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	03/27/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 1 (near Activities Area) of 2 kitchenettes reviewed, in that: The door to kitchenette #1 was open and unlocked; the steam table was on and hot to the touch, and the refrigerator held a gallon container of milk and three trays with approximately 40 glasses of liquid marked to be served at lunchtime. No staff were present in the kitchenette or within the surrounding area. This deficient practice could result in residents coming into contact with a hot surface, and/or consuming liquids of the incorrect texture for their diet, and/or contaminating the food and drinks in the refrigerator. The findings were: Observation on 03/24/2026 at 2:20 p.m. revealed the door to kitchenette #1 was open and unlocked; the steam table was on and hot to the touch, and the refrigerator held a gallon container of milk and three trays with approximately 40 glasses of liquid marked to be served at lunchtime. Further observation revealed no staff were present in the kitchenette or within the surrounding area. Further observation revealed there were staff and residents within approximately 30 feet of the kitchenette conducting a scheduled activity at the time. During an interview with the Activities Director on 03/24/2026 at 2:22 p.m., the Activities Director confirmed the door to kitchenette #1 was open, that no staff were present, the steam table was on and hot, and a refrigerator containing a gallon container of milk and glasses of liquid. During an interview with the Administrator on 03/27/2026 at 7:15 a.m., the Administrator stated he had directed new locks to be installed on the doors to both facility kitchenettes and directed staff to ensure the doors remain locked at all times. Record review of the facility policy, Physical Environment, revised January 2023, revealed, The community is designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.

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 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** Number of residents sampled:Number of residents cited:The findings included: Record review of Resident #76's face sheet, dated 03/26/2026, reflected a [AGE] year old female who was originally admitted on [DATE] with current admission date 01/20/2026 with diagnoses including Low Vision Right Eye Category 2 (severe visual impairment), Tubulo-interstitial Nephritis (a type of inflammation that damages the tubules in the kidneys and the tissue that surrounds them), Spinal Stenosis (narrowing in the spine which puts pressure on nerves and spinal cord), Type 2 Diabetes Mellitus with Hyperglycemia (the body can't use insulin properly and/or doesn't make enough insulin resulting in high blood sugar levels), Essential Hypertension (high blood pressure), Uninhibited Neuropathic Bladder (a type of bladder dysfunction caused by brain or upper spinal cord damage), and Other Obstructive and Reflux Uropathy (a blockage in the urinary system that cause urine to back up into the kidneys). Record review of Resident #76's quarterly MDS assessment, dated 01/28/2026, revealed resident had a BIMS score of 15 which indicated intact cognitive status, resident has an indwelling urinary catheter with diagnosis of Neurogenic Bladder and Bowel Incontinence (always incontinent). Record review of Resident #76's comprehensive care plan, dated 02/10/2026, revealed Incontinence related to activity intolerance and impaired mobility. Intervention- incontinence care every shift and as needed. Comprehensive care plan also revealed I require a catheter: at risk for infection and catheter related injury/issues. Intervention- catheter care every shift and as indicated. Observation on 03/26/2026 at 09:45 a.m., of CNA A and CNA B providing incontinent care, CNA A cleaned resident #76 suprapubic area, left and right groin, separated labia wiping front to back, and cleaned catheter tubing using disposable wipes. Resident was turned to left side revealing resident had a bowel movement. CNA A cleaned resident's rectal area and buttocks but did not remove soiled brief. Resident rolled onto her back, with buttocks touching the soiled brief before being turned to right side. CNA B removed soiled brief but did not clean resident's buttocks before applying clean brief. Interview on 03/26/2026 at 10:00 a.m., CNA A stated she may have missed a step while performing care. CNA A and CNA B confirmed the soiled brief should have been removed before the resident rolled onto it and the resident's buttocks should have been cleaned again before applying the clean brief. Interview on 03/26/2026at 11:10 a.m., the DON stated CNA A and CNA B should have removed soiled brief before resident rolled onto it and her buttocks should have been cleaned again before applying new brief. Skills check-offs/training for CNA A and CNA B related to incontinence care was provided by DON as requested. Record review on 3/26/2026 of skills competency checkoffs Pericare/incontinence female and Foley catheter care female indicated CNA A and CNA B were provided training and checked off for competency. CNA A on 01/29/2026 and CNA B on 01/09/2026. Record Review on 3/26/2026 Procedural Guideline #20 Perineal Care/Incontinent Care- Female provided with skills check- off stated the following step after washing genital area, turn to side, then wash and rinse rectal area moving from front to back using a clean area of washcloth for each stroke, dry with towel.

