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	11/19/2025

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 transfers. CNA failed to safely transfer Resident #1 on 11/09/25, when she did not use a gait-belt to assist the resident on or off the toilet. As a result, Resident #1 fell when being transferred from the toilet to the wheelchair, and the resident sustained a 10th rib fracture and a right tibia spiral fracture (break that twists around the right shin bone) as well as a proximal (where the limb begins) and distal (where the limb ends) right fibula (bone on the outside of your lower leg) fracture to Resident #1's right leg. The noncompliance was identified as past noncompliance. The IJ began on 11/09/2025 and ended on 11/14/2025. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk of serious injury or death.Findings included: Record review of Resident #1's Face Sheet, dated 11/19/25, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE].Record review of Resident #1's Quarterly MDS Assessment, dated 10/02/25, reflected she had a BIMS score of 15, indicating no cognitive impairment. Her MDS indicated she required substantial/maximal assistance with transfers. Her MDS also indicated she exhibited no behaviors related to rejection of care. Her active diagnoses included Unspecified Sequelae of Cerebral Infarction (long term effects of a stroke with non-specific symptoms), Hemiplegia affecting right dominant side (paralysis on right side of body), Generalized Muscle Weakness, Long Term (current) use of Anticoagulants, and Insomnia (trouble falling asleep or staying asleep). Record review of Resident #1's Care Plan, dated 11/19/25, reflected the following: Focus: ADLs: [Resident #1] has an ADL Self Care Performance Deficit. Goal: Resident will participate to the best of their ability and maintain current level of functioning with activities of daily living (ADLs) through the next review date. Interventions: use gait belt for safety for transfers. Focus: Falls: [Resident #1] has the potential for falls related to Gait/balance problems, history of falls with major injury. right side weakness. Goal: The resident will be free of falls through the next review date. Resident will not sustain additional fall related injury by utilizing fall precautions through next review date. Interventions: Allow [Resident #1] time to communicate how she prefers to be transferred. Which includes staff using a gait belt with all transfers. Allow time for [Resident #1] to position her right leg in the most comfortable position to be able to stand or transfer. Assess pt for weakness prior to transfers.Record review of Resident #1's Fall Risk Assessment, dated 09/01/25, reflected that she was a moderate fall risk with a score of 09. Record review of an Incident Note, dated 11/09/25 at 11:08 PM, written by RN B reflected the following: CNA called help. [sic] Upon entering room resident sitting on the floor in the front of toilet, W/c at side, non-slide socks to feet, resident alert, oriented, c/o severe pain to RLE. The CNA stated that after she helped resident using toilet, helped resident to stand up and put a new diaper on, then helped resident to turn to sit on w/c, suddenly resident fell down to floor, right leg twisted, resident c/o severe, another nurse held resident and checked VS: [Blood pressure] 171/62, [Heart rate] 100, [Temperature] 97.0, [Respirations] 18, [Oxygen Saturation] SpO2 96% RA. This nurse called 911, resident left to [the hospital] via 911 at 6:18 PM with documents. Notified DON, [family member] and [Company Name] MD. Called ER to give report to the ER nurse.Record review of Resident #1's hospital records reflected she was admitted on [DATE]. The hospital records reflected the following, This a [AGE] year-old female with a very extensive medical history with known history of essential hypertension history of stroke with weakness and wheelchair-bound, and below other extensive medical history who presents to the emergency room after sustaining a ground-level fall and complaining of right sided rib cage pain as well as pain in the right foot. Patient is non-ambulatory and wheelchair-bound and upon evaluation in the ED patient is noted to have a 10th rib fracture as well as a right tibia and spiral fracture extending to the IM nail as well as proximal and distal right fibular fracture. Orthopedic surgeon has been consulted, and this is felt to be nonoperative mostly admitted for pain management and other supportive treatment. Record review of the Provider Investigation Report, dated 11/10/25 reflected the following, [Resident #1] fell after using the toilet during transfer from toilet to wheelchair and sustained a fracture to 10th rib, right tibia/fibula. Family made an allegation of neglect. Visual assessment and vital signs: Excruciating pain to right lower extremity, 911 called, resident sent to ER for further evaluation: Nondisplaced, nonoperative fracture of right 10th rib and right tibia/fibula. Nonoperative treatment and support, pain management and cast.Interview on 11/19/25 at 9:22 AM with Resident #1 revealed that CNA A was assisting her off the toilet on 11/09/25. She stated CNA