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	08/29/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 43791

Based on observations, interviews, and record reviews, 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 three (Residents #36, #107, and #69) of eight residents reviewed for ADL care.

1. The facility failed to provide two female residents, Residents #36 and #107, with grooming to ensure their facial hair was shaved.

2. The facility failed to provide Resident #69 assistance with timely incontinence care.

These failures could place the residents at risk for decreased feelings of self-worth, skin breakdown, and infection.

Findings included:

1. Record review of Resident #107's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia, ulcer, and communication deficit.

Record review of Resident #107's Quarterly MDS Assessment, dated 06/02/24, reflected a BIMS score of 4 indicating severe cognitive impairment. Her Functional Status evaluation indicated she required assistance with her personal hygiene.

Record review of Resident #107's care plan, dated 07/03/24, reflected she had an ADL self-care deficit, with interventions including Provide shower, shave, oral care, hair care, and nail care per schedule and when needed. Her care plan did not reflect she refused ADL care.

Observation and interview on 08/27/24 at 2:30 PM revealed Resident #107 was noted to have white facial hair on her chin, consisting of 6 hairs approximately an inch long. Resident #107 stated she was not aware of the hair on her chin, but she did not like the idea of having any facial hair. Resident #107 stated she thought her last shower was on the previous day (08/26/24) but could not recall her last shave.