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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 observations, interviews, and record reviews, the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences in 1 (Resident #50) of 3 residents reviewed receiving supplemental oxygen via nasal cannula. The facility failed to ensure that Resident #50's oxygen tubing was stored properly to prevent contamination. Resident 50's oxygen tubing was on the floor in her room with nasal cannula resting on metal bed frame under headboard. This failure could put residents receiving supplemental oxygen via nasal cannula at risk for cross-contamination and respiratory infection.The findings included: Record review of Resident #50's face sheet, dated 03/25/2026, reflected a [AGE] year-old female with current admission date of 03/17/2026. Diagnosis include fracture of superior rim of right pubis (crack or break of pelvic bone), chronic respiratory failure with hypoxia (lungs cannot get enough oxygen into the blood), type 2 diabetes mellitus with diabetic neuropathy (high blood sugar damages nerves causing pain, tingling, or numbness in the feet and legs), chronic obstructive pulmonary disease (a group of lung diseases that make it hard to breathe) dependence on supplemental oxygen, heart failure (heart cannot pump enough blood to meet the body's needs), end stage renal disease (the final stage of chronic kidney disease) and essential hypertension (high blood pressure). Record review of Resident #50's 5-day MDS, dated [DATE] revealed resident BIMS score of 15 which indicated intact cognitive status. Record review of Resident #50's physician order dated 03/25/2026, indicated Oxygen 2-4 L/min prn as needed for shortness of breath. Record review of Resident #50's comprehensive care plan dated 03/25/2026 indicated Oxygen Therapy as needed r/t Ineffective gas exchange. Interventions included- encourage/cue/assist as needed with positioning in bed, intervention- monitor for s/sx of respiratory distress and report to MD, intervention- promote lung expansion and improve air exchange by positioning with proper body alignment (if tolerated, head of bed at 45 degrees). Observation on 03/25/2026 at 9:08 a.m. Resident #50 in bed with head of bed elevated approximately 45 degrees, oxygen concentrator was on opposite side of room with oxygen tubing noted on floor and nasal cannula resting on metal bed frame under the headboard of bed. No receptacle was observed in the room in which to store the tubing and nasal cannula. Interview with Resident #50 on 03/25/2026 at 9:08 a.m., Resident #50 stated she only wears her oxygen at night and I don't usually need it during the daytime when I am awake. Resident confirmed there was no receptacle to place her oxygen tubing into when she removed it and that she had not been offered a plastic bag or anything to place the tubing, stating I just lay it on the bed. Resident confirmed that she eats breakfast in bed every day and staff deliver her tray and that she requires transfer assistance to get from bed to wheelchair. Observation on 03/25/2026 at 10:07 a.m., oxygen tubing noted in same place under the bed. Resident was not in room. Interview on 03/25/2026 at 10:07 a.m., CNA C stated oxygen tubing and nasal cannula should not be on the floor and under resident's bed. CNA C stated, oxygen tubing should be placed in a plastic bag because the floor can be dirty. When asked what the potential outcome could be to contaminated tubing CNA C confirmed risk of infection. CNA C immediately removed tubing and nasal cannula to be replaced. Interview on 03/26/2026 at 11:10 a.m., the DON stated, the expectation is that oxygen tubing be placed in a plastic bag when not in use. and confirmed that placing in a bag was to avoid cross-contamination and potential respiratory infection. Record review of facility policy Oxygen-Respiratory Tubing/Equipment Management dated 03/12/2018, revised January 2022 with Compliance Guidelines: To maintain properly functioning equipment and decrease the potential for the spread of infection by maintaining clean equipment and tubing bottles and masks, listed 1. Change tubing weekly and provide storage receptacle for proper storage when not in use.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 3 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure Resident #1's Zyrtec (Cetirizine) an allergy medication had a dosage ordered on MARS. This failure could place residents at risk of not receiving the therapeutic effects of their prescribed medications.The findings included: Record review of Resident #1's face sheet, dated 3.26.2026, reflected a [AGE] year-old female with an initial admission date of 1/22/26 and diagnoses including: hypertension (is a chronic condition defined as consistently high force of blood against artery walls), Heart failure (is a chronic, progressive condition where the heart muscle cannot pump blood efficiently enough to meet the body's needs for oxygen) and