

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/03/2025
NAME OF PROVIDER OR SUPPLIER Heritage House at Keller Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the interdisciplinary team determined if it was clinically appropriate to self-administer medications for 1 of 5 residents (Resident #7) reviewed for medication administration. The facility's interdisciplinary team failed to ensure Resident #7 was clinically appropriate to self-administer antihistamine eyedrops that was at the resident's bedside. This failure could place residents at risk of not receiving the therapeutic benefit of medication or an adverse drug reaction. Findings included:Record review of Resident #7's quarterly MDS dated [DATE] reflected Resident #7 was an [AGE] year-old male admitted to the facility on [DATE]. Resident #7's BIMS score of 15 indicated his cognition was intact. Resident #7's diagnoses included amputation (removal of body limbs), high blood pressure (when the force of blood flowing through the blood vessels is consistently too high), renal insufficiency (characterized by reduced kidney function), diabetes (high blood sugar), lack of coordination, with adequate vision with no use of corrective lenses. Observation and interview on 09/23/25 at 11:30 AM, revealed Resident #7 had a bottle of Olopatadine Hydrochloride Ophthalmic Solution (antihistamine eye drops) at his bedside table. Resident #7 said his family member might have brought him the eye drops because his eyes had been itching, especially his right eye. Resident #7 stated he used the eye drops once in the morning and then again in the evening hours, and he did this daily.Record review of Resident #7's order summary reflected orders for eye drops had been started on 09/23/25 and 09/24/25 with no prior orders, and the orders reflected the following: - Ketotifen Fumarate Ophthalmic Solution 0.035 % Instill 1 drop in right eye two times a day for Itch Relief Active with order date 09/23/25 Start date 09/23/25 - Blink Tears Ophthalmic Solution 0.25 % Instill 1 drop in both eyes one time a day for dry eyes unsupervised self-administration. Active with order date 09/23/25 Start date 09/24/25.Interview with RN C on 09/23/25 at 12:36 PM, who was the charge nurse for Hall 100, revealed he was not aware Resident #7 had eye drops at his bedside to administer to himself. RN C stated he was not aware of any concerns with Resident #7's eye irritation. RN C stated someone from Resident #7's family may have brought him the eye drops, however there was supposed to be a prescription for the eye drops and they should be stored in our medication cart. I will let the physician know so I can get an order so he can have it at his bedside. According to RN C, a physician's order was required to administer all medications whether it was for nursing staff to administer or residents to self-administer. RN C was observed removing the eyedrops from the bedside table. RN C stated all staff was responsible for removing medications from bedside and alerting the nursing staff, ADONs, or the DON. RN C stated allowing residents to have medications at the bedside without a physician's order placed residents at risk of over-using medication, forgetting how and when to use them. Interview on 09/25/25 at 2:00 PM, ADON B revealed residents should not have any medications in the room with them. ADON B stated residents would have to pass an assessment which would indicate they are capable of administering medications on their own. ADON B stated nursing staff was responsible for ensuring residents did not have any type of medications whether over the counter or prescribed in their rooms. ADON B stated Resident #7 should not have eye drops in his room because it could place him at risk of overdose, overusing the medication. Interview on 09/25/25 at 2:16 PM, (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DON revealed residents are not supposed to have medication of any kind in their rooms. The DON stated she expected all staff to be more vigilant while making rounds in resident rooms. The DON stated in order for residents to have medication at their bedside, a safe survey, care plan updated, and an order for the medication. The DON stated it was the responsibility of the nursing staff to remove any pills, prescriptions, or over the counter medications from resident rooms. The DON stated residents having medications in their rooms put them at risk of overmedicating, staff not knowing what they are taking, or other residents getting the medications. Record review of facility's policy titled Medication storage dated 1/20/2021 revealed It is the policy of this facility to ensure that all medications housed on our premises will be stored, dated and labeled according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. A. All drugs and biologicals will be stored in locked compartments.B. Only authorized personnel will have access to the keys to locked compartmentsC. During a medication pass, medications must be under direct observation of the person administering medications or locked in the medication storage area/cart.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 4 medication carts (Halls 300 nurse medication cart) reviewed for labeling of drugs and biologicals. The facility failed to ensure expired medications was removed from the Hall 300 medication cart. This failure could place residents at risk of not receiving the therapeutic benefit of medication or an adverse drug reaction. Findings included: Observation on 09/24/2025 at 1:27 PM of the Hall 300 nurse medication cart with LVN A revealed one bottle of Nitroglycerin 0.4 mg (used to treat or prevent attacks of chest pain) with an expiry date of July 2025 and 12 tablets of Oxycodone 10 mg (Schedule II opioid pain medication) with a use by date of 09/04/25. Interview on 09/24/2025 at 1:45 PM, LVN A revealed she was responsible for checking the cart for expired medications. She stated she checked the cart once a month for expired medications, and she last