STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676138	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of Gonzales	701 N Sarah Dewitt Gonzales, TX 78629

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observation, interview and record review the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents goals and preferences for 3 of 5 residents (Resident #6, #7 and #8) reviewed for respiratory care. 1. The facility failed to ensure Resident #6's oxygen tubing was not on the floor. 2. The facility failed to ensure Resident #7's oxygen tubing was not on the floor. 3. The facility failed to ensure Resident #8's nasal canula was not on the floor. These deficient practices could place residents at risk of receiving incorrect or inadequate oxygen support, possible contamination/cross contamination/infection and could result in a decline in health. The findings were: 1. Record review of Resident #6's face sheet reflected she is a [AGE] year-old female with an original admitted [DATE] and a readmitted [DATE]. Resident #6 had diagnoses which included Chronic Obstructive Pulmonary Disease (a group of lung diseases causing constriction of the airways and difficulty breathing) and type II diabetes mellitus (causes high blood sugar due to the pancreas not producing enough insulin). Record review of Resident #6's consolidated physician orders for March 2024 reflected orders for Oxygen at 2-4 Liters per N/C PRN (order date 08/04/2021). Further review of the consolidated orders reflected an order to change O2 and /or nebulizer tubing Q week, every night shift every Sunday (order date 08/04/2021). Record review of Resident #6's care plan, revised 12/26/2023, reflected Resident #6 has oxygen therapy related to ineffective gas exchange related to COPD. The goal was will have no s/sx of poor oxygen absorption through the review date with a target review date of 05/01/2024. The interventions reflected administer oxygen per order. Record review of Resident #6's Quarterly MDS, dated [DATE], reflected a BIMS score of 12, indicating mild impaired cognition. Resident #6 was on oxygen therapy for COPD. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/29/2024 at 11:48 am revealed Resident #6's oxygen tubing on the floor. Resident #6 was in the dining room seated at a table. Her oxygen concentrator was plugged into the wall and her concentrator was 6 feet away from the resident. Her oxygen tubing was stretched across the floor from the concentrator to the resident. During an interview on 03/29/2024 at 11:49 am with Resident #6, she stated the staff bring her oxygen into the dining room and set it up for her. She said she has asked them to not let the tubing touch the floor but they do not care. During an interview with CNA C on 3/29/24 at 11:55 am, CNA C acknowledged Resident #6's tubing on the floor. She stated the staff are responsible for setting up Resident #6's oxygen and stated the oxygen should not be touching the floor. CNA C stated this deficient practice could result in cross contamination or the tubing getting run over or bent, causing the resident to not get as much oxygen. CNA C stated she had received training regarding oxygen tubing not touch the floor. 2. Record review of Resident #7's face sheet reflected she is a [AGE] year-old female with an admitted [DATE]. Resident #7 has diagnoses which included Chronic Obstructive Pulmonary Disease (a group of lung diseases causing constriction of the airways and difficulty breathing) Dependence on Supplemental Oxygen and Dementia (a general term for impaired ability to remember, think, or make decisions). Record review of Resident #7's consolidated physician orders for March 2024 reflected oxygen at 2-3 liters per n/c PRN and change O2 and/nebulizer tubing Q week every night shift every Sunday (order date 11/28/2023). Record review of Resident #7's Quarterly MDS, dated [DATE], reflected a BIMS score of 5 indicating severe cognitive impairment and oxygen therapy with a diagnosis of COPD. Record review of Resident #7's care plan, revised 09/26/2023, reflected oxygen therapy related to CHF, ineffective gas exchange, COPD. The goal was to have no s/sx of poor oxygen absorption through the next review date of 04/18/2024. The interventions reflected monitor for s/sx of respiratory distress and report the MD PRN. Observation on 03/29/2024 at 11:47 am revealed Resident #7's oxygen tubing on the floor while Resident #7 was seated at the dining room table. Resident #7's oxygen tubing was connected to an oxygen cylinder attached to the back of Resident #7's wheelchair. During an interview with CNA C on 3/29/24 at 11:55 am, CNA C acknowledged Resident #7's oxygen tubing was on the floor. CNA C stated the staff are responsible for the placement of the oxygen and oxygen tubing and stated the oxygen tubing should not be touching the floor. 3. Record review of Resident #8's face sheet reflected she is an [AGE] year old female with an original admitted [DATE] and a readmitted [DATE]. Resident #8 has diagnoses which include Acute Respiratory Failure (caused by a disease or injury that effects breathing). Record review of Resident #8's consolidated physician orders for March 2024 reflected orders for continuous oxygen 2-4 liters per n/c every shift (order dated 03/01/2024). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's Quarterly MDS, dated [DATE], reflected a BIMS score of 08, indicating moderate cognitive impairment. Resident #7 is on oxygen therapy for respiratory failure. Record Review of Resident #8's care plan, revised 10/05/2023, reflected Resident #8 is on oxygen therapy r/t ineffective gas exchange, respiratory illness, resident wears CPAP at HS. The goal was she would have no s/sx of poor oxygen absorption through the review date of 04/01/2024. The interventions reflected monitor for s/sx of respiratory distress and report to MD PRN. Observation on 04/01/24 at 1:30 p.m. revealed Resident #8's oxygen nasal canula on the floor in the bathroom. Resident #8 was sitting in a recliner in her room. An oxygen cylinder was in the bathroom with the oxygen tubing nasal cannula lying on the floor in front of the toilet. During an interview with Resident #8 on 04/01/24 at 1:30 p.m., Resident #8 stated she was unaware of the nasal canula being on the floor in the bathroom. During an interview with LVN B on 04/01/2024 at 11:10 am she stated oxygen tubing should not touch the floor because it can get dirty and cause cross contamination. She stated it can cause a resident to get a respiratory infection or other sicknesses. Furthermore, LVN B stated she had received training on oxygen tubing placement. During an interview with LVN B on 04/01/2024 at 1:32 p.m. she acknowledged the oxygen nasal canula on the floor and stated, it should not be there, I am going to change it out right now. During an interview with the Administrator 04/01/2024 at 1:45 p.m. he stated nasal canula oxygen tubing should not touch the floor because it can become contaminated and introduce germ into the nose. For the oxygen tubing itself, it is going to touch the floor if the resident moves around. The tubing has to be long enough for them to move around the room. The Administrator stated staff have received training on oxygen and tubing. During an interview with the DON on 04/01/2024 at 2:00 p.m. the DON was asked why is it important that oxygen tubing not be on the floor in the dining room or a resident room, she stated if it is a long tubing and the resident is going to and from the bathroom, the tubing could be on the floor She also stated I do not think the tubing itself is an issue but the nasal cannula itself could introduce germs. Furthermore, the DON stated staff had received training on changing and labeling tubing and where to place tubing when not in use. Record review of the facility's policy on Oxygen-Respiratory Tubing/Equipment Management, revised 01/2022, states the guideline is to maintain properly functioning equipment and decrease the potential for the spread of infection by maintaining clean equipment and tubing bottles and mask. A procedure is to change tubing weekly and provide storage receptacle for proper storage when not in use.