

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: 675890	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER The Heights at Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a comfortable, and homelike environment including a window that would open to allow fresh air in for 1 (Resident #54) of 1 observed for comfortable and homelike environment. The facility failed to ensure Resident #54's room window was not screwed shut and would be able to open when resident desired fresh air. This failure could place the residents at risk of feeling uncomfortable and could diminish quality of life. The findings were: Record review of Resident #54's face sheet, dated 08/15/2025, revealed he was admitted to the facility on [DATE] with diagnoses which included: acute respiratory failure, unspecified whether hypoxia or hypercapnia (a condition where the lungs are unable to adequately oxygenate the blood or remove carbon dioxide, and the specific cause (either low oxygen or high carbon dioxide) is not identified), sleep apnea (a common disorder where breathing repeatedly stops and starts during sleep), and chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe). Record review of Resident #54's Optional State MDS assessment, dated 07/22/2025, revealed the resident's BIMS score was 15, which indicated resident's cognition to be intact. Record review of the last 6 months grievances and resident council minutes revealed no concerns noted regarding windows or windows being screwed shut. During resident group interview on 08/14/2025 at 11:00 a.m. Resident #54 stated his room window was screwed shut and wondered if he could have it opened so he could open it when he wanted fresh air. Resident #54 further stated he did sign out every day usually due to his being a photographer but would like to be able to open his window sometimes. Observation on 08/14/2025 at 11:21 a.m. LSC observed a screw to Resident #54's window while rounding after being informed of what Resident #54 had said during resident group. During an interview on 08/14/2025 at 12:33 p.m. the Maintenance Supervisor stated the facility at one time had a couple residents who were trying to go out the windows and screws were put in the windows. The Maintenance Supervisor further stated he now had the locks to be able to minimize how much the windows would be able to be opened if needed. During an observation and interview on 08/15/2025 at 11:23 a.m. Resident #54's room window revealed a hole and metal shavings in the area where a screw had been. Resident #54 stated he had not asked anyone about the screws in the window nor to have them removed from the window so he could open it. Resident #54 further stated he really did not give it much thought because he was near and emergency exit. Resident #54 stated even though he did not ask about why the window had been screwed shut, it did bother him that he was not able to open the window. During an interview on 08/15/2025 at 11:53 a.m. LVN A stated Resident #54 would communicate with staff anytime he had a concern however, Resident #54 had never mentioned his window was screwed shut. LVN A further stated he was not aware there had been a screw in Resident #54's room window. LVN A stated if Resident #54 had voiced a concern regarding the window he would have put information regarding the concern in the portal for maintenance to address. LVN A stated he was not aware of anyone with screws in windows and had not had anyone complain about windows being screwed shut. During an interview on 08/15/2025 at 1:18 p.m. the DNS stated Resident #54 had never voiced to her a concern regarding his window being (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	screwed closed. The DNS stated she was aware the windows had been screwed closed for patient safety, but they were supposed to be able to open a small amount. The DNS stated the windows should not have been screwed totally shut. The DNS stated she did not feel it would affect Resident #54 in the event of an emergency as he would be dependent on staff to assist him out due to his being a Hoyer transfer and reliant on staff for transfers. The DNS further stated it would only affect his ability to open the window if he wanted fresh air. During an interview on 08/15/2025 at 1:57 p.m. the Administrator stated he was aware that windows were prevented from opening fully but not that some could not open at all. The Administrator further stated the company policy was that the windows were to only be able to open partially for the safety of the resident to keep people from being able to get in through the windows. The Administrator stated Resident #54 never came to him to tell him the window would not open. The Administrator stated Resident #54 should have been able to