Epilepsy (is a chronic neurological disorder characterized by recurrent, unprovoked seizures caused by sudden, excessive electrical discharges in the brain). Record review of Resident #1's Initial MDS assessment, dated 1/29/26, revealed Resident #1 had with a BIMS score of 12, which indicated moderate cognitive impairment Review of Resident #1's Physician orders for March 2026 revealed that Resident #1 was prescribed Zyrtec once daily in the morning, with no dosage specified. Record review of medication administration history for Resident #1, dated 3/26/26, revealed that Zyrtec was administered throughout March 2026 without a specified dosage. Observation on 3/26/26 at 8:20 a.m. revealed MA D pulling medication from the cart and reading the MAR, at which time she noted the order did not specify a dosage. Interview with on 3/26/26 at 8:25 am MA D said the Zyrtec order for Resident #1 did not list a dosage; therefore, she had the order clarified by DON prior to administering it to Resident #1. Interview with Resident #1 on 3/26/26 at 9:00 a.m. stated she did not recall how many pills she takes in the mornings or what they were for, but trusted nurses to administer the correct medications. During an interview on 03/26/2026 at 9:45 AM, the DON stated that certified medication assistants are expected to administer medications according to physician orders and notify the charge nurse of any deviations. She was unaware why the Zyrtec order for Resident #1 did not include a dose on the MARS, but clarified the order promptly once informed. The DON expects all MAs to verify orders before administering medication, confirming the correct patient, dose, time, and route, and to inform charge nurses of any discrepancies so orders can be clarified, especially since Zyrtec is available in 5 mg or 10 mg. She added that her ADON monitors this process at random and provides oversight. Record review of the facility's policy titled, Policy Medication Administration, dated March 2017, revised January 2023, revealed, Verify the medication label against the medication sheet for accuracy of drug frequency, duration, strength, and route.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were secured properly for 1 of 5 residents (Resident #23) reviewed for medication storage, in that: The facility failed to ensure medication Vick's (nasal decongestant) was not left on Resident #23's bedside table. This failure could place residents at risk for not receiving the intended therapeutic benefit of their medications as ordered.The findings were: Record review of Resident #23's face sheet, dated 3/25/26, revealed an [AGE] year-old female admitted to the facility on [DATE] with the diagnosis that included Chronic obstructive pulmonary disease, (refers to a group of diseases that cause airflow blockage and breathing-related problems), hypertension (is a chronic condition defined as consistently high force of blood against artery walls) and Diabetes mellitus (is a chronic metabolic disorder characterized by high blood sugar). Record review of Resident #23's Quarterly MDS, dated [DATE], revealed a BIMS score of 15, which indicated intact cognition. Record review of Resident #23's physician orders for March 2026, reviewed on 3/25/26, did not reveal an order to self-administer medications. Further review revealed there was no order for the resident's use of Vicks. Observation on 03/25/2026 at 11:30 a.m. of Resident #23's room revealed there was a jar of Vicks on the nightstand. Interview with Resident #23 on 3/25/26 at 12:15 p.m., the Resident stated her family purchased Vicks for her and brought it sometime right before February 14th of 2026. The Resident further stated that no one had given her a self-medication assessment, and she had not used the Vick's. Interview with CNA F on 3/25/2026 verified she was assigned to Resident #23, and recalls assisting Resident #23 with morning care today; however, she does not recall seeing a jar of Vicks on the nightstand. Interview with LVN E on 3/25/26 at 12:30 p.m., LVN E confirmed she was assigned to Resident #23 and verified that a jar of Vicks was on the resident's bedside table. She stated Resident #23 had not received a self-medication assessment and should not have access to medication for self-administration, as this poses a risk of improper use by the Resident or accidental ingestion by others due to lack of secure storage and cognition. Interview with the DON on 03/24/26 at 9:35 a.m., the DON reported a jar of Vicks was found on Resident #23's bedside table. The DON explained that no medication should be left on a resident's bedside table without a self-medication assessment, as this may lead to the resident taking more than the prescribed dosage. Record review of the facility's policy titled, Medication Administration, March 2019, revised January 2023, revealed, Avoid leaving medications with the Resident to self-administer unless the Resident is approved for self - administration on the medicine.