

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2025
NAME OF PROVIDER OR SUPPLIER The Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 1855 W Goodwin Pleasanton, TX 78064	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47622</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure that residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 2 of 8 residents (Resident # 25, Resident #75) reviewed for call lights.</p> <ol style="list-style-type: none"> 1. Resident #25's call light was not in reach. 2. Resident #75's call light was not in reach. <p>This failure could place residents at risk of achieving independent functioning, dignity, and wellbeing.</p> <p>The findings included:</p> <p>Record review of Resident #25's face sheet dated 5/16/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] initially with diagnoses that included: hemiplegia following a stroke, atrophy (muscle wasting away), vascular dementia.</p> <p>Record review of Resident #25's Annual MDS dated [DATE] revealed he had a BIMS score of 8, indicative of moderate cognitive deficit.</p> <p>Record review of Resident #25's Care Plan dated 4/23/2025 revealed pain due to a history of fractures, falls related to balance problems.</p> <p>Record review of Resident #75's face sheet dated 5/16/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: stroke, epilepsy, type 2 diabetes, and above the knee amputation of the left leg.</p> <p>Record review of Resident #75's Quarterly MDS dated [DATE] revealed he had a BIMS score of 14, indicative of cognition intact.</p> <p>Record review of Resident #75's Care Plan dated 3/21/2025 revealed risk for falls due to attempting to void standing in front of the toilet, pain or discomfort due to amputation and other diagnoses.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 5/13/2025 at 10:01 AM Resident #25 was sitting in his bed with the head of his bed at a 90-degree angle. Resident #25's call light was dangling on the left side of his bed, wedged between the bed rail and the mattress.</p> <p>Interview on 5/13/2025 at 10:01 AM Resident #25 said when he used the call light they answered quickly. He said it was on his side of the bed (left side).</p> <p>Observation on 5/13/2025 at 10:23 AM Resident #75 was sitting up in his bed. Resident #75's call light was on the floor at the head of the bed near the wall.</p> <p>Interview on 5/13/2025 at 10:23 AM Resident #75 said staff did not play when it came to answering the call light. He said the call light was around somewhere but did not know where.</p> <p>Interview on 5/13/2025 at 10:30 AM RN E said it was important for the call lights to be in reach for the residents' safety. She said the call lights needed to always be in reach for the residents.</p> <p>Interview on 5/13/2025 at 2:12 PM LVN D said she was not aware of the call lights for Resident #25 and Resident #75 were out of reach. She said it was important for the residents to have the call lights in reach because it could be an emergency or need help and the call light was the way to notify staff. She said the call light needed to be accessible to the residents. LVN D said staff that go in the room should make sure the call light was accessible to the residents before they left the room.</p> <p>Interview on 5/16/2025 at 1:22 PM the DON said the call should always be within reach for the residents because they could have a fall or a medical emergency and would not be able to call for help. The DON said all staff that interact with the residents were responsible to make sure the call lights were in reach for the residents.</p> <p>Record review of facility policy titled Routine Resident Care dated 1/2024 stated, 9. Call lights should be placed within easy reach of the resident.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049</p> <p>Based on observations, interview, and record review, the facility failed to ensure the resident has a right to personal privacy for 1 (Resident #47) of 18 residents reviewed the privacy.</p> <p>Resident #47 did not have privacy in the resident's room because the resident's room was seen from outside due to the broken blinds of window.</p> <p>This failure could place residents at risk of violation of right to personal privacy.</p> <p>The findings were:</p> <p>Record review of Resident #47's face sheet, dated 05/16/2025, revealed the resident was [AGE] years old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with the diagnosis of cerebral infarction (area of brain tissue that dies due to cessation of blood flow), type 2 diabetes mellitus (the body has trouble controlling blood sugars and using it for energy), muscle weakness, hypertension (high blood pressures), and chronic kidney disease (kidneys not waste and excess fluid from the body).</p> <p>Record review of Resident #47's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 14 out of 15, which indicated the resident's cognitive was intact and required setup or clean up assistance (helper sets up or clean up; resident completes activity) to all activities of daily living, such as eating, sit to stand, chair to bed transfer, and toilet transfer.</p> <p>Record review of Resident #47's comprehensive care plan, dated 01/28/2025, revealed the resident had occasional incontinence related to disease process and for intervention, check and change on rounds and as needed and incontinent care assistance every shift and as needed.