open his window to get fresh air. During an interview at 08/15/2025 at 3:07 PM Administrator stated the facility did not have a written policy regarding windows. Record review of facility's resident rights Statement of Resident Rights (26 Tex. Admin. Code 554.401), no date, read You, the resident, do not give up any rights when you enter a nursing facility. The facility must encourage and assist you to fully exercise your rights. Record review of facility's rights of the elderly Rights of the Elderly, no date, read An elderly individual has all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States, except where lawfully restricted. The elderly individual has the right to be free of interference, coercion, discrimination, and reprisal in exercising these civil rights.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure the MDS assessment accurately reflected the resident's status for two residents (Resident #2 and Resident #76) of twenty-one residents reviewed for MDS assessments. 1.The facility failed to ensure Resident #2's annual MDS, dated [DATE], indicated the resident was receiving the services of the state level II PASRR due to his intellectual disability. 2. The facility failed to ensure Resident #76's quarterly MDS, dated [DATE], indicted the resident used a CPAP (Continuous Positive Airway Pressure) at hours of sleep due to his sleep apnea. These deficient practice could affect residents who receive care and could result in missed or inappropriate care.The findings included: 1. Record review of Resident #2's face sheet, dated 08/15/2025, revealed the resident was [AGE] years old male, originally admitted to the facility on [DATE] and re-admitted on [DATE] with the diagnosis of intellectual disability (disability that affects the acquisition of knowledge and skills), and seizures (sudden burst of electrical activity in the brain). Record review of Resident #2's annual MDS assessment, dated 01/07/2025, revealed the resident's BIMS was 8 out of 15, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident was not considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Record review of Resident #2's comprehensive care plan, dated 09/26/2024, revealed [Resident #2] is considered PASRR positive due to intellectual disability. For intervention, coordinate services and plan of care with the local mental health authority and provide PASRR services. Record review of Resident #2's Local Intellectual and Developmental Disabilities Authorities' Habilitation Service Plan, dated 12/01/2024, revealed Resident #2 was receiving PASRR level II services per the plan because the resident was PASRR level II positive due to his intellectual disability. During an interview on 08/15/2025 at 10:45 a.m. with the Director of Clinical Reimbursement stated she had a responsibility to oversee the facility's MDS assessments, and Resident #2's annual MDS assessment dated 01/07/ was inaccurate, and it should have been coded Yes because Resident #2 was PASRR II positive resident due to his intellectual disability. The Director of Clinical Reimbursement said it was a mistake and did not affect Resident #2 because the resident was anyway receiving PASRR services, but MDS assessment should be accurate. 2. Record review of Resident #76's face sheet, dated 08/15/2025, revealed the resident was [AGE] years old male, originally admitted on [DATE], and re-admitted on [DATE] to the facility with diagnosis of sleep apnea (breathing stops and restarts many times while sleeping). Record review of Resident #76's quarterly MDS assessment, dated 05/22/2025, revealed the resident's BIMS was 10 out of 15 indicated the resident had moderate cognitive impairment. Further record review of the MDS assessment revealed the resident did not have Non-invasive Mechanical Ventilator use. Record review of Resident #76's comprehensive care plan, dated 06/10/2025, revealed the resident had the care plan of [Resident #76] am at risk for experience shortness of breath related to sleep apnea. For intervention - Administer CPAP (Continuous Positive Airway Pressure) for sleep apnea as ordered. Record review of Resident #76's physician order, dated 06/27/2025, revealed the resident had the order of Apply CPAP (Continuous Positive Airway Pressure) at bedtime at 10:00 p.m. and remove at 6:00 a.m. for Sleep Apnea. Observation and interview on 08/12/2025 at 10:44 am revealed there was Resident #76's CPAP (Continuous Positive Airway Pressure) on the nightstand covered with a plastic bag, and the resident said he put on his CPAP every 10:00 p.m. During an interview on 08/15/2025 at 12:48 p.m. with the Director of Clinical Reimbursement stated she had a responsibility to oversee the facility's MDS assessments, and Resident #76's quarterly MDS assessment