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	04/23/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40679 Based on interviews and record reviews the facility failed to ensure residents were free from significant medication errors for 2 of 3 residents (Resident #1 and Resident #2) reviewed for administration of medications. LVN B failed to ensure she administered medications to the correct resident. LVN B administered Resident #2's medications (Hydralazine 25mg, Gabapentin 600mg, Risperdal 2mg, Tylenol-Codeine #3 300 mg-30 mg, Omeprazole 20 mg, Eliquis 5mg, acetaminophen 325mg) to Resident #1 on 04/15/22 in addition to the resident receiving her own medications that same morning. Resident #1 had nausea and vomiting and was admitted to the hospital for accidental overdose for several days. On 04/21/22 at 04:11 pm an actual harm that is not immediate jeopardy was identified. While the IJ was removed on 04/22/22 the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents requiring assistance with medication administration at risk for adverse effects and/or it may have resulted in subsequent medication errors. Findings Included: Review of Resident #1's face sheet, dated 04/15/22, indicated Resident #1 was an 87-old-female admitted on [DATE] with diagnoses of low blood pressure disease, high blood pressure disease, an inflammation of the lining of the lungs, stroke, heartburn, depressive disorders, and muscle weakness. Resident #1 was discharged to an emergency department of an acute care hospital on 04/15/22. Review of Resident #1's MDS, dated [DATE], indicated Resident #1 scored a 15 on a Brief Interview for Mental Status test indicating the resident's mental status was determined to be intact in cognitive response cognition. Review of Resident #1's care plan, dated 04/15/22, indicated Resident #1 had the potential for side effects related to psychotropic medications and use of anti- psychotics. It also revealed pertinent diagnoses included disorders of the cardiac and circulatory system. Record review of Resident #1's consolidated physician's orders, dated 04/10/22, listed medications ordered on admission: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Toprol XL (treatment of high blood pressure) 25mg tablet, 1 time a day. Lisinopril (treatment of high blood pressure) 40 mg tablet, 1 time a day. Fexofenadine (antihistamine) 180 mg tablet, 1 tablet, 1 time a day as needed for allergies. Celexa (antidepressant) 20 mg tablet, 1 time a day. Buspirone (antidepressant) 15 mg tablet, 1 time, 1 time a day. Atorvastatin (lowers cholesterol) 10 mg tablet, 1 time a day. Aspirin (blood thinner) 81 mg tablet, 1 time a day. Amlodipine (lowers blood pressure), 10 mg tablet, 1 time a day. Pantoprazole (treats heartburn) 40 mg capsule, 1 time a day; and Acetaminophen (pain reliever) 325 mg tablet, 2 tablets every 4 hours as needed for pain. Review of Resident #2's face sheet, dated 04/22/22, indicated Resident #2 was a 77-old-female admitted on [DATE] with diagnoses of high blood pressure, high cholesterol, Schizophrenia, stroke, heartburn, and muscle weakness. Review of Resident #2's MDS, dated [DATE], indicated Resident #2 scored an 11 on a Brief Interview for Mental Status test indicating she had moderate impairment cognition, required supervision in walking, eating and assistance in bed mobility, transfer, dressing, toilet use and personal hygiene. Review of Resident #2's care plan, dated 03/29/22, indicated Resident #2 had the potential for side effects related to psychotropic medications and use of anti- psychotics. Also, she had a history of stroke, and needed medications to thin the blood as prescribed by medical doctor. Nursing staff were to administer medications as ordered, monitor and record side effects of medication, notify the physician and family as needed regarding concerns. She was a fall risk due to the use of anti-anxiety and anti-depressant medications; unsteady gait and balance, generalized weakness and poor safety awareness. Record review of Resident #2's consolidated physician orders dated 04/10/22 listed medications ordered on admission: Hydralazine (lowers blood pressure) 25mg tablet, 1 time a day. Gabapentin (to relieve nerve pain)600 mg tablet, 1 time a day. Risperdal (for schizophrenia) 2 mg tablet, 1 time a day. Tylenol 3 (for pain)300 mg, 2 tablets; 2 times a day Eliquis (Blood thinner) 5 mg tablet, 1 time a day; and (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Tylenol (for pain) 325 mg tablet, 2 tablets, as needed. Review of Resident #1's hospital records, dated 04/15/22 at 8:00 p.m., indicated Resident #1 was brought to the emergency department for onset of a medication administration error. The document reflected the patient (Resident #1) was accidently given the wrong medication earlier on this day. The medications belonged to [Resident #2] and were the following, hydralazine, gabapentin, Risperdal, Tylenol 3, omeprazole, Eliquis, and Tylenol. The error caused the patient (Resident #1) to develop nausea and vomiting, become very sleepy prompting the family to call emergency services to transfer her to the emergency room . Resident #1 was admitted to the hospital for observation. Review of Resident #1's hospital plan of care after admission to the hospital dated 04/15/22 included holding aspirin due to high levels of anticoagulant (blood thinner) medicine detected in Resident #1's lab work. An order for withholding Resident #1's meals and drinks was initiated, and she was given intravenous hydration. The orders reflected for more lab work to be performed to check Resident #1's liver function, as well as, monitoring her blood pressure readings. Review of Resident #1's hospital records, dated 04/18/22, revealed a progress note written by Care Transition Manager F reflecting she spoke to Resident #1 at bedside and Resident #1's family member on the speakerphone. Resident #1's family member said Resident #1 would not be returning to the skilled nursing facility and she would accept the attending doctor's recommendation. Review of Resident #1's hospital record, dated 04/19/22, revealed Attending Doctor G stated, Resident is weaker, and below baseline, Plan to D/C (discharge) to SNU (skilled nursing facility). (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/16/22 at 11:25 a.m. with LVN A revealed the DON told her that on the morning of 04/15/22 am she had a nurse call in sick, so the DON asked LVN A to take over medication administration for the off going night shift nurse. When LVN A came into the facility that morning, she began passing medications on the 600 halls. LVN A said around 8:30 a.m. an agency nurse, LVN B, met her on the 600 hall and informed her that she was there to relieve LVN A and would begin passing medications and caring for the residents herself. LVN A said she told LVN B that she had given medications to 4 residents in rooms 618, 617, 616 (Resident #1), and 615. LVN A said she gave verbal instructions to LVN B to begin administering medications to the rest of the residents on the 600 hall and LVN A said she went off with her own duties as the staffing coordinator. She denied orientating LVN B to the floor or the residents whom she was going to care for the rest of the 8-hour shift and said that the DON told her that LVN B had worked in the facility before and thought she could orientate herself. LVN A said, she went to lunch with the DON when a call came in from LVN B to the DON's cell phone and she informed the DON of nausea and vomiting experienced by Resident #1. LVN A said the DON informed LVN B she was returning to the facility soon. LVN A stated that after the phone call with the DON and LVN B she remembered a conversation she had previously to going to lunch with LVN B, she said, It was right before I went lunch, and then [LVN B] told me she had been looking for me, it was around 11:30 a.m., and she asked if me if [Resident #1] was one of the persons that I gave medications to and I said yes. So, I asked [LVN B] if [Resident #1] was okay, and [LVN B] said the resident was nauseated. So, I told her to go assess the resident again and she said she had done so already, and so I said, then call the doctor and then I went to lunch. LVN A was asked if she had told the DON about the conversation, she had with LVN B regarding Resident #1 and she said, The DON had told me that she assessed the resident herself, so I thought it had been taken care of. LVN A said while she was in the car with the DON, she began to think that LVN B might have given medications to Resident #1 by mistake but said she was not sure. LVN A said when she returned from lunch, she approached the 600 hall and noticed family was in Resident #1's room. She said, I went to [Resident #1's] room, and saw the [family member] was there and said that [Resident #1] told her [family member] that another nurse had given her a second cup of morning medications while she was in the physical therapy gym, and she (LVN A) told the [family member] that it had not been her, and [Resident #1's] [family member] said she knew that, that [Resident #1] said it was another nurse with a different name. LVN A said there was a lot of confusion at the time, and emergency medical personnel walked in the room and began to ask about medications and the name of LVN B, then the DON arrived in the room and LVN A said she left the room, to take over LVN B's responsibilities. She said the DON told her (LVN A) to take over the medication cart assigned to LVN B because she was to get off the floor and not provide any more resident care. Review of LVN B's nursing note dated 04/15/2022 at 01:02 pm relating to Resident #1's condition, she wrote, around noon CNA E notified this nurse that resident was complaining of nausea and vomiting Resident was safely transferred to bed from wheelchair and assessed, her vital signs were taken, and family was present at this time. Her vitals were: 109/59, p62, 94% r 18 oxygen saturation temp 98.0. Zofran 4 mg was administered. LVN A had administered Zofran 4 mg (for nausea) and then wrote, Around 1:20 pm, EMS arrived at resident room and took resident to the hospital at the request of family. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 04/16/22 at 11:15 am with Resident #2, resident was sitting in her wheel chair in her room, she was asked whether she had received her medications the previous morning, she looked confused, said that the DON had come to her room on the evening of 04/15/22 and asked her the same question, she asked the surveyor if there was a problem, she was assured that there was not, and was asked again if she had received her morning medications the previous morning and she stated yes. Resident#2 if it there was a possibility that she might have forgotten and not received the medications, she said no, she had taken her morning medications. Interview on 04/21/22 at 12:35 pm with DON regarding whether Resident #2 had received her morning medications on 04/15/22 and the DON said she spoke to Resident #2 who told her that she was given her morning medications, but was told by LVN B that she gave Resident #1 the medications that belonged to Resident #2, so she said there was confusion and it was hard to know if Resident #2 had received her medications on 04/15/22, she said the doctor was notified and the family was called. An Observation on 04/15/22 at 12:25 pm of medication administration for Resident #4 by RN G provided Tramadol tab 50 mg (pain medication) and 20 units of Novolog insulin injected on Resident #4's on right side of the abdomen. Record review of LVN A's statement, dated 04/15/22, provided an account of the beginning of the shift for that day. The statement reflected LVN A she began to work at 6:15 a.m. She went to Resident #1's room and the resident was up in her wheelchair, alert and oriented. LVN A noted the presence of Occupational Technologist C, reflecting, A therapy lady was in there talking to her as well. I took her blood pressure and then went to pull her meds. She took all of her meds and then I went back to the computer and signed them out. LVN A's statement reflected LVN B came to relieve her around 8:15 a.m. and she told LVN B the medications that she had given were signed out in the computer. Telephone interview on 04/16/22 at 1:00 p.m. with Occupational Therapist C, she stated Resident #1 was getting ready to exercise the morning of 04/15/22 around 8:30 a.m. and had to wait for LVN A to bring morning medications to her. Occupational Therapist C said LVN A brought in a medication cup full of medications and gave the cup to Resident #1 who took all the medications with water. Occupational Therapist C said she took Resident #1 to the physical therapy gym and helped with the exercise regimen and after the exercises Resident #1 was turned over to the physical therapy staff. Occupational Therapist C said later in the day around 12:00 p.m. on Resident #1's family member came into the gym looking for her and said, What happened to my mom? She sounded like she had a stroke, and OT C told her she had no idea what she meant. Occupational Therapist C said, It was not until I spoke to [Physical Therapy D], did we realize of the double dose given to Resident #1 by two different nurses. We decided to go inform the Administrator when we realized the error. Record review of Occupational Therapy C's statement, dated 04/16/22, given via e-mail at 12:48 p.m. to the Administrator's email revealed, OT C had picked up Resident #1 from her room after OT C observed her taking morning medications. OT C worked with Resident #1 for 30 minutes after which Physical Therapy began to continue with the therapy session. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview on 4/16/22 at 1:15 p.m. with Physical Therapist D, she said she worked with Resident #1 on 04/15/22. She said, I was with her in the gym, and it was close to 9:00 a.m. We were doing leg exercises, so then a nurse who I don't know came around 9:30 a.m. into the gym and brought medications in a cup, and [LVN B] asked [Resident #1] if she was [Resident #2], and [Resident #1] said yes, and then told [LVN B] that she had already taken them that morning, and [LVN B] told [Resident #1] that she would go double check and left the gym. PT D said LVN B returned and said to Resident #1, You have not taken your morning medications. I just took your blood pressure and did not give you the pills. PT D said Resident #1 did not look confused and took the medications given to her by LVN B. PT D said 04/15/22 was the first time she had worked with Resident #1 and was not very familiar with the resident. PT D said she asked LVN B if she meant to give Resident #1 the medications, telling LVN B that Resident #1's room number was 616, and LVN B said yes, she had the correct resident. PT D said she finished working with Resident #1 and took her back to room [ROOM NUMBER] around 11:00 am, set her up in a chair, heated up her breakfast and gave Resident #1 the call light and PT D said Resident #1 had no complaints of nausea or vomiting. Record review of Physical Therapy D's statement, dated 04/15/22, given via email at 2:32 p.m. to the Administrator's email revealed, PT D reported Resident #1 answered to the name voiced by LVN B, and was given a cup with medications and Resident #1 took all the medications contained in the cup. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 04/16/22 at 11:00 a.m. with the DON revealed the morning of 04/15/22 the facility was short staffed for one nurse, so the DON called LVN A to come in and help by filling in on the floor and providing patient care. The DON said LVN A began administering the residents morning medications on the 600 hall, then the DON said she received a staff agency nurse, LVN B, and then both LVN A and LVN B counted the medications in the cart so that LVN B could take over the patient care. She said as far as she knew LVN A orientated LVN B to which rooms she had already given medications to and to which residents. The DON said around 11:15 a.m. she received a call from Resident #1's family member with concerns that Resident #1 was telling him she was dizzy, and that Resident #1 sounded drunk. The DON said the family member asked if she could go in Resident #1's room and assess her and take some vital signs. The DON said Resident #1's blood