</p> <p>Observation on 05/13/2025 at 4:03 p.m. revealed Resident #47 was on the bed and watching on TV. There was a window at bedside, and the window had a blind, but the blind was broken so that it could not cover the window. Further observation revealed the surveyor and resident could see some people from outside were walking around the facility though the window.</p> <p>Interview on 05/13/2025 at 4:04 p.m. Resident #47 stated the resident could not cover the window with the blind because it was broken, so when the resident changed her clothes in her room by herself, the resident worried about her privacy because people could see the resident through the window. Further interview with Resident #47 stated the resident did not know when the blind was broken, and the resident thought she reported her broken blind to the facility.</p> <p>Interview on 05/15/2025 at 2:35 p.m. with CNA-A stated Resident #47's window blind was broken, so it could not cover the window. Further interview with CNA-A said Resident #47 could change her clothes in her room by herself, and the resident might have privacy issue because any person could see her from outside through the window, and CNA-A did not know the resident's window blind was broken because the resident did not say it. However, sometimes CNAs helped Resident #47's incontinent care, and CNAs usually covered window with blinds to protect residents' privacy.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/15/2025 at 2:38 p.m. with LVN-B said Resident #47 might have privacy issues because the resident's blind was not working correctly, so it could not cover the window. Somebody from outside might see inside through the window. All staff had responsibility to protect residents' privacy while they were providing care.</p> <p>Interview on 05/16/2025 at 11:17 a.m. with the DON stated Resident #47's broken blind might affect the resident's privacy because somebody from outside could see the resident through the window. Resident #47 did not report to the facility regarding her broken blind, but it was all staff's responsibility to protect residents' privacy while they were providing care.</p> <p>Record review of the facility policy, titled Rights of Nursing Home Residents, 2003, revealed Right to privacy and confidentiality - Private and unrestricted communication with any person of their choice, and during treatment and care of one's personal needs.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049</p> <p>Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 (Resident #47) out of 18 residents reviewed for environmental concerns.</p> <p>Resident #47's window blind was broken, and it could not cover the window fully.</p> <p>This failure could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe.</p> <p>The findings were:</p> <p>Record review of Resident #47's face sheet, dated 05/16/2025, revealed the resident was [AGE] years old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with the diagnosis of cerebral infarction (area of brain tissue that dies due to cessation of blood flow), type 2 diabetes mellitus (the body has trouble controlling blood sugars and using it for energy), muscle weakness, hypertension (high blood pressures), and chronic kidney disease (kidneys not waste and excess fluid from the body).</p> <p>Record review of Resident #47's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 14 out of 15, which indicated the resident's cognition was intact and required setup or clean up assistance (helper sets up or clean up; resident completes activity) to all activities of daily living, such as eating, sit to stand, chair to bed transfer, and toilet transfer.</p> <p>Record review of Resident #47's comprehensive care plan, dated 01/28/2025, revealed the resident had occasional incontinence related to disease process and for intervention, check and change on rounds and as needed and incontinent care assistance every shift and as needed.</p> <p>Observation on 05/13/2025 at 4:03 p.m. revealed Resident #47 was on the bed and watching on TV. There was a window at bedside, and the window had a blind, but the blind was broken so that it could not cover the window. Further observation revealed the surveyor and resident could see some people from outside were walking around the facility though the window.</p> <p>Interview on 05/13/2025 at 4:04 p.m. Resident #47 stated the resident could not cover the window with the blind because it was broken, so when the resident changed her clothes in her room by herself, the resident worried about her privacy because people could see the resident through the window. Further interview with Resident #47 stated the resident did not know when the blind was broken, and the resident thought she reported her broken blind to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/15/2025 at 2:35 p.m. with CNA-A stated Resident #47's window blind was broken, so it could not cover the window. Further interview with CNA-A said Resident #47 could change her clothes in her room by herself, and the resident might have privacy issue because any person could see her from outside through the window, and CNA-A did not know the resident's window blind was broken because the resident did not say it. However, sometimes CNAs helped Resident #47's incontinent care, and CNAs usually covered window with blinds to protect residents' privacy.</p> <p>Interview on 05/15/2025 at 2:38 p.m. with LVN-B said Resident #47 might have privacy issues because the resident's blind was not working correctly, so it could not cover the window. Somebody from outside might see inside through the window. All staff had responsibility to protect residents' privacy while they were providing care.