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	03/28/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 3 residents (Resident #1) reviewed for accuracy of assessments. The facility staff failed to ensure Resident #1's quarterly MDS dated [DATE] addressed resident Safety and Quality of Performance: Eating; Oral hygiene; C. Toileting hygiene; E. Shower/bathe self; F. Upper body dressing; G. Lower body dressing; H. Putting on/taking off footwear; Personal hygiene.Indicate the type of wheelchair or scooter used. This failure could result in residents missing essential treatments and interventions for care. Findings included: Record review of Resident #1's Quarterly MDS dated [DATE] completed by LVN-D reflected the resident was a [AGE] year-old female that was admitted on [DATE]. Resident #1 had a BIMS score of 03, indicating she was severely impaired cognitively. MDS dated [DATE] addressed resident Safety and Quality of Performance: Eating; Oral hygiene; C. Toileting hygiene; E. Shower/bathe self; F. Upper body dressing; G. Lower body dressing; H. Putting on/taking off footwear; Personal hygiene.Indicate the type of wheelchair or scooter used.Record review of Resident #1's quarterly care plan dated 03/24/2026 reflected the resident had an ADL Self Care Performance Deficit and was at risk for not having their needs met in a timely manner. The care plan reflected she was at risk for emotional distress . will have express feeling of safety in facility and show no s/s of emotional distress r/t improve current level of function in Bed Mobility, Transfers, Eating, Dressing, allegation.Administer medications as ordered. Monitor/document for side effects and effectiveness. The Care plan further stated the resident required Assist x1 Personal Hygiene: Assist x1 Bathing: Assist x1.Provide shower, shave, oral care, hair care, and nail care per schedule and when needed.Encourage to participate to the fullest extent possible with each interaction and praise when attempts are made.Encourage to use call light to call for assistance before attempting any activities of daily living (ADLs) that resident cannot do independently. Record review of Resident #1's physician orders dated 02/24/2026 reflected: 08/28/24, Geri sleeves to BUE (Bilateral Upper Extremities,) q shift, .During an observation and interview on 03/27/2026 at 12:10 PM, Resident #1 was in the dining area watching television. She was well groomed, sitting in a chair with a doll. She was alert to her name; however, she was not interviewable due to severe cognitive impairment. During an interview on 03/28/2026 at 4:00 PM, the ADON stated that she was not aware that Resident #1's MDS did not address her functional abilities and had incomplete sections, or that Resident #3's MDS was not updated according to guidelines. She stated that the MDS staff were not here today. She stated that it was important for the MDS to be completed timely as it reflected the daily care and needs of the resident for them to maintain highest level of care. During an interview on 03/28/2026 at 4:15 PM, with the DON she stated that it was her expectation that the MDS conducts a timely comprehensive quarterly assessment to address the resident current status of care and prevent decline. She stated that it was the DON and MDS staff responsibility to ensure MDS were completed comprehensively. The facility Administrator was not interviewed, as she resigned a week prior to the investigation, and the MDS Coordinator was not interviewed, because she was not working on the weekend. Record review of the facility's Clinical Practice Guidelines MDS Completion policy, dated 11/05/2024, reflected in part: resident are (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. Quarterly assessments completed using ARD no >92 days from the most recent prior quarterly or comprehensive assessment (counting ARD to ARD).