

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER The Heights of Gonzales		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #1) of 3 residents reviewed for medical records. The facility nurses did not document accurately on Resident #1's Medication Administration Record on 07/15/2026 regarding the resident's [NAME] Hose (medical stockings used to help prevent blood clots in people who are not moving much). This failure could place residents at risk for records not accurately documented. Findings included: Record review of Resident #1's face sheet, dated 07/31/2026, revealed the resident was an 85-years-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnosis of dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), transient cerebral ischemic attack (temporary blockage of blood flow to the brain), and heart failure (the heart cannot pump enough oxygen-rich blood to meet the body's need). Record review of Resident #1's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 15 out of 15, which indicated the resident cognitive was intact, and in the Section GG (Functional Abilities), the resident was independent (Resident completes the activity by themselves with no assistance from a helper) for most activities of daily living, such as sit to stand and chair to bed transfer. Record review of Resident #1's comprehensive care plan, dated 08/03/2026, revealed I have Heart Disease. I am at risk for associated cardiac complications such as chest pain, short of breath, fatigue, dizziness, poor endurance/activity intolerance and edema, Hypertension, and peripheral insufficiency venous. For intervention - Administer my medications as ordered by my physician. Record review of Resident #1's physician order, dated 10/09/2025, revealed the resident had an order for [NAME] Hose in am and Remove in pm - two times a day. Record review of Resident #1's Medication Administration Records from 07/01/2026 to 07/31/2026 revealed the resident received her [NAME] Hose as ordered and scheduled [NAME] Hose On at the morning time and [NAME] Hose Off at the bed time. Further record review of the resident's Medication Administration Records revealed there was blank (empty - no document) on 07/15/2026 at Morning time but documented at the bedtime as Off. Interview on 07/31/2026 at 3:29 p.m., LVN-A who worked on 07/15/2026 at morning time said that she applied the [NAME] Hose to Resident #1 at the morning time as ordered, but she forgot to document on the resident's Medication Administration Record because she was very busy. LVN-A stated it was her mistake and she should have documented on the resident's Medication Administration Record after applying the [NAME] Hose to the resident to provide accurate information to other nurses and inaccurate medical record might provide incorrect care to the resident. Interview on 07/31/2026 at 3:35 p.m., the ADON said the facility DON was on vacation, so she could interview with the surveyor, and the nurse who worked on 07/15/2026 at (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	morning time applied the [NAME] Hose to Resident #1 as ordered because evening nurse took off the [NAME] Hose at bedtime. The ADON stated LVN-A should have documented accurately on Resident #1's Medication Administration Record regarding [NAME] Hose on 07/15/2026 because inaccurate medical records might provide incorrect care to the resident. Record review of the facility policy, titled Professional Standard of Care, dated 01/2023, revealed . F. Nurses should conduct assessments or evaluations and document nurses' notes in the following instances: 1) routine charting for residents should reflect the recipient's ability as assessed upon admission, re-admission and as clinically indicated; and 2) at the time of accidents, incidents or change in condition. All exceptions to stable, baseline or usual status should be recorded as exceptions and included in the clinical record.		