings included: 1. Review of Resident# 8's Quarterly MDS Assessment, dated 07/19/24, reflected the resident was [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included displaced intertrochanteric fracture of left femur. The resident had moderately impaired cognition with a BIMS score of 9. Review of Resident #8's physician's orders dated 7/13/24 reflected an order for the resident to receive one tablet of Hydrocodone 5 mg/acetaminophen 325 mg (pain medication) by mouth as needed every four hours. 2. Review of Resident# 21's Quarterly MDS assessment, dated 08/30/24, reflected the resident was [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included pain. The resident had moderate cognitive impairment with a BIMS score of 8. Review of Resident #21's physician orders dated 04/13/24 reflected an order for the resident to received two tablets of Tramadol 50 mg by mouth three times daily for pain. 3. Review of Resident #66's entry MDS Assessment, dated 08/22/24, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. The resident had a diagnosis of pain. The resident's cognition was intact with a BIMS score of 15. Review of Resident #66's physician orders dated 08/27/24 reflected the resident had an order to receive the pain medication, Percocet 10 mg-325 mg tablet, one tablet by mouth every four hours while awake. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #126's entry MDS assessment, dated 08/09/24, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. The resident had a diagnosis of wedge compression fracture T11-T12 vertebra. The resident had moderate cognitive impairment with a BIMS score of 8. Review of Resident #126's physician orders dated 08/27/24 reflected the resident had an order to receive one tablet of Tramadol 50 mg tablet by mouth three times daily. Observation and record review on 09/05/24 at 12:51 PM of 600 Hall nurses' medication cart and the Narcotic Administration Record, with LVN F, revealed Resident #126's Narcotic Administration Record for Tramadol 50 mg reflected a total of 20 pills remaining, while the blister pack count was 19 pills. It was last administered on 09/05/24 at 12:00 PM. Observation and record review on 09/05/24 at 1:16 PM, of split hall nurses' medication cart and the narcotic administration record, with LVN G, revealed the following: - Resident #8's Narcotic Administration Record sheet for hydrocodone-acetaminophen 5-325 mg was last signed off on 09/04/24 for one-tablet dose given at 10:18 PM, for a total of 14 pills remaining, while the blister pack count was 12 pills. - Resident #21's Narcotic Administration Record sheet for Tramadol 50 mg was last signed off on 09/04/24 for a two-tablet dose given at 9:00 PM for a total of 113 pills remaining while the blister pack count was 111 pills. - Resident #66's Narcotic Administration Record sheet for oxycodone 10-325 was last signed off on 09/5/24 for a one-tablet dose given at 12:30 AM for a total of 39 pills remaining while the blister pack count was 37 pills. Interview with LVN G on 09/05/24 at 1:35 PM revealed he administered oxycodone 5-235 mg 1 tablet to Resident #66 two times at 7:00 AM and 11:00 AM, hydrocodone -acetaminophen 5-325 mg 1 tablet to Resident #8 as needed every 4 hours and Tramadol 50 mg 2 tablets to Resident #21 and he had not signed off on the narcotic administration record log. He stated he gave the residents the medication, but he forgot to sign off on the narcotic administration log. He stated he knew he was supposed to sign-out on the narcotic count sheet after administration and on the Medication Administration Record, but he did not. LVN G stated he had no excuse for not signing off. He stated failure to log off would cause the narcotic count to show less on the next count, and it could lead to medication error. He stated he had done an in-service on medication administration. Interview with LVN F on 09/05/24 at 1:40 PM revealed she administered tramadol 50 mg 1 tablet to Resident #126, and she had not signed off on the narcotic administration record log. She stated she was aware she was supposed to administer and log on the narcotic log sheet at once, but she did not she forgot. She stated failure to log off would cause the narcotic count to show less on the next count, and it could lead to medication error. She stated she had not done in-service on medication administration. Observation on 09/05/24 at 2:01 PM of the facility's Central Supply over-the-counter cabinet with LVN R revealed 2 bottles of Vitamin A 3000 mcg (10000 units) with expiry date April 2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/05/24 at 2:02 PM with LVN R revealed it was all nurses' responsibility to check the cabinet for expired medications. LVN R stated the central supplier was also responsible for ensuring there were no expired medication on the cabinet. He stated the risk of having expired medication in the cabinet was that if administered they will not be effective. He stated he had done an in-service on labelling and checking of expired medications. Interview was attempted with the Central Supply Staff on 09/05/24 at 2:23 PM by phone was not successful. Interview on 09/06/24 at 12:05 PM with the ADON revealed her expectation was when staff administer narcotics, they should document on medication administration record and log off on narcotic administration record. She was not able to say when she had last checked the carts. She stated failure to log off after administering could lead to medication error and medication diversion. Interview on 09/06/24 at 2:23 PM, the ADON revealed the Central Supply Staff was responsible for ensuring the cabinet was stocked, which included checking for expired medications. She stated it was her responsibility and the other ADONs to check the cabinet after the Central Supply Staff. Interview on 09/06/24 at 05:53 PM, the DON revealed her expectation was for staff administering narcotic medications to document the medications when they were given to the resident on the medication administration record and to sign on the narcotic log to prevent discrepancies and to have proof the medications were administered. The DON stated failure to document could lead to discrepancy and adverse effects. She stated it was her responsibility and the ADONs to audit the medication carts, and she stated she had checked in the morning. She stated she had started training of staffs on narcotic