

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676224	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER The Heights on Huebner		STREET ADDRESS, CITY, STATE, ZIP CODE 10127 Huebner Rd San Antonio, TX 78240	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 48753</p> <p>Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for that described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 8 residents (#5, #6 and #7) reviewed for care plans.</p> <ol style="list-style-type: none"> 1. Resident #5's care plan did not indicate that she had a colostomy (a surgical opening for the colon in the abdomen). 2. Resident #6's care plan did not indicate that she had a foley catheter (a flexible tube that was inserted through the urethra and into the bladder to drain urine). 3. Resident #7's care plan did not indicate that he had a suprapubic catheter (a tube that was inserted through the lower abdomen and directly into the bladder in order to drain urine). <p>The deficient practice could place residents at risk of not having needs identified and interventions established.</p> <p>The findings were:</p> <ol style="list-style-type: none"> 1. Review of Resident #5's face sheet revealed she was an [AGE] year-old female who had an initial admitted [DATE] and a readmitted [DATE]. She had diagnoses which included surgical aftercare following surgery on the digestive system, hypertensive heart disease (heart problems caused by high blood pressure), and dementia (general term for impaired ability to remember, think, or make decisions). <p>Review of Resident #5's MDS, dated [DATE], revealed a BIMS score of 13 indicating no cognitive impairment.</p> <p>Review, on 05/14/2024, of facility list of residents with indwelling devices revealed Resident #5 had a colostomy.</p> <p>Review of Resident #5's May 2024 physician orders revealed orders with a start date of 2/29/2024, that stated to empty colostomy bag every shift for hygiene, check stoma for edema/bleeding Q shift for hygiene and to prevent infection, and clean area around stoma with soap and H2O, pat dry, apply skin prep/stoma adhesive QD every shift for hygiene.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #5's care plan revealed a care plan for a colostomy with a date initiated and created on date of 05/14/2024 (after state surveyor intervention).</p> <p>During an interview with Resident #5 on 05/15/2024 at 11:30am, she stated she had surgery to insert the colostomy approximately three to four months ago and the facility staff provided assistance with emptying and changing the colostomy.</p> <p>2. Review of Resident #6's face sheet revealed he was a [AGE] year-old male who had an admitted [DATE] and readmitted [DATE]. He had diagnoses which included benign prostatic hyperplasia (noncancerous enlargement of the prostate gland).</p> <p>Review of Resident #6's Admission MDS, dated [DATE], revealed Resident #6 had a BIMS score of 3 indicating severe cognitive impairment.</p> <p>Review on 05/14/2024, of facility list of residents with indwelling devices revealed Resident #6 had a foley catheter.</p> <p>Review of Resident #6's May 2024 physician orders revealed an order for a foley catheter with a start date of 04/15/2024.</p> <p>Review of Resident #6's care plan revealed a care plan for an indwelling foley catheter with a date initiated and created on date of 05/14/2024 (after state surveyor intervention).</p> <p>3. Review of Resident #7's face sheet revealed he was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included urine retention (difficulty urinating and emptying of the bladder).</p> <p>Review of resident's MDS dated [DATE] revealed no BIMS score completed on the MDS.</p> <p>Review, on 05/14/2024, of facility list of residents with indwelling devices revealed Resident #7 had a suprapubic catheter.</p> <p>Review of Resident #7's May 2024 physician orders revealed an order for a suprapubic catheter with a start date of 05/08/2024.</p> <p>Review of Resident #7's care plan revealed a care plan for an indwelling suprapubic catheter with an date initiated and created on date of 05/14/2024 (after state surveyor intervention).</p> <p>During an interview with the MDS Coordinator on 05/16/2024, she stated the purpose of the care plan was to plan the residents care and personalize the care to the resident so that the facility is following the resident's wishes and preferences. She stated the care plan was fluid and should reflect the resident's current care. She stated the care plan should be updated upon admission and when something changes with the resident's care. She furthermore stated, she updated several resident's care plans to include indwelling devices on 05/14/2024 after this state investigator's arrival to the facility and stated these devices should have been care planned upon admission or when the devices were implanted. She stated it was important to care plan these devices because they were part of the resident's plan of care.</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 - Some</p>	<p>During an interview with the DON on 05/16/2024 at 1:12pm, she stated her expectation was for a resident's care plan to be updated upon admission and within twenty-four hours of any changes. She also stated it was important for the care plan to be accurate because it was a reflection of the resident's individualized care and needs.</p> <p>Review of the facility policy titled Care Plans, dated February 2017 and revised January 2023, stated the community develops a comprehensive care plan for each resident that includes measurable objectives to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The care plan in conjunction with the plan of care throughout the medical record is developed and or recommended to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. It also stated, the care plan should be initiated upon admission, continued to be developed during the initial 48-72 hours, throughout the completion of the admission comprehensive assessment.</p>