dated [DATE]'s coding regarding CPAP (Continuous Positive Airway Pressure) was inaccurate, and it should have been coded Yes because Resident #76 was wearing CPAP (Continuous Positive Airway Pressure) every night due to his sleep apnea. The Director of Clinical Reimbursement said it was a mistake and did not affect Resident #76 (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because the resident was anyway receiving care, but MDS assessment should be accurate. Further interview with the Director of Clinical Reimbursement said they did not have specific policy regarding MDS accurate, and they followed CMS's RAI Manual. Record review of CMS's RAI version 3.0 Manual, dated 10/2024, revealed Code - yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or intellectual disability or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions and For Non-invasive Mechanical Ventilator, code any type of CPAP (Continuous Positive Airway Pressure) and BiPAP (bi-level positive airway pressure) respiratory support devices that prevent airway from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 (Resident #51 and #60) of 4 residents reviewed for incontinence care. 1. When CNA-B was providing peri care to Resident #51, CNA-B cleaned the resident's genital area without separating the labia. 2. When CNA-C was providing peri care with urinary indwelling catheter to Resident #60, CNA-C did not clean entire scrotum. These failures could place residents who required incontinence care at risk for cross contamination and the development of urinary tract infections. The findings included: 1. Record review of Resident #51's face sheet, dated 08/15/2025, revealed the resident was [AGE] years old female, originally admitted to the facility on [DATE], and re-admitted on [DATE] with diagnosis of overactive bladder. Record review of Resident #51's quarterly MDS assessment, dated 05/13/2025, revealed the resident's BIMS score was 5 out of 15 indicating the resident had severe cognitive impairment and was always incontinent of bladder and bowel. Record review of Resident #51's comprehensive care plan, dated 09/18/2024, revealed the resident has incontinence related to overactive bladder. For intervention - incontinent care assistance every shift and as needed and check and change on rounds and as needed. Observation on 08/14/2025 at 2:38 p.m. revealed CNA-B removed Resident #51's dirty brief, and CNA-B started cleaning the resident's suprapubic area, left groin, and right groin. When CNA-B cleaned the middle area of Resident #51's genitals, CNA-B did not separate the resident's labia. CNA-B cleaned the middle area of the resident's genitals without separating the labia, then rolled the resident to her left side and cleaned the resident's buttock area. During an interview on 08/14/2025 at 2:56 p.m. CNA-B stated when she cleaned the middle area of Resident #51's genitals, she did not separate the resident's labia, and she said she should have separated the resident's labia area when cleaning to prevent infection. CNA-B said she got checked-off regarding female peri care every year. During an interview on 08/14/2025 at 4:16 p.m. DNS stated the facility did not have a specific policy regarding peri care. The DNS said they used a skill check-off sheet for female peri care without catheter, and the sheet did not indicate separating female labia area when providing peri care, but the facility was following general professional guidelines. DNS said improper incontinence care might cause infection. Record review of professional guidelines (National Library of Medicine - Chapter 5: Provide for Personal Care Needs of Clients - Nursing Assistant - NCBI Bookshelf), titled Provide for Personal Care Needs of Client - perineal care for female, undated, revealed Expose their perineum only, Separate the labia, Use water and a soapy washcloth, Clean one side of the labia from top to bottom, and Using a clean portion of the first washcloth, clean the other side of the labia from top to bottom. 2. Record review of Resident #60's face sheet, dated 08/15/2025, revealed the resident was [AGE] years old male, originally admitted to the facility on [DATE], and re-admitted to the facility on [DATE] with diagnosis of dementia (loss of memory and thinking ability). Record review of Resident #60's Medicare five days MDS assessment, dated 07/28/2025, revealed the resident's BIMS was 0 out of 15 which indicated the resident had severe cognitive impairment, had urinary indwelling catheter, and was always incontinence to bowel. Record review of Resident #60's comprehensive care plan, dated 04/03/2025, revealed the care plan had the care of the resident has urinary indwelling catheter and incontinence of bowel. For intervention - incontinent and urinary