checked her cart two weeks ago. She stated failing to remove the expired medication could result in the medications being administered which could cause reactions, and the residents would not get the required therapy. She stated she had done training on checking the carts for expired medications, but she could not recall when she had completed the training. She stated she had been trained regarding labeling of medications, storage of medications, and putting the open date on insulin; however, she did not remember when she had been trained. Interview on 09/24/2025 at 2:14 PM, the DON revealed it was all nurses' responsibility to check the carts and refrigerator to ensure expired medications were removed for destruction. She stated it was the responsibility of the ADON to monitor and ensure the nurses was labelling and discarding the expired medications, but she did not specify how often. She stated if the staff was not checking carts for expired medications, it would place residents at risk of having reactions like the medication being ineffective since they could not tell of the potency. She provided documentation on training courses which included dating insulin once it was opened. The training was dated 08/16/25 and LVN C was not in attendance. Interview on 09/25/2025 at 1:27 PM, ADON B revealed her expectation was for nurses to check their cart for medication labelling and to look for expired medications every week. She stated she last checked the carts and the refrigerators at the end of August. She stated the risk of having expired medications on the cart was that if they were administered, they would not be effective. She stated she had done in-service training on medication labelling and storage, in August. Record review of facility's Medication Storage dated 01/20/21 reflected: .iii. Expiration dating (beyond-use dating) .3. Certain medications or package types, such as intravenous solutions, multiple dose injectables vials. require an expiration date shorter than the manufactures expiration date once opened to ensure medication purity and potency.8. Medication carts are routinely inspected for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are removed and destroyed in accordance with the facility policy.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 2 medication refrigerators reviewed for pharmacy services. The facility failed to ensure insulin vials were dated after they were opened in the medication refrigerator. This failure had the potential to result in decreased therapeutic efficacy which could lead to uncontrolled blood sugars. Findings included: Observation on 09/24/2025 at 1:41 PM with LVN A of the medication room refrigerators for Halls 100, 200, and 300 revealed one vial of Lantus insulin 100 unit/ml (used to improve blood sugar control) which was opened, partially used, and not labeled with the open date. Interview on 09/24/2025 at 1:45 PM, LVN A revealed she knew insulin pens/vials were supposed to be dated once they were opened or after they were removed from the refrigerator. She stated all nurses were responsible for putting date and labelling the insulin vials once they were opened because short acting insulin was good for 28 days. She also stated failure to label and date insulin with opened dates could result in staff not noticing when the insulin had expired, and they could continue to administer the expired medications, which would result in blood sugar levels not being controlled. She stated she had been trained regarding labeling of medications, storage of medications, and putting the open date on insulin; however, she did not remember when she had been trained. Interview on 09/24/2025 at 2:14 PM, the DON revealed she expected the nursing staff to date the insulin pens once they were opened. She stated it was all nurses' responsibility to check the carts and refrigerator to ensure insulin was dated and labeled. She stated it was the responsibility of ADON to monitor and ensure the nurses were labelling medications, but she did not specify how often. She stated if the staff was not putting the open dates on the insulin pens and vials, it would place residents at risk of having reactions like the medication being ineffective since they could not tell of the potency. She provided documentation on training courses which included dating insulin once it was opened. The training was dated 08/16/25, and LVN C was not in attendance. Interview on 09/25/2025 at 1:27 PM, ADON B revealed her expectation was for nurses to check their cart for medication labelling every week. She stated she expected the nurses to date insulin when opened. She stated she was responsible for checking the refrigerators to ensure insulins were dated and labeled. She stated she missed the vial that was opened, not dated, and was returned to the refrigerator. She stated once the vial was opened and used it should be placed on the cart. She stated she last checked the carts and the refrigerators at the end of August. She stated the risk of not putting the opening date on insulin vials/pens was that they could not tell when they expired. If administered, they might not meet the therapeutic effects as expected. She stated the short acting insulins were good for only 28 days. She stated she had done in-service training on medication labelling and storage, in August. Record review of the facility's training record, dated 08/16/25, reflected that once insulin was opened it should be dated. The ADON was in attendance. Record review of facility's Medication Storage policy. dated 01/20/21 reflected: .iii. Expiration dating (beyond -use dating) .3. Certain medications or package types, such as intravenous solutions, multiple dose injectables vials. require an expiration date shorter than the manufactures expiration date once opened to ensure medication purity and potency.8. Medication carts are routinely inspected for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are removed and destroyed in accordance with the facility policy.		