logs documentation. DON revealed the Central Supply Staff was responsible for ensuring the cabinet was free from expired medication. She stated it was her responsibility and the ADONs to check the cabinet after the Central Supply Staff. She stated she checked every morning on the carts, and she had checked that morning on 09/05/24. She was not asked on what they did with expired Medications. No training given to the Central Supply Staff. Review of the facility trainings reflected in services on all narcotics need to be signed as you give them on 08/02/24. Review of the facility's current Controlled Substances Medication Administration and Documentation- policy, dated January 2024, reflected: All administered controlled substance must be charted in medication administration record at the time of administration .if the medication is removed from the locked area, signed out on the inventory (count) sheet, but is not documented on the MAR it is considered a missing tablet which is open for interpretation as a diverted dose since it can't be definitely proven it was given to a resident without documentation on MAR to confirm. Record review of the facility's Medication Labeling and Storage policy, revised 2023, reflected: .Does not address the expired medications Recor review of the facility's Management of Controlled Medications policy, dated January 2024 reflected: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.6. During drug destruction ,all narcotics will be removed from their container, placed in the biohazard bag/box and destroyed by applying liquids over them .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44937 Based on observation, interview, and record review, the facility failed to ensure the facility provided food that was palatable, for one of one observed meal reviewed for dietary services. The facility failed to serve food that had a palatable texture during the lunch meal on 09/05/24. This failure could affect residents by placing them at risk of weight loss, altered nutritional status, and a diminished quality of life. Findings included: Review of the facility's menu on 09/05/24 revealed the planned lunch consisted of soft tacos, refried beans, shredded lettuce, and diced tomato with alternate meal to include grilled chicken, Brussels sprouts, and mashed potatoes, brownie, bread. Observation on 09/05/24 at 12:51 PM of the soft taco to include ground beef with flour tortilla and refried beans, pureed texture ground beef, tortilla, Brussels sprouts, refried beans test tray with three surveyors, the Regional Dietitian and Dietary Manager revealed the food was warm; however, pureed Brussels sprouts, mashed potato, and pureed beans were without flavor and the grilled chicken patty was colorless, bland, and flavorless. Regional Dietitian and Dietary Manager stated they did not see concerns with the taste of the food, they had not received any concerns from staff about the bland taste of food. The Dietary Manager stated the cooks were responsible for the taste and presentation of the food. According to the Regional Dietitian the facility will look into different ways to add flavor to food without adding salt. Dietary Manager stated she would be responsible to ensure the cook was adding flavor to the food moving forward, not doing so placed residents at risk of not eating, weight loss and hungry if they are not eating because they don't like the food provided. A confidential interview with thirteen alert and oriented residents revealed the on a normal day, when state was not in facility food was served cold when eating both on the halls and in the dining room. It was also mentioned that food was not tasty and did not have any flavor. Review of the resident council meeting minutes dated June 2024-September 2024 did not mention anything about food being served cold or flavorless. Interview on 09/05/24 at 1:00 PM with the Dietitian and Dietary Manager revealed they had not received any complaints regarding the food being cold or bland. Review of the facility's policy titled Food Storage undated, reflected: facilities are to keep foods safe, wholesome, and appetizing.

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	676317	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Harrison at Heritage	4600 Heritage Trace Parkway Fort Worth, TX 76244

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41781 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen and the 300-hall nutrition room. 1. The facility failed to ensure food items stored in the freezer were properly labeled with the contents after being removed from the original packages and not dated to reflect when the food items were opened. 2. The facility failed to ensure food items stored in the refrigerator were properly discarded. 3. The facility failed to ensure the 300-hall nutrition room's ice machine was cleaned prior to being used. These failures could place all residents at risk for food contamination and food borne illness. Findings included: Observation of the freezer on 09/04/24 beginning at 9:14 AM revealed the following were not properly labeled or dated for storage: - Two separate bags of breaded chicken patties, - 1 bag of meatballs, - 1 bag of French fries and fries wrapped in clear wrap. - 1 bag of breaded fish Observation and interview on 09/04/24 at 9:17 AM of the walk-in freezer revealed 2 separate bags of breaded chicken patties, 1 bag of meatballs, 1 bag of French fries and fries wrapped in clear wrap, and 1 bag of breaded fish. Interview with Dietary Manager revealed the food items were left over from preparing previous meals. The Dietary Manager stated these food items were taken from their original packing. The Dietary Manager stated the process when storing foods in the freezer included: to place left over food items in a storage bag labeled with name of food item, dated with open date, and concealed properly. The Dietary Manager stated it was the responsibility of the cooks to do walk thru daily to remove anything 10 days out from dates written on the stored food items. The Dietary Manager stated she also did a walk through to ensure cooks were not missing food items that required proper label and dating. Observation revealed the Dietary Manager removing items that were not properly labeled or dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 09/04/24 at 9:20 AM with the Dietary Manager revealed in the