indwelling catheter care assistance every shift and as needed and check and change on rounds and as needed. Observation on 08/14/2025 at 2:04 p.m. revealed CNA-C removed dirty brief from Resident #60, cleaned the urinary indwelling catheter and only penis with circular motions, cleaned right and left groin areas, and turned the resident to right side without cleaning Resident #60's scrotum, especially middle of scrotum. CNA-C cleaned Resident #60's buttock areas and put new and clean brief under the (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident after sanitizing his hands. During an interview on 08/14/2025 at 2:29 p.m. with CNA-C stated when he cleaned Resident #60's left and right groin area, he cleaned left and right side of Resident #60's scrotum. However, he said he did not clean middle area of Resident #60's scrotum. CNA-C said he should have cleaned Resident #60's entire scrotum area to prevent possible infection. Further interview with CNA-C said he received skill check for peri care of male resident on 08/2025. During an interview on 08/14/2025 at 4:16 p.m. DNS stated the facility did not have a specific policy regarding peri care. The DNS said they used a skill check-off sheet for male peri care with catheter, and the sheet did not indicate cleaning male scrotum area when providing peri care, but the facility was following general professional guidelines. DNS said improper incontinence care might cause infection. Record review of professional guidelines (National Library of Medicine - Chapter 5: Provide for Personal Care Needs of Clients - Nursing Assistant - NCBI Bookshelf), titled Provide for Personal Care Needs of Client - perineal care for male, undated, revealed Using a clean portion of the first washcloth, start from the urethra and clean in a circular motion toward their scrotum. Using a clean portion of the first washcloth, clean one groin fold and the scrotum. Using a clean portion of the first washcloth, clean the other groin fold and the other side of scrotum. Put the first washcloth in a linen bag. Using the second clean washcloth, rinse from the urethra in a circular motion toward the scrotum. Using a clean portion of the second washcloth, rinse one groin fold and the scrotum. Using a clean portion of the second washcloth, rinse the other groin fold and the other side of the scrotum.		

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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** Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care, was provided such care, consistent with professional standards of practice and the comprehensive person-centered care plan for 1 (Residents #36) of 1 Resident whose records were reviewed for oxygen use. The facility failed to ensure Resident #36's oxygen tubing was changed every week, and oxygen filter was checked and cleaned every week per the physician order. This deficient practice could affect any respiratory on oxygen therapy and could contribute to respiratory distress, infections, pneumonia and an overall decline in their physical condition. The findings included: Record review of Resident #36's face sheet, dated 08/15/2025, revealed the resident was [AGE] years old female, originally admitted to the facility on [DATE], and re-admitted on [DATE] with diagnoses of shortness of breath, and hypertension (high blood pressure). Record review of Resident #36's quarterly MDS assessment, dated 08/06/2025, revealed the resident's BIMS was 9 out of 15, which indicated the resident had moderate cognitive impairment, the resident was dependent (Helper does ALL of the effort) to activities of daily living, such as sit to stand and chair to bed transfer, and was receiving oxygen therapy. Record review of Resident #36's comprehensive care plan, dated 12/10/2024, revealed the resident had the care of oxygen therapy related to chronic lung disease. For intervention - provide oxygen as ordered and monitor for signs and symptoms of respiratory distress and report to medical doctor as needed. Record review of Resident #36's physician orders, dated 04/17/2025, revealed Change nasal cannula/mask and oxygen tubing every Sunday and as needed and Oxygen Filter; Check, Clean and/or replace filter every Week every night shift every Sunday - started 07/30/2025. Observation on 08/12/2025 at 10:38 a.m. revealed Resident #36 was on the bed in her room with oxygen via nasal cannular. The oxygen tubing was dated on 08/03/2025. Further observation revealed the oxygen concentrator had oxygen filter, and the oxygen filter was dirty with gray colored dust. During an interview on 08/12/2025 at 11:27 a.m. with LVN-A stated Resident #36 had oxygen via nasal cannular. She stated Resident #36's oxygen tubing was dated 08/03/2025, and oxygen filter