STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676221	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Park of Katy Nursing and Rehabilitation	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure controlled drug counts were in order and reconciled for two of two medication carts observed during change-of-shift. -Two medication carts controlled medication counts were conducted without staff cross-checking the medications cards and controlled medication count sheets. -The staff did not state the name of the medication when calling out the resident name and quantity. -The facility policy did not require both staff to confirm the quantity being verbalized was the quantity written on the controlled medication count sheet. The failure placed residents at risk for controlled medications to not be available when needed, and for controlled drug diversion. Findings include:Observation on 02/19/2026 at 2:02 p.m., revealed MA A and MA B conducting the change-of-shift count of the controlled medications for the Hall 400 Medication Aide cart. MA A was standing in front of the controlled medication lockbox, which was open. The lockbox was located on the right/front side of the cart. MA B was standing in front of the left side of the cart. MA B had the controlled medication count sheet book for the cart opened in front of her. MA A was starting her shift, relieving MA B. Continued observation revealed MA B looked at the medication count sheets in the book and called out a resident's name, then a quantity. She did not state what the medication was. MA A looked at the medication card and agreed to the number. The process was repeated for each of the controlled medications on the cart. Continuous observation revealed that at no time did MA B look at the medication cards and at no time did MA A look at the medication count sheets. Both staff signed the page in the book that designated MA A was responsible for all of the controlled medications on the cart, and that the counts were correct.Observation on 02/19/2026 at 2:05 p.m., revealed MA C and MA D conducted the change-of-shift count of the controlled medications for the Hall 400 Medication Aide cart. MA C was standing in front of the controlled medication lockbox, which was open. The lockbox was located on the right/front side of the cart. MA D was standing in front of the left side of the cart. MA D had the controlled medication count sheet book for the cart opened in front of her. MA C was starting her shift, relieving MA D. Continued observation revealed MA D looked at the controlled medication count sheets in the book and called out a resident's name, then a quantity. She did not state what the medication was. MA C looked at the medication card and agreed to the number. The process was repeated for each of the controlled medications on the cart. Continuous observation revealed that at no time did MA D look at the medication card and at no time did MA C look at the medication count sheets. Both staff signed the page in the book that designated MA C was responsible for all of the controlled medications on the cart, and that the counts were correct.In an interview on 02/19/2026 at 2:10 p.m., MA C said she did not look at the medication count sheets. In an interview on 02/19/2026 at 2:16 p.m., MA A initially said she looked at the cards and the medication count sheets. Three Surveyors had witnessed she had not looked at the medication count sheets as MA B called out the names and quantities. MA A then confirmed she did not look at the medication count sheets. In an interview on 02/19/2026 at 2:23 p.m., the DON said the change-of-shift count was to be conducted between the incoming MA and the MA that is at the end of her shift. The MA starting her shift was to be at the medication cards. The MA ending her shift was to be at the controlled medication count (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:	(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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sheet book. She said the MA ending her shift was to say the quantity that was on the sheet, and the MA starting her shift confirmed. She said the two MAs did not need to say the name of the medication because the cards were in the same order as the medication count sheets in the book. The DON was given a scenario: If the outgoing MA was looking at the medication count sheet, and it said ?21' but there were only 20 tablets on the medication card, if the outgoing MA said 20 instead of 21, would the incoming MA know the count was off if she did not look at the medication count sheet? The DON said the MA at the cards did not need to look at the controlled medication count sheets. In an interview on 02/19/2026 at 5:35 p.m., the Administrator was asked about the count system and was informed there was a concern with the technique used to count the controlled medications at change of shift. The concern was explained that if the MA or nurse ending her shift had diverted controlled medications and then told the MA or nurse starting her shift a quantity that matched the medication card instead of the number on the controlled medication count sheet, the discrepancy would be missed. The Administrator replied, I would not go with a hypothetical. I would follow our policy. He added that if the counts were off it may or may not affect the resident.Review of the facility policy Controlled Substance Reconciliation (revised July 2015) read, in part, .5. All narcotics need to be counted by two nurses or medication aides who are responsible for the cart. While one staff looks at the narcotic count sheet and calls out the name of the medication and the number of pills or the amount of MLs [milliliters] left the other staff member will confirm the medication name and number by looking at the actual blister pack or medication container. 6. Any discrepancies in narcotic count will be reported to administration before taking responsibility for the keys.