refrigerator a bag labeled ground meat that was dated 08/11/24 with no end date. According to the Dietary Manager the ground meat was used often and was kept in the refrigerator for easy access when needed. The Dietary Manager revealed all food items were dated when they were placed for storage, and she or the cooks were to do a walk through daily to remove items that were 10 days past their open date. The Dietary Manager stated an end date was not usually written on storage bags, and she could not confirm how long this ground meat had been in the refrigerator, she removed the bag of ground meat during the interview. The Dietary Manager stated the bag of ground meat was something that should not have been used due to it could cause food born illnesses if it had been in the refrigerator since 08/11/24. Review of the facility's undated policy titled Food Storage policy, reflected: Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. All stock must be rotated with each new order received. Rotating stock is essential to ensure the freshness and highest quality of all foods. Foods should be covered, labeled, and dated. 3. Observation on 09/04/24 at 2:12 PM of the 300-hall nutrition room's ice machine was filled with ice and had a white flap on the inside touching the ice. The white flap had a brown substance on it covering the entire bottom part of the white flap. Interview on 09/06/24 at 11:37 AM with CNA Y revealed the 300-hall nutrition room had an ice machine in it that had a white flap touching the ice that had a brown substance on it. CNA Y said the Maintenance Director normally cleaned it and she had not noticed the brown substance on the white flap before. CNA Y said this was the machine the staff used to get ice for the residents. Interview on 09/06/24 at 11:46 AM with the Maintenance Director revealed a contractor came to the facility to clean the ice machine and was last here about five months ago. The Maintenance Director said he saw the ice machine had a white flap on the inside that had a brown substance on it that was coming in contact with the ice. The Maintenance Director said he last checked the ice machine about a month ago and did not see the brown substance on there at that time. The Maintenance Director said no staff had mentioned it to him about the ice machine being dirty. Interview on 09/06/24 at 6:18 PM with the DON revealed staff got ice for the residents from the ice machines in the nutrition rooms. The DON said the ice machines were cleaned by the housekeeping and maintenance department. The DON said staff were supposed to report to the Executive Director (Administrator), Maintenance Director, and the DON immediately if they notice that the ice machine was dirty on the inside. The DON said the purpose of the ice machine being cleaned was to make sure residents have safe ice to consume. The DON said the risk was that the ice could be contaminated and put residents at risk for any type of being sick. Review of the maintenance logs from July 2024 reflected nothing for the ice machine needing to be cleaned. 44937

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to maintain clinical records that were complete and accurate for one (Resident #46) of six residents reviewed for clinical records. The facility failed to accurately document in Resident #46's progress notes about her care. This failure could place residents at risk for incomplete and inaccurately documented medical record that included their progress treatment, services, and interventions. Findings includde: Review of Resident #46's Face Sheet reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Review of Resident #46's 5-day MDS Assessment, dated 08/03/24, reflected she had a BIMS score of 14, indicating no cognitive impairment. Further review revealed she had an indwelling catheter. Her active diagnoses included diabetes mellitus, hyperlipidemia, and a hip fracture. Review of Resident #46's orders reflected an order for her catheter to be discontinued on 08/12/24. Review of Resident #46's progress notes reflected the following: - On 08/12/24, LVN F wrote: This nurse received order from NP to discontinue foley and do voiding trail for 8 hours .this nurse discontinued foley catheter .Resident tolerated foley being taken out well . -On 08/13/24, LVN C wrote: Resident foley Catheter discontinued. [sic]. -On 08/22/24, LVN Z wrote: .Resident has foley catheter in place and draining clear yellow urine. -On 09/03/24, LVN Z wrote: .Resident has foley catheter in place and draining clear yellow urine. -On 09/04/24, LVN Z wrote: .Resident has foley catheter in place and draining clear yellow urine. Observation and interview on 09/04/24 at 3:40 PM with Resident #46 revealed she was lying in her bed watching television. Resident #46 said when she originally arrived at the facility, she did have a catheter, and then it was discontinued. Resident #46 said she was not sure what date it was discontinued, but it was a while ago she thought. Resident #46 said she was not receiving any catheter care from the staff because she did not have one at the moment. A catheter was not observed to be used by Resident #46. Attempted interview via phone was made on 09/06/24 at 11:45 AM to LVN Z but went unanswered. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/06/24 at 11:32 AM with LVN F revealed she had been working at the facility for a few weeks and was familiar with Resident #46. LVN F said Resident #46 did not use a catheter and would not add any documentation in her progress notes about catheter care because none was being provided. LVN F said she only added information to a resident's chart related to their care. Interview on 09/06/24 at 6:18 PM with the DON revealed she was in Resident #46's room one day this week and did not see she had a catheter. The DON said staff were supposed to document accurate information about the resident and do an assessment on them each shift. The DON said staff should be aware of any care the resident received. The DON said the purpose of this was to make sure they were documenting accurately in a resident's chart. The DON said when staff document wrong information in a resident's chart it can result in a miscommunication regarding that resident's care. Review of the facility's policy, revised July 2017, and titled Charting and Documentation reflected: .3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.