was dirty with gray colored dust. Further interview with LVN-A said night nurse should have been changed Resident #36's oxygen tubing on 08/10/2025 (Sunday) and cleaned or replaced the oxygen filter on 08/10/2025 (Sunday) as ordered. It might cause possible respiratory infection. During an interview on 08/15/2025 at 1:18 p.m. with DNS stated Resident #36 had oxygen via nasal cannular and night nurse should have been changed Resident #36's oxygen tubing on 08/10/2025 (Sunday) and cleaned or replaced the oxygen filter on 08/10/2025 (Sunday) as ordered. It might cause possible respiratory infection. Record review of the facility policy, titled Oxygen - Respiratory Tubing/Equipment Management, dated 03/12/2018, revealed 1. Change tubing weekly . 6. Air filter should be changed and/or cleaned at least monthly and as needed.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for 1 of 1 kitchen observed for food service. Cook failed to wear beard restraints while working in the kitchen. Dietary Aide did not properly wear hair restraints in a way that covered all their hair. This failure could place residents who receive food prepared in the facility's only kitchen by placing them at risk for food-borne illness and food contamination. The findings were: Observation of the facility kitchen on 08/13/2025 at 03:48 PM revealed Cook's beard restraint not covering his facial hair while in the kitchen's food prep area. Observation of the facility's kitchen on 08/14/2025 at 10:40 AM revealed Dietary Aide not wearing hair restraint that covered all his hair while in the kitchen's food prep area. Interview with Dietary Aide on 08/14/2025 at 3:10 PM revealed he had received training from the dietary manager on appropriate hygiene when he started. The Dietary Aide stated hair restraints should cover all hair on top the head. Dietary Aide stated any hair not in the hair restraint could fall into the food and cause foodborne illness in those who ate food from the kitchen. Dietary Aide stated it was his responsibility to ensure his hair was fully in the hair restraint. Interview with [NAME] on 08/14/2025 at 3:12 PM revealed the [NAME] received training from the dietary manager on appropriate hygiene when first hired. The [NAME] stated hair restraints are to cover all hair to prevent hair from falling into food. The [NAME] stated that hair falling into food could cause foodborne illness in the residents. [NAME] stated it was his responsibility to ensure his hair was fully in the hair restraint. Interview with Dietary Manager on 08/14/2025 at 3:15 PM AM revealed staff are trained on appropriate hygiene when they start and all hair, including facial hair, was to be in a hair restraint when in the kitchen. Dietary manager stated hair that was not in a hair restraint could fall into food being prepared causing it to be contaminated. Dietary Manager stated contaminated food could cause foodborne illness in the residents. Dietary manager stated it was her responsibility to ensure staff wore their hair restraints properly. Record review of the facility policy named Employee Sanitation, dated October 1, 2018, revealed 3. Employee Cleanliness Requirements b. Hairnets, headbands, caps, beard coverings or other effective hair restraints must be worn to keep hair from food and food-contact surfaces. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022 states Except as provided in, (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 1 (Resident #60) of 21 residents reviewed for infection control practices. LVN-A was administering medications via Resident #60's gastrostomy tube, LVN-A did not wear a gown while . Resident #60 had EBP (Enhanced Barrier Precautions) status. This deficient practice could place residents at risk for cross contamination and infections. The findings included: Record review of Resident #60's face sheet, dated 08/15/2025, revealed the resident was [AGE] years old male, originally admitted to the facility on [DATE], and re-admitted to the facility on [DATE] with diagnosis of dementia (loss of memory and thinking ability), acute respiratory failure (usual exchange between oxygen and carbon dioxide in the lungs does not occur), heart failure (the heart cannot pump enough oxygen-rich blood to meet the body's needs), and type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels). Record review of Resident #60's Medicare five days MDS assessment, dated 07/28/2025, revealed the resident's BIMS was 0 out of 15 which indicated the resident had severe cognitive impairment and had eternal feeding tube. Record review of Resident #60's comprehensive care plan, dated 07/08/2025, revealed the care plan had the care of [Resident #60] require a feeding tube related to dysphagia (difficulty of swallowing) - for