pressure was low, but not significantly so. She was asked what the normal blood pressure reading was, and she said based on her nursing education she believed a good blood pressure reading could range from110-120 over 70-80. The DON said she took the vital signs and assessed Resident #1 and told the resident she had been drained from working with physical therapy and informed Resident #1's spouse who was in the room. The DON said that she went off to pick up her lunch. She said while she was waiting in line for her food, she said Resident #1's family member called her again and told her the resident had said two different nurses gave her morning medications, and the family member told her (the DON) that Resident #1 might have gotten medications twice. The DON said the family member was assured that she was returning to the facility to sort out the problem She said after hanging up with the family member she called LVN B and asked her point blank if she had given Resident #1 a double dose of morning medications and the nurse said yes. The DON said when she returned to the facility which was close to 1:00 p.m. she noticed that an emergency medical ambulance was parked by the front door. The DON admitted that she did not record any of the phone calls she had LVN B, saying that she only documented a note on 04/15/2022 at 12:30 pm, writing that the DON had received a notification from the receptionist that said to assess Resident #1 and return call to her son. She wrote, Upon assessment, resident lying on her right side in her bed with husband at bedside. Resident interviewed and able to provide that she was feeling dizzy and nauseous. She stated she had gone to therapy and felt fine, then upon return she started feeling off. The DON wrote she took Resident #1's vital signs and then called the son to give him the information. The DON said she assured the son that Resident #1 was just tired from the therapy session and finished the note by writing, Discussed the DON would re-assess the resident after eating lunch. The DON said that after Resident #1 was sent to the hospital, she began an in-service education regarding the 7 rights of medication administration for nursing staff, record review of the attendance sheets that is undated reveals a total of 13 nursing staff members who participated. The DON was asked for the date of the participation of these nurses, and she said they all were in serviced on 04/15/22 and said that they would begin to have medication pass observations. Record review of an undated Facility licensed nurses and certified medication aids list revealed there are a total of 33 nursing staff who can administer resident medications. The list was provided by the administrator on 04/21/22 and compared with the medication pass observation sign off sheet, it is evident that not all staff employed by the facility had been checked off for proper medication administration. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 04/16/22 at 11:50 a.m. with the Administrator revealed she was aware of the allegations of a possible medication error that had allegedly occurred on 04/15/22. She said initially two physical therapists came to her approximately at 12:00 pm and told her about what they had witnessed happened to Resident #1. The Administrator said that Occupational Therapist C and Physical Therapist D told her they were worried about the resident and a report they received from the family member of change of condition noticed by Resident #1's other family member. The Administration said the therapists suspected that Resident #1 had been double dosed. The Administrator said OT C told her one of Resident #1's family members came into the gym looking for her and asked what happened to Resident #1; she sounded like she had a stroke. The Administrator said she immediately called the DON around 12:30 pm who informed her that she was contacted by another one of Resident #1's family members who asked her to assess the resident because the family was concerned about the resident's health condition, and the DON told the Administrator that Resident #1's vitals were good, and she said, And I felt that at the time the resident was okay. The Administrator said she told the DON about what the therapists said they witnessed about the double dose and the DON said she had questioned LVN B, and the nurse denied giving Resident #1 morning medications. The Administrator said then when the ambulance arrived at the facility, the DON told the Administrator that LVN B told the DON that she had given Resident #1 another resident's medications, the medications belonging to Resident #2. The Administrator said the DON told her that she called Resident #1's family member and he became angry with her, and the family member told the DON that the family had called 911 because they wanted Resident #1 checked at the emergency room . The Administrator was asked if she knew if Resident #2 had received her morning medications and she denied knowing that information but said the DON had asked Resident #2 if she had taken any medications that morning and the resident said yes, she had received her morning medications. The Administrator said, It is impossible to know if [Resident #1] received [Resident #2's] medications, but I Immediately removed [LVN B] from the floor and made sure both [Resident #1] and [Resident #2's] medication list was given to the emergency medical staff. I then notified the temporary agency about the medication error and flagged [LVN B] not to return to the facility. The administrator said she called the temporary nursing agency on 04/15/22 and informed them that LVN B administered medications in error and caused a resident to be sent to the emergency room , and that LVN B was banned from returning to the facility. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 04/18/22 at 3:00 p.m. with LVN B, she stated she arrived at the facility on 04/15/22 around 8:30 a.m. She said, So I went to the hall 600 and spoke to [LVN A]. I was going to take over for her 6 [AM]-2 [PM] shift, and she said LVN A told her she had given medications to the first four rooms on the 600 hall and that she should start at room [ROOM NUMBER] and back to 604. She said, So that is the report she gave me. She did not give me people's names, just room numbers. LVN B said she opened the medication administration record in the computer and saw that the first resident that was due medications was Resident #2, a d that the medications had not been pulled and administered and she said, I pulled all her medication cards out of the cart and put them in a medication cup and went in to the [Resident #2's] room, but she was not in the room. She said, I looked out for her down the hall but did not see her. I thought she might be in the gym, so I took the medication cup, and I went to the physical therapy gym, and looked to see if she is in there. She said based on Resident #2's picture, I thought the only resident that was in the gym was [Resident #2]. LVN B said she called out Resident #2's name and the resident in the gym acknowledged, and LVN B said she was not aware that this was a different resident at the time and approached Resident #1 who was working with PT D. LVN B said, I told [Resident #1] that she had medications to take, and the resident told me that she had already taken her morning medications. LVN B said she told Resident #1 he would check with LVN A if she had given the medications and left the gym. LVN B said she found LVN A and asked her if she had given morning medications to Resident #2, and LVN A told her that she had not given Resident #2 medications, and LVN B said, Based on the confirmation that I received from [LVN A], I went back to the gym and gave [Resident #1] medications believing it was [Resident #2]. LVN B said, After I finished giving medications, I went to the nurse's station to chart and around noon CNA G told her the resident in room [ROOM NUMBER] (Resident #1) was complaining of nausea, and said, So I went and assessed the resident. [Resident #1] complained of nausea and I still did not become aware of the medication error. I went and got some medication for her for nausea, and I put her in bed. LVN B said, I went back to charting; about 20 minutes later I went back to room [ROOM NUMBER], [Resident #1's] room and her [family member] was in the room. [Resident #1] was vomiting, and the [family member] told me that [Resident #1], [Resident #1's name], told her that two different nurses gave her medications in the morning. LVN B said, That is when I realized that she was the resident in the therapy gym, and that I had not recognized her at first because she was wearing a mask in the therapy gym and that I had medicated the wrong person. LVN B said she called the doctor, spoke to the nurse practitioner, and informed her about the double dose, error of administration. LVN B said that at 01:25 pm she had told the DON that she noticed that she gave the wrong patient medications due to an identification error. LVN B said the doctor gave an order to call 911. She said, But the family had called themselves. I notified the DON and emergency medical staff asked for the paperwork of the meds I had given [Resident #1]. I was ordered to sit in the DON's office. LVN B said that Complainant #3 came to ask her which were the medications she had given Resident #1, and that at the time LVN B felt very confused and told Complainant #3 that she would need to speak to the DON and LVN A to help with a list of the medications and left him to look for the nursing staff. After providing the Complainant #3 with a list of both the residents medications, Resident # 1, and Resident #2, she left the facility after giving the DON them a statement of the error around 03:00 pm. LVN B said, I was also educated on the 7 rights of giving medications by the DON. I am not sure exactly what I gave [Resident #1]; I was very confused and provided [Resident #2's] medication orders to see if the hospital could figure out what was given with the help of blood labs. LVN B denies knowing that the DON had assessed Resident #1 at the request of family concerns that the resident appeared to have had a change in condition. (continued on next page)