</p> <p>Interview on 05/16/2025 at 11:17 a.m. with the DON stated Resident #47's broken blind might affect the resident's privacy because somebody from outside could see the resident through the window. Resident #47 did not report to the facility regarding her broken blind, but it was all staff's responsibility to protect residents' privacy while they were providing care.</p> <p>Record review of the facility policy, titled Rights of Nursing Home Residents, 2003, revealed Right to privacy and confidentiality - Private and unrestricted communication with any person of their choice, and during treatment and care of one's personal needs.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47622</p> <p>Based on observations, interviews, and record reviews, the facility failed to implement a person-centered care plan for 2 of 8 (Resident #25, Resident #75) reviewed for care plans.</p> <p>The facility failed to follow care planned interventions for Resident#25 and Resident #75 on 5/13/2025 when their call lights were not placed in reach.</p> <p>This failure could place the resident at risk of not receiving person-centered care that is needed for communicating with staff to ensure the residents' needs are met.</p> <p>Findings included:</p> <p>Record review of Resident #25's face sheet dated 5/16/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] initially with diagnoses that included: hemiplegia following a stroke, atrophy (muscle wasting away), vascular dementia.</p> <p>Record review of Resident #25's Annual MDS dated [DATE] revealed he had a BIMS score of 8, indicative of moderate cognitive deficit.</p> <p>Record review of Resident #25's Care Plan dated 4/23/2025 revealed pain due to a history of fractures, falls related to balance problems. Intervention for falls was for his call light to be in reach.</p> <p>Record review of Resident #75's face sheet dated 5/16/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: stroke, epilepsy, type 2 diabetes, and above the knee amputation of the left leg.</p> <p>Record review of Resident #75's Quarterly MDS dated [DATE] revealed he had a BIMS score of 14, indicative of cognition intact.</p> <p>Record review of Resident #75's Care Plan dated 3/21/2025 revealed risk for falls due to attempting to void standing in front of the toilet, pain or discomfort due to amputation and other diagnoses. Intervention for falls was for his call light to be in reach.</p> <p>Observation on 5/13/2025 at 10:01 AM Resident #25 was sitting in his bed with the head of his bed at a 90-degree angle. Resident #25's call light was dangling on the left side of his bed, wedged between the bed rail and the mattress.</p> <p>Interview on 5/13/2025 at 10:01 AM Resident #25 said when he used the call light they answered quickly. He said it was on his side of the bed (left side).</p> <p>Observation on 5/13/2025 at 10:23 AM Resident #75 was sitting up in his bed. Resident #75's call light was on the floor at the head of the bed near the wall.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 5/13/2025 at 10:23 AM Resident #75 said staff did not play when it came to answering the call light. He said the call light was around somewhere but did not know where.</p> <p>Interview on 5/13/2025 at 10:30 AM RN E said it was important for the call lights to be in reach for the residents' safety. She said the call lights needed to always be in reach for the residents.</p> <p>Interview on 5/13/2025 at 2:12 PM LVN D said she was not aware of the call lights for Resident #25 and Resident #75. She said it was important for the residents to have the call lights in reach because it could be an emergency or need help and the call light was the way to notify staff. She said the call light needed to be accessible to the residents. LVN D said the Care Plan should be followed because it indicated the care needed for each resident.</p> <p>Interview on 5/16/2025 at 1:22 PM the DON said the Care Plan should be followed for patient centered care. The DON said the call should always be within reach for the residents because they could have a fall or a medical emergency and would not be able to call for help.</p> <p>Record review of facility's policy titled Care Plans dated 1/2023 stated in part, The care plan in conjunction with the plan of care is developed and recommended to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. and The care plan should be utilized in conjunction with the entire medical record. The care plan should serve as a guide that identifies risks, direct care needs .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47622</p> <p>Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety for 1 of 1 kitchen observed.</p> <ol style="list-style-type: none"> 1. The deep fryer was not clean from previous day usage. 2. The deep fryer was still uncleaned after 2 meals were served for the day. <p>This failure could place residents who received meals and or snacks from the kitchen at risk for food borne illness.</p> <p>The findings included:</p> <p>Observation on 05/13/25 at 09:30 AM the kitchen had a deep fryer that sat next to the stove, that had 2 frying baskets with crumbs and food in the weaves of the baskets. There was a pan underneath the baskets that covered the opening of the fryer, it also had crumbs and grease on the pan. There was grease and crumbs on the outside of the deep fryer as well.