intervention, maintain NPO (nothing by mouth) status and provide feeding tube care as ordered and monitor any infection and At risk for infection or recurrent/chronic infection r/t compromised medical condition - for intervention, Enhanced Barrier Precaution practices as clinically indicated. Observation on 08/14/2025 at 8:44 a.m. revealed LVN-A entered to Resident #60's room, sanitized his hands, put on only gloves, and started administering morning medications via Resident #60's gastrostomy feeding tube, and LVN-A completed administering all medications then came out from the resident's room and washed his hands. At 9:00 a.m. further observation revealed there was a big signage posting on the resident's door indicated Wear gown and gloves during high-contact resident care, such as device care or use - central line, urinary catheter, and feeding tube. During an interview on 08/14/2025 at 9:05 a.m. with LVN-A stated he did not wear a gown when administering medications via Resident #60's gastrostomy tube. LVN-A said he forgot wearing a gown and he should have put on a gown because Resident #60 had EBP (Enhanced Barrier Precautions) to prevent possible infection. He stated the signage posting on the resident's door indicated Wear gown and gloves during high-contact resident care, such as device care or use - central line, urinary catheter, and feeding tube. Not wearing a gown might cause possible infection to the resident. During an interview on 08/14/2025 at 4:16 p.m. with DNS stated LVN-A should have put on a gown when he administered medications via feeding tube because Resident #60 had EBP (Enhanced Barrier Precautions) to prevent possible infection Not wearing a gown might cause possible infection to the resident. Record review of the facility policy, titled Infection Prevention and Control, dated 03/13/2019, revealed EBP (Enhanced Barrier Precautions) required the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer pf MDRO (Multidrug-resistant Organism) to staff hands and clothing. High-contact resident care activities are device care or use: Central line, urinary catheter, feeding tube, and tracheostomy/ventilator.		

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: 675890	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER The Heights at Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transmit encoded, accurate, and complete MDS data to the CMS System for 1 of 8 residents (Resident #26) reviewed for MDS transmission. The facility failed to transmit a discharge MDS assessment to the CMS system for Resident 26 who discharged on 04/29/2025 within 14 days of the discharge date. This failure could place residents at risk of not having assessments completed and submitted in a timely manner as required. Findings were: Record review of Resident #26's face sheet, dated 08/15/2025, revealed he was a [AGE] year-old male admitted to the facility on [DATE] and discharged on 04/29/2025 to an assisted living facility. Resident #26's face sheet indicated resident had diagnosis of encounter for orthopedic aftercare following surgical amputation, acute hematogenous osteomyelitis, left ankle and foot, and type 2 diabetes mellitus with unspecified complications. Record review of Resident #26's Medicare-5 day MDS revealed it was completed on 04/01/2025. Record review of Resident #26's medical record, progress note, dated 04/29/2026, revealed Resident 26 was discharged home with home health care. Interview with MDS Coordinator on 08/15/2025 at 1:35 PM revealed Resident #26 was discharged on 04/29/2025 and a discharge MDS was not completed. MDS Coordinator stated it was her responsibility to complete discharge MDS when a resident was discharged. MDS Coordinator stated the discharge MDS should be submitted to CMS within 14 days of a resident's discharge. MDS Coordinator stated the facility followed the RAI (Resident Assessment Instrument) to complete resident MDS. Interview with DNS on 08/15/2025 at 1:48 PM revealed MDS Coordinator was responsible for completing a discharge MDS when a resident was discharged. DNS stated the discharge MDS was to be submitted to CMS within 14 days of a resident's discharge. DNS stated there was no impact on a resident if a discharge MDS was not completed. Interview with Administrator 08/15/2025 at 2:01 PM revealed a discharge MDS should have been completed for all discharged residents. Administrator stated he was unsure of the exact timeframe the discharge MDS should have been submitted to CMS for Resident 26. Administrator stated it was the responsibility of the MDS Coordinator to complete the discharge MDS when a resident was discharged. Policy on MDS completion and transmission was requested on 08/15/2025 at 1:35 PM. MDS coordinator said she followed the RAI manual.		