Observation and interview on 08/28/24 at 12:24 PM revealed Resident #107 remained unshaved and stated she had not asked the CNA to shave her.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Heritage House at Keller Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 Whitley Road Keller, TX 76248	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #36's undated Admission Record reflected she was admitted to the facility on [DATE] with diagnoses which included right ankle injury, morbid obesity, sleep apnea, and high blood pressure. Record review of Resident #36's admission MDS, dated [DATE], reflected a BIMS score of 12 indicating she was cognitively intact. Her Functional Status evaluation indicated she required partial assistance with her personal hygiene. Record review of Resident #36's care plan, dated 07/17/24 reflected she had an ADL self-care deficit, with interventions including Provide shower, shave, oral care, hair care, and nail care per schedule and when needed. Her care plan did not reflect any refusal of personal hygiene. Observation and interview on 08/27/24 at 2:34 PM revealed Resident #36 was noted to have white facial hair consisting of four hairs on her chin that were approximately 1/2 inch long. Resident #36 stated she did not like having facial hair of any kind, it was embarrassing. Her last bed bath was on 08/26/24 but the CNA did no mention the facial hair. Observation on 08/28/24 at 12:24 PM revealed Resident #36 was still unshaven. Interview on 08/28/24 at 2:25 PM CNA A stated she had bathed both Resident #36 and #107 on 08/26/24. She stated she did not notice their facial hair at the time because she was in a hurry because she was too busy with her patient load. Interview on 08/29/24 at 3:02 PM the DON stated the facility had plenty of staff to care for the residents, and any CNA could call for help any time they needed. The DON stated they did not have a policy that addressed shaving residents. She stated it should be done as part of the bathing process. 2. Record review of Resident #69's face sheet, dated 08/27/24, indicated Resident #69 was a [AGE] year-old male, admitted to the facility on [DATE], 09/04/19 and readmitted on [DATE]. Resident #69's diagnosis included Cerebral Infarction (stroke, poor blood flow to the brain), Contracture of Muscle (shortening of muscles causes joints to become stiff), Urinary Tract Infection (infection that affects part of the urinary tract), Acute Kidney failure (sudden decrease in kidney function), Type 2 Diabetes Mellitus (high blood sugar), Major Depressive Disorder (pervasive low mood, low self-esteem), absence of right leg above knee. Record review of Resident #69's admission MDS assessment, dated 07/18/2024, indicated Resident #69 had the ability to make himself understood and understood others. The assessment indicated Resident #69's BIMS score was not indicated, because he was rarely understood. Resident #69 was dependent on staff with toileting. Resident #69 required substantial/maximal assistance with shower/bathing and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #69's care plan, undated, indicated Resident #69 was incontinent of bowel and bladder due to disease process and Resident #69 has potential for development for pressure ulcer related to immobility impairment. Goal: Resident will remain free from skin breakdown due to incontinence and brief use. Resident # 69 will be free of preventable breakdown. Interventions included: Check frequently for wetness and soiling, every two hours and change as needed. Briefs or incontinent products as needed for protection. Apply barrier cream after each incontinent episode. Weekly skin checks to monitor for redness, circulatory problems, breakdown, report any new skin conditions to the physician. Record review of Resident #69's task for toileting care revealed Resident #69 had received incontinent care last at 03:17 (3:17 AM) on 08/27/24. Interview and observation on 08/27/24 at 2:57 PM of Resident #69 revealed him in bed, Resident #69 stated lunch was great, and he had no concerns with his care at this time. Observation revealed Resident # 69's cloth bed pad was discolored with dark colored rings that indicated the resident may have been incontinent several times throughout the day. When Resident #69 was asked if he was soiled, he responded no. Surveyor did not observe any strong urine smells, however observation of the pad revealed his bedding had been wet at some point throughout the day. When Resident #69 was asked if he had any burning or irritation in his groin area he responded no. When Resident #69 was asked when the last time was, he had been changed he stated, I don't know. Observation and interview on 08/27/24 at 3:22 PM revealed CNA C exiting the room emptying contents in the dirty laundry barrel. During interview with Resident #69 revealed he had his bedding changed, clothing changed, and was wearing a new brief. Resident #69 stated staff came in and changed him and bedding, he was not having any issues or concerns in his groin area. Interview on 08/28/24 at 2:44 PM with CNA C revealed she arrived late to work on 08/27/24, and CNA D had to remain on shift to cover for her until she arrived. CNA C stated she entered the facility around 3:00 PM to begin her shift. CNA C stated she worked the 200 hall, CNA C stated she found Resident #69 heavily soiled. CNA C stated Resident #69 drank lots of fluid and was a heavy wetter. CNA C stated she had to change Resident#69 and his bedding and because she observed different colored rings on his bed pad indicating he soiled himself through the brief onto his bed. CNA C stated it was unknown when the last time Resident #69 had been changed, and the aide on previous shift did not report any concerns for Resident #69. According to CNA C the previous aide was responsible to ensure residents were clean and dry prior to end of their shift and she should report any concerns if she noted otherwise. CNA C stated if Resident #69 was changed around 2:00 PM, when she entered at 3:00 PM, Resident #69 would not have soiled to his bedding. CNA C stated since she was late to arrive to her shift, she felt it was necessary to jump in and get him changed. CNA C stated she had not reported this to the nurse because she had to ensure all residents had been cleaned and changed. CNA C stated having residents waiting too long to receive incontinent care could result in skin breakdown, infection, and irritation to the skin. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/28/24 at 3:24 PM with CNA D revealed she worked hall 200 and cared for Resident #69 on 08/27/24. According to CNA D she usually completed incontinent care for Resident #69 twice during her shift, once in the morning and again prior to end of her shift. According to CNA D she was really busy on 08/27/24, towels were late which made her late for completing showers. CNA D stated she was aware she did not change the resident for a second time. CNA D stated she observed the surveyor going into Resident #69's room. CNA D stated she was upset when she returned to resident at the end of her shift to find him soiled down to his bed sheets. CNA D stated she then completed care, changed his bedding, and cleaned up Resident #69. CNA D revealed she could not recall the last time she was inserviced on activities of daily living care. CNA D stated not changing a resident in a timely manner could result in skin breakdown. CNA D stated she was responsible to ensure residents were changed in timely manner. CNA D stated she did not report her findings to her nurse or the oncoming aide. Interview on 08/29/24 at 10:56 AM with LVN E revealed she was notified of the incident with Resident #69 had not received proper incontinent care. LVN E stated CNA D was very good and works very hard at her job duties. LVN E stated it was reported to her that Resident #69 was a heavy wetter. LVN E stated aides that worked the floor were responsible to ensure residents were changed, clean and dry in a timely manner. LVN E stated she expected aides to notify her if they needed help with providing care so she could get adequate help or provide help herself. LVN E stated she noticed the linen closet was short on bed sheets and towels however it was not an excuse to prevent residents from having adequate care when it came to being changed. According to LVN E not changing residents in a timely manner could result in redness in their private areas and skin breakdown or infection. Interview on 08/29/24 at 1:20 PM with the DON revealed she was alerted to incident with staff not changing Resident #69 in a timely manner. The DON stated Resident #69 was a heavy wetter so she did not understand how CNA D could have gone all day without changing him. The DON stated there was plenty of staff in the building that could have assisted on the hall to ensure residents had adequate care. The DON stated her expectations included nursing staff to alert the nurses on the floor if they were running behind or off schedule. According to The DON not changing Resident #69 placed him at risk of skin breakdown, infection, emotional abuse, dignity concerns and re-igniting previous pressure sores. Review of the facility's policy Resident Showers , updated on 2/11/22, reflected: 3. The CNA will assess the skin for any changes while performing bathing and inform the nurse of any changes. 11. Assist the resident with showering as needed. The policy did not address personal hygiene, specifically shaving of female residents. Review of the facility's Provision of Quality of Life policy, revised 01/10/22, reflected: based on comprehensive assessments, the facility will ensure that each resident will receive the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well being, consistent with resident's comprehensive assessment and plan of care In order to achieve a culture and environment that supports quality of life the facility leadership will validate that all staff, across all shifts and departments receives training that provides understanding on the principles of quality of life. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Incontinence Care policy, revised 02/14/20, reflected an outlined procedure for cleaning the perineum and buttocks after an incontinence episode. The policy did not address timeliness of incontinent care. 44937