</p> <p>Interview on 5/13/2025 at 9:32 AM the DM said the fryer was used yesterday evening.</p> <p>Observation on 5/13/2025 at 11:35 AM revealed the deep fryer still had the baskets and the pan were still not cleaned.</p> <p>Observation and interview on 5/13/2025 at 2:40 PM revealed the deep fryer and the baskets still had not been cleaned. The DM said the deep fryer was used yesterday to fry shrimp and it should have been cleaned after it was used, and it should be cleaned after each use. The DM said it was all staffs' responsibility to ensure the cleanliness of the kitchen. The DM said when cooks use an appliance, they should make sure the appliance and everything used with it were cleaned. She said they had daily cleaning, weekly and monthly deep cleaning schedules.</p> <p>Interview on 5/16/2025 at 12:28 PM the RD said dirty utilities or appliances for cooking could run the risk of contamination for the residents or food borne illness. The RD said items in the kitchen should be cleaned daily and the fryer should have been cleaned on the day it was used.</p> <p>Interview on 5/16/2025 at 12:33 PM the DM said the items that were used in the kitchen needed to be cleaned to prevent cross contamination and food borne illness.</p> <p>Record review of the facility policy titled General Kitchen Sanitation dated 2018 stated: The facility recognizes that food borne illness has the potential to harm elderly and frail residents. All Nutrition and Food service employees will maintain clean, sanitary kitchen facilities in accordance with the state and US Food Codes in order to minimize the risk of infection and food borne illness. Section 4 stated, in part: Clean and sanitize all multi-use utensils and food-contact surfaces of equipment used in preparation.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049</p> <p>Based on observation, 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 #46) out of 18 residents reviewed for medical records.</p> <p>Facility nurses did not document their initials when they changed Resident #46's oxygen tubing and nasal cannular on the resident's medication administration record.</p> <p>This failure placed residents at risk for missed treatment regarding changing oxygen tubing and nasal cannular as ordered which could result in decline in healing and well-being.</p> <p>Findings included:</p> <p>Record review of Resident #46's face sheet, dated 05/16/2025, revealed the resident was [AGE] years old male and admitted to the facility on [DATE] with diagnosis of osteomyelitis of vertebra (spinal infection), discitis (infection at disc space), heart failure (heart not pumping enough blood to the body), hypertension (high blood pressure), muscle weakness, urinary tract infection (bladder infection), and cirrhosis of liver (chronic liver damage from a variety of causes leading to scarring and liver failure).</p> <p>Record review of Resident #46's admission MDS, dated [DATE], revealed the resident's BIMS was 13 out of 15, which indicated the resident's cognitive was intact, required substantial/maxima; assistance (helper does more than half the effort) to most activities of daily living such as sit to stand, chair to bed, and toilet transfer, and receiving oxygen therapy on Section O (Special Treatments and Programs).</p> <p>Record review of Resident #46's comprehensive care plan, dated 05/14/2025, revealed Oxygen therapy related to heart failure. For intervention - Monitor for signs and symptoms of respiratory distress and report to medical doctor as needed.</p> <p>Record review of Resident #46's physician order, dated 04/24/25, revealed the resident had the orders of continuous oxygen 2 liter per minute via nasal cannular for heart failure and change oxygen tubing every week - every night shift every Sunday.</p> <p>Record review of Resident #46's treatment administration record from 05/01/2025 to 05/31/2025 revealed changing oxygen tubing every Sunday night was scheduled to 05/04/2025 (Sunday) and 05/11/2025 (Sunday), but the dates (5/4/25 and 5/11/25) were left blank.</p> <p>Observation on 05/15/2025 at 4:23 p.m. revealed Resident #46 was sleeping on the bed in his room. The resident had oxygen 2 liter per minute via nasal cannular, and the oxygen tubing and nasal cannular had label for change, and the label indicated they were changed on 05/11/2025.</p> <p>(continued on next page)</p>		

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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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/15/2025 at 4:27 p.m. with ADON stated night nurses changed Resident #46's oxygen tubing and nasal cannular on 05/04/2025 and 05/11/2025, but they did not document on the resident's treatment administration record. Night nurses should have documented on Resident #46's treatment administration record after changing the resident's oxygen tubing and nasal cannular to keep accurate medical record and communicate with other nurses with the documentation.</p> <p>Interview on 05/16/2025 at 11:17 a.m. with DON stated the facility did not have specific policy regarding documenting oxygen tubing and/or nasal cannular after changing them. However, based on reasonable nursing practice, nurses should have documented on Resident #46's treatment administration record after changing the resident's oxygen tubing and nasal cannular to keep accurate medical record and communicate with other nurses with the documentation.</p>		