STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675890	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights at Medical Center	3935 Medical Dr San Antonio, TX 78229

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a discharge summary that included a post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, and the resident representative that included where the individual planned to reside, any arrangements that have been made for the resident's follow up care and any post discharge medical and non-medical services for 1 of 1 resident (Resident #1) reviewed for inappropriate discharge.The facility failed to ensure Resident #1 was given a proper discharge when the resident checked out on pass on 7/11/25 and did not return to the facility. This deficient practice could place residents at risk of being discharged and causing a disruption in their care and services and potential decline in health. The findings included:Record review of Resident #1's face sheet dated 7/30/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] and 4/16/25 with diagnoses that included heart failure, seizures (sudden, uncontrolled electrical disturbance in the brain that may cause changes in behavior, movements, feelings, or levels of consciousness), diabetes (chronic medical condition in which the body either doesn't produce enough insulin or doesn't use insulin effectively which helps regulate blood sugar levels), chronic kidney disease stage 3 (moderate stage of kidney damage where the kidneys aren't functioning as well as they should to filter waste and fluids from the blood), atrial fibrillation (irregular heartbeat rhythm where the heart beats rapidly and irregularly), hypertension (elevated blood pressure), and pain.Record review of Resident #1's most recent quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills, utilized a wheelchair for mobility, was dependent on staff with transfers, and was always incontinent of bowel and bladder.Record review of Resident #1's comprehensive care plan with revision date 1/28/25 revealed the resident had a self-care deficit related to poor mobility, debility, weakness, and seizures with interventions that included to assist the resident with bed mobility, required the use of a wheelchair, and required assistance with transfers with use of a mechanical lift. The comprehensive care plan revealed Resident #1 was at risk for falls related to debility, weakness, amputation, and seizures. The comprehensive care plan revealed Resident #1 wished to return to his home with supportive care and services group home with home health and the resident wished to leave community AMA several times despite education, with interventions that included to discuss discharge goals with the resident/family/representative; establish plan, set tentative discharge date as indicated, evaluate the resident's progress and revise the plan as indicated.Record review of Resident #1's Exit Seeking Risk Tool dated 5/15/25 revealed the resident was not at risk for exit seeking.Record review of Resident #1's IDT Discharge Planning/Instructions/Recapitulation document dated 7/11/25 revealed the resident discharged AMA, the anticipated discharge date was 7/11/25, the resident/representative declined post discharge care elections, and orders were reviewed and confirmed with the medical provider.Record review of the facility document titled, Release of Responsibility for Leave of Absence revealed Resident #1 signed out to go on pass on Friday, 7/11/25 at 12:09 p.m. The document had Resident #1's signature under the section which read, Signature of Person Accepting Responsibility.Record review of Resident #1's electronic record revealed a progress note dated 7/10/25 with time stamp 5:08 p.m. and authored by LVN B revealed, Resident #1 wanted to go AMA. LVN B's progress note indicated she provided the resident with an AMA form, provided patient teaching, and referred the resident to the Social Worker. LVN B's progress note indicated Resident #1's friend called and would be picking him up the following day, 7/11/25, to take the resident out on pass to lunch and shopping. LVN B's progress note revealed Resident #1 stated he would wait until the following day when his friend, who used to be his former home health aide, to decide about going AMA. Record review of Resident #1's electronic record revealed a progress note dated 7/11/25, with time stamp 12:15 p.m. and authored by the Administrator revealed, Resident #1 stated that he was going out on pass with friend. He [Resident #1] said he was planning on leaving and staying at her house overnight to attend church tomorrow for services. Patient signed himself out in the sign out book.Record review of Resident #1's electronic record revealed a progress note dated 7/11/25, with time stamp 1:55 p.m. and authored by the SW revealed, Patient [Resident #1] stated he was going out on pass with his friend. He stated that he would be leaving today and staying overnight at her house and would be going out to eat, shop, and attend church services tomorrow. Patient signed himself out in the sign out book.Record review of Resident #1's electronic record revealed a progress note dated 7/12/25 (Saturday), with time stamp 3:35 p

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure sufficient nursing staff with appropriate competencies and skills set to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plan of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for 1 of 3 nursing staff (LVN A) reviewed for nursing services. LVN A did not notify the DON or the Administrator until Monday 7/14/25 when Resident #1 went out on pass on Friday 7/11/25, and the resident did not return. Resident #1 was scheduled to return to the facility on Saturday 7/12/25.This failure could place residents at risk of staff not providing nursing or related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being.The findings included:Record review of Resident #1's face sheet dated 7/30/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] and 4/16/25 with diagnoses that included heart failure, seizures (sudden, uncontrolled electrical disturbance in the brain that may cause changes in behavior, movements, feelings, or levels of consciousness), diabetes (chronic medical condition in which the body either doesn't produce enough insulin or doesn't use insulin effectively which helps regulate blood sugar levels), chronic kidney disease stage 3 (moderate stage of kidney damage where the kidneys aren't functioning as well as they should to filter waste and fluids from the blood), atrial fibrillation (irregular heartbeat rhythm where the heart beats rapidly and irregularly), hypertension (elevated blood pressure), and pain.Record review of Resident #1's most recent quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills, utilized a wheelchair for mobility, was dependent on staff with transfers, and was always incontinent of bowel and bladder.Record review of Resident #1's comprehensive care plan with revision date 1/28/25 revealed the resident had a self-care deficit related to poor mobility, debility, weakness, and seizures with interventions that included to assist the resident with bed mobility, required the use of a wheelchair, and required assistance with transfers with use of a mechanical lift. The comprehensive care plan revealed Resident #1 was at risk for falls related to debility, weakness, amputation, and seizures. Record review of the facility document titled, Release of Responsibility for Leave of Absence revealed Resident #1 signed out to go on pass on Friday, 7/11/25 at 12:09 p.m. The document had Resident #1's signature under the section that read, Signature of Person Accepting Responsibility.Record review of Resident #1's electronic record revealed a progress note dated 7/11/25, with time stamp 12:15 p.m. and authored by the Administrator revealed, Resident #1 stated that he was going out on pass with friend. He (Resident #1) said he was planning on leaving and staying at her house overnight to attend church tomorrow for services. 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Patient signed himself out in the sign out book.Record review of Resident #1's electronic record revealed a progress note dated 7/12/25 (Saturday), with time stamp 3:35 p.m., and authored by LVN A revealed Resident #1 was OOP (out on pass).Record review of Resident #1's electronic record revealed a progress note dated 7/14/25 (Monday), with time stamp 7:48 a.m., and authored by LVN A revealed Resident #1 was Out on pass.During an interview on 7/31/25 at 11:33 a.m., LVN A stated, Resident #1 told him he was only going out on pass for a couple of hours and was coming back the same day (7/11/25), which was why he did not give the resident medications to take with him on pass. LVN A stated he reported to the Administrator on Monday 7/14/25 that Resident #1 had gone out on pass on Friday 7/11/25 and it was now Monday (7/14/25), and the resident was not back. LVN A stated he reported that information to the Administrator because it was more than three days. LVN A stated the Administrator took the information from him but did not say anything to him. During an interview on 7/31/25 at 12:35 p.m., the DON stated Resident #1 was leaving out on pass with a friend but was not aware the resident was going to leave overnight until she saw the SW's progress note the following working day, Monday 7/14/25. During an interview on 7/31/25 at 4:55 p.m., Resident #1 stated he told the Administrator he was going out on pass on Friday 7/11/25 and would return on Monday 7/14/25. Resident #1 stated he communicated with the DON about leaving out on