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	04/23/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 04/21/22 at 5:05 p.m. with facility's Medical Director, she said, I am aware regarding the resident was given the medications for both of the residents, (named Resident #1 and Resident #2). She said her nurse practitioner told her LVN B had made a medication administration error. She was asked what the risks for as elderly person were if they received the types of medications that were listed on the emergency departments admission record and she said anyone who would receive that number of medications would have nausea and vomiting and other risks could be experiencing low or high blood pressure, and serious allergic reactions. She said, A person given a mixture of antidepressants, antipsychotics, blood pressure medications to raise or lower blood pressure and narcotics and they are not used to taking these types of medications could suffer from dizziness, drowsiness, heart rhythm problems, have an allergic reaction. She said, We just don't know, but the best thing for the resident was to go to the emergency room . She said the potential for death was difficult to assess and the adverse effects were different for all persons, and in this case, observation was the best thing to do to guard the resident's safety. She said, She had to go to the ER, at the facility it is not possible to do any procedures as soon as possible, in the hospital they can perform x-ray, labs and provide intravenous fluids. A review of the facility's policy on medication, dated 12/2017, reflected: A medication error occurs when a medication is administered in any manner that is inconsistent with the physician's order for a medication. Medication errors include, but not limited to administering the wrong medication, administering at the wrong time, administering the wrong dose strength, administering by the wrong route of administration and/or administering to the wrong resident. rights of administering medication as right person, medication, route, time and dose, frequency, and documentation. On 04/21/22 at 5:30p.m. the Administrator and DON were notified an Immediate Threat was identified and a Plan of Removal was requested. The facility Administrator and the DON were notified on 04/22/22 at 4:50 pm. the Plan of Removal was accepted. An Immediate Jeopardy Plan of Removal dated 04/21/22 stated that facility Director of Nursing (DON) initiated an audit on 04/15/22 verifying residents' charts contained the correct identification for medication administration to include pictures and names of the residents. On 04/15/22 the DON began verifying licensed nursing staff listing for full time, part time and PRN nurses and medication aides to ensure education/in-servicing to be completed prior to working their next shift. The in-service subject matter reviewed was 7 Rights of Medication Administration, and the completed lists would be maintained by the abuse coordinator, the Administrator. Medication Pass observation audits for all staff who administer medications in the facility were started on 04/19/22, and the plan stated the skills checkoffs would be completed for all licensed nursing staff and medication aides by 12pm on 4/22/2022, except for one LVN (LVN AA), who was currently out of the country, and the DON would ensure LVN AA is educated on the 7 rights of medication administration and compliant with medication pass observation check off upon her return. The DON will conduct in-service training monthly for the next 30 days on the following topics: The additional training will cover 7 Rights of Medication Administration and observations of proper procedures and technique, of medication administration. (continued on next page)

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	04/23/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/21/22 at approximately 6:00 pm monitoring of nursing staff began to be conducted by the facilities administrative staff, medication administration observations and in services for education of the 7 rights of medication administration was started. During an interview on 04/21/22 at 1:15 pm the Administrator said the plan of correction to ensure medications would be given as prescribed had been implemented which included training for all nursing staff. The Administrator said the medication error would be placed on the agenda for the QAPI meeting and the plan would be monitored by the QAPI team. Monitoring of the Plan of Removal: During interviews with Medication aids, MA's (I, M, Z) s, Licensed vocation nurse, LVN's (A, B, H, N, O, P, Q, R, S, T, U, V, W, AA, X), and Registered nurse, RN's (G, J, K, L, M) on 04/21/22 and 4/22/22 said they received verbal in-service training on administering medications and observed medication administration by nursing management. They were able to identify the 7 rights of medication administration. Interview on 04/21/22 at 5:45 pm with MA M revealed she was educated on the 7 rights of medication administration, he was able to name all 7 rights, he said, give mediations to the right person, right medication, right dose, right route, right reason, and right documentation. MA M said she had been checked off for safe medication administration by the DON, she described drawing up insulin after getting a resident's blood sugar reading and administering safely. Interview on 04/21/22 at 5:55 pm with LVN N revealed she had been educated on the 7 rights of medication administration, she could name all 7 rights and knew the consequences of giving the wrong medications to a resident, and the risks of overdosing a person, she said, giving the wrong medications to a residents can cause a significant change in condition such as death, an allergic reaction, or a stroke. Interview on 04/21/22 at 6:00 pm with LVN P revealed she had been educated on the 7 rights of medication administration, she named all 7 rights, right person, right route, right medication, right dose, right reason, right documentation and said that dire consequences could occur to a person's healt [TRUNCATED]