STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675153	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House at Keller Rehab & Nursing	1150 Whitley Road Keller, TX 76248

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #1) reviewed for accidents. CNA A failed to use a gait-belt to transfer Resident #1 from her bed to the shower chair on 09/03/24 causing a 1.0 cm x 1.5 cm skin tear on Resident #1's right arm. This failure could place residents at risk of injury. Findings included: Record review of Resident #1's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included psychotic disturbance (loss of touch with reality and having abnormal thoughts, precerptions and behaviors), muscle wasting, history of falls, and unsteadiness on her feet. Record review of Resident #1's admission MDS assessment, dated 05/04/22, and her discharge MDS assessment, dated 10/07/24, reflected she had a BIMS score of 5, indicating she had severe cognitive impairment. Her Functional Status assessment indicated she required total assistance with all ADLs, to include transfers. Record review of Resident #1's care plan, dated 10/07/24, indicated she had an ADL self-care deficit with an intervention of extensive assistance of one for transfers. Record review of an x-ray report, dated 09/04/24, reflected Resident #1 had an x-ray done of her right tibia and fibula (lower leg) and right ankle, and there was no fracture indicated. Record review of the NP's Progress Notes, dated 09/05/24, reflected Resident #1 seen and noted to have no injury, redness, bruising or edema to her right leg. The Progress Note reflected Resident #1 was seen after the resident had complained of pain following a transfer. The NP noted an x-ray was done of the resident's right leg, and there was no fracture noted. The NP also noted the resident had a superficial left arm skin tear during this transfer which is being treated. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of LVN B's written statement, dated 09/05/24, reflected she was notified of Resident #1 having a skin tear by CNA A. When LVN B assessed the resident, she noted a skin tear measuring 1.0 cm x 1.5 cm. She noted no other injury and treated the skin tear with steri-strips. LVN B made the appropriate notifications. LVN B was later notified by Resident #1' s family the resident was complaining of right leg and ankle pain. The NP was notified, and an x-ray was ordered. The x-ray revealed no fractures. Interview on 11/13/24 at 11:30 AM with LVN B revealed when she assessed Resident #1, the resident had been showered and put back in bed. She stated CNA A did not know how the skin tear had occurred. She stated CNA A did not notice it until she was putting the resident back to bed. LVN B stated the injury did not require a dressing because there was no bleeding. Record review of the Social Worker's written statement, dated 09/05/24 reflected she was contacted on 09/03/24 by Resident #1's family complaining the resident had been handled roughly during a transfer to the shower chair, resulting in a skin tear to her arm. The Social Worker initiated a grievance for Resident #1. The resident's family visited the Social Worker on 09/05/24 and informed her that after viewing video footage from Resident #1's room the resident had refused a shower, but the CNA had proceeded with the transfer and shower. Interview on 11/13/24 at 11:49 AM with the Social Worker revealed she had not been shown the video footage the family referenced, and her notes and the grievance report were from her communication with Resident #1's family. Record review of the facility's Provider Investigation Report, signed and dated by the DON on 09/12/24, reflected on 09/03/24 Resident #1 sustained a skin tear to her right arm, measuring 1 cm x 1.5 cm, when she was transferred from her bed to a shower chair by CNA A. The family reported the occurrence to the facility after seeing the incident on video recorded in the resident's room. The Provider Investigation Report reflected after the facility learned of the incident, they suspended CNA A on 09/03/24 and then terminated her employment. Observation of the video, dated 09/03/24 at 11:40 AM, provided by Resident #1's family, included audio. The video revealed Resident #1 in bed and CNA A attempting to transfer the resident from bed to a shower chair that was on the left side of the bed. CNA A had Resident #1 sitting up in bed with her legs off the side of the bed, with Resident #1 holding onto CNA A's shirt. Without using a gait-belt, CNA A held Resident #1 up with her hand on the back of the resident's neck. Resident #1 fell back on to the bed. CNA A then lifted Resident #1 up with her hands under the resident's left arm and by the right arm. CNA A counted to three and then put the resident into a shower chair. The resident complained of pain to her leg after being put into the shower chair. The video clip did not show the resident being combative or verbally/physically resisting care. Interview on 11/13/24 at 2:26 PM with the Administrator and the DON revealed the family had not provided them with the video of the transfer. During this interview, they were shown the video, and the Administrator stated he did not know the transfer was that bad. He added that was why CNA A was terminated. The DON stated she did not see CNA A use a gait-belt, which was against policy, as was lifting the resident by their arms. The DON stated she had done a one-on-one in-service with CNA A on resident rights and customer service immediately and before CNA A was suspended, but not on transfers or accident prevention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview was attempted on 11/13/24 at 1:10 PM and 2:35 PM with CNA A, but the attempts were unsuccessful. Record review of the facility's Transfers of Residents policy, dated 09/02/24, reflected: The goal is to ensure the safety of the resident when moving from one place to another, to prevent injuries to the resident .Use a gait belt around the resident to protect both the resident and yourself, unless contraindicated and as applicable.