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview, and record review, the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice for one (Resident #57) of three residents reviewed for respiratory care. The facility failed to ensure Resident #57's had a physician's order for oxygen treatment. This deficient practice could affect residents who received oxygen therapy from receiving inadequate oxygen support and a decline in health. Findings included: Record review of Resident #57's significant change MDS assessment dated [DATE] reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included end stage renal disease , non-Alzheimer's dementia, respiratory failure, hypertension (high blood pressure), atrial fibrillation (an irregular often rapid heart rate). The MDS further reflected the resident was on hospice services. Record review of Resident #57's progress notes dated 06/11/24 reflected the resident was on oxygen via nasal cannula. Observation and interview on 08/27/24 at 11:40 AM of Resident #57 revealed she in bed watching TV. The resident was on continuous oxygen via nasal cannula, and it was running at 2 liters per minute. Resident #57 was asked if her oxygen was working well for her and she stated it was. The resident did not appear to be in any distress. Record review of Resident #57's clinical record revealed there was no physician's order for the oxygen. Interview on 08/29/24 at 12:08 PM with LVN B revealed Resident #57 had been put on continuous oxygen a while back, possibly two months prior, because her oxygen saturations were not staying above 90% on room air. LVN B did not realize there was not a physician's order for the oxygen when she checked the clinical record. LVN B said the nurse that received the order should have put the order into the system but she did know who the nurse was that got the initial order. LVN B further stated it was important to have an oxygen order so staff would know what care was needed for the residents. Interview on 08/29/24 at 1:46 PM with the DON revealed she was not aware Resident #57 was on continuous oxygen and thought it was only as needed. The DON said all residents with oxygen should have a physician's order so that all staff knew what care was needed for the residents. Review of the facility's Oxygen Administration policy, dated September 2014, reflected the following: Policy (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	To describe methods for delivering oxygen to improve tissue oxygenation. Procedure 1. Verify Physician Order 2. Order should have when to call the physician parameters