

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Heritage Park of Katy Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6001 George Bush Dr Katy, TX 77493	
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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider and before transferring or discharging to send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 1 of 2 (Resident #2) residents reviewed for proper discharge. -The facility did not send a copy of Resident #2's 30-day discharge notice of the intended discharge date to the Ombudsman at the same time the facility notified Resident #2 on 06/17/2026. The Ombudsman was first notified of Resident #2's discharge on [DATE] by e-mail exchange. This failure could place residents at risk of improper discharge and not having access to a knowledgeable advocate and a support system to guide them through the process of finding new placement or appealing. Findings included: Record review of Resident #2's face sheet, dated 07/24/2026, indicated a [AGE] year-old female originally admitted [DATE] and readmitted [DATE] with medical diagnoses including pressure ulcer of left heel (localized damage to the skin and underlying tissue caused by prolonged pressure, friction, or shear), hydrocephalus (abnormal buildup of cerebrospinal (brain and spine area) fluid in the brain which could put pressure in the brain and cause damage), muscle wasting and atrophy (loss of muscle mass and strength) and weakness and paralysis due to history of stroke. Resident #2 was her own RP Record review of Resident #2's Quarterly MDS Assessment, dated 06/05/2026, indicated no discharge status at the time of the MDS. Resident #1 had a BIMS score of 11, indicating moderate cognitive impairment. Resident #2 was totally dependent on staff for putting on and taking off footwear, lower body dressing, showering and toileting and required maximal assistance with eating, oral and personal hygiene and upper body dressing. She was totally dependent with tub/shower transfer and going from chair to bed and bed to chair. Resident #2 was always incontinent of bowel and bladder. Record review of Resident #2's 30-day notice, dated 06/17/2026, indicated it had Resident #2's signature on the front page of the fax sheet which was signed on 06/17/2026 and was to be mailed to Resident #2's family member's address. Resident #2's 30-day notice, which indicated services would end on 07/17/2026, was signed and dated 07/02/2026. There was no documentation that the notice was sent to the Ombudsman. Record review of the email containing the 30-day notice dated 07/07/2026 at 4:50p.m., indicated the Administrator copied the facility Ombudsman into the e-mail. The Administrator sent the fax addressed to Resident #2's family member. The notice indicated that Resident #2 was discharged for non-payment. Record review of Resident #2's progress notes, it read as follows: -07/14/2026 at 1:12p.m., Resident #2's family member called emergency services for a wound infection. When emergency services arrived, Resident #2 stated she did not want to go to the hospital. Emergency services took her vitals and stated Resident #2 was stable and left the facility. Resident #2's family (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member came in later and said she wanted to discharge Resident #2 and called emergency services again. At that time, Resident #2 agreed to be transported to the hospital when emergency services came. Interview with the Administrator on 07/24/2026 at 4:09p.m., he said he usually notified the Ombudsman by calling or e-mailing regarding individual residents or sending off notices for multiple residents at a single time. The Administrator said he could not locate any documents showing the Ombudsman was notified of Resident #2's discharge on [DATE] but that the facility bent over backward for Resident #2 and tried to help her with finding a new facility and they did not have her removed 30 days after the original notification. The Administrator said he followed the protocol and notified the Ombudsman before discharge. The Administrator said because Resident #2 was her own RP and could make her own decisions, the facility was not obligated to send the family member anything regarding her discharge. The Administrator said that Resident #2 was due to discharge to a personal care home the facility helped Resident #2 sign because Resident #2 or her family member failed to pay towards her stay after her insurance stopped paying for her facility stay. During an interview on 07/24/2026 at 4:19p.m., the Ombudsman stated Resident #2's family member requested the 30-day notice and when the Administrator e-mailed the notice to the family member he added the Ombudsman into the e-mail as well. The Ombudsman said that was the first time he received a notice about Resident #2's discharge which was on 07/07/2026. The Ombudsman said there were concerns from the family member that she was threatened with Resident #2's discharge for not providing some information. The Ombudsman said notification of discharge should be sent to the resident and Ombudsman at the same time so that the Ombudsman could advocate for the resident if need be. The Ombudsman said he saw Resident #2 at the hospital where the family member had requested Resident #2 be discharged to. During an interview on 07/24/2026 4:09p.m., Resident #2's family member said she had spoken to the Ombudsman on 07/07/2026 and talked to him about what she considered an improper facility-initiated discharge because the facility was sending Resident #2 to a personal care home that Resident #2 felt like could not manage all of Resident #2's medical conditions and the family member felt like she was not notified or given a chance to find more suitable place to discharge Resident #2. Resident #2's family member said the Ombudsman advised her to request a discharge notice and she received that notice by e-mail on 07/07/2026 which the family member said was sent to the Ombudsman as well. Resident #2's family member said she had Resident #2 discharged to a hospital on [DATE] because she was worried about Resident #2's wounds and wanted them to be examined. Resident #2's family member said Resident #2 was back to living with the family member and Resident #2 was very confused and would not be able to make decisions or know exactly what happened but that she was safe. Record review of the facility's policy titled, Discharge Planning Process, with an implement date of 03/01/2024, read in part, It is the policy of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. 8. The facility will document any referrals to local contact agencies or other appropriate entities made for the purpose of the resident's interest in returning to the community. This policy did not mention notifying the Ombudsman.		