

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 11/20/2025
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 - 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>(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 - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that include measurable objectives and time frames to meet residents' mental, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and to ensure that the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including the right to refuse treatment for 2 of 6 residents (Residents #1 and #2) reviewed for care plans, in that: Resident #1 and Resident #2's care plan was not updated to reflect their need of being fed at mealtimes. This failure could affect residents who have care areas not addressed by the care plans by not having their needs met and putting them at risk of not receiving appropriate care. The findings included: Record review of Resident #1's admission record, dated 11/04/25, reflected an [AGE] year-old female initially admitted [DATE] and re-admitted [DATE] with diagnoses to include dementia (loss of cognitive functioning that interferes with daily life and activities), Parkinson's disease (movement disorder of the nervous system) with dyskinesia (involuntary muscle movements), and Protein calorie malnutrition. Record review of Resident #1's quarterly MDS assessment, dated 10/20/25, reflected Resident #1 had a BIMS of 4 out of 15, indicating severely impaired cognition. It revealed Resident #1 needed supervision or touching assistance when eating. Record review of Resident #1's care plan, undated, reflected .Eating & Drinking: I am able to feed my self and drink without physical assistance. May need to prepare my tray/foods and drinks.; initiated 10/04/22. Record review of Resident #1's SLP Evaluation and Plan of Treatment, dated 10/06/25-11/04/25, reflected Resident #1 required supervision/assistance at mealtime 76-90% of the time. Record review of Resident #2's admission record, dated 11/05/25, reflected a [AGE] year-old female initially admitted [DATE] and re-admitted [DATE] with diagnoses to include muscle wasting and atrophy, protein-calorie malnutrition, cognitive communication deficit, muscle weakness, lack of coordination, and dementia (loss of cognitive functioning that interferes with daily life and activities). Record review of Resident #2's MDS assessment (no type selected), dated 10/20/25, reflected Resident #2 had a BIMS of 4 out of 15, indicating severely impaired cognition. It further reflected Resident #2 needed partial/moderate assistance with eating. Record review of Resident #2's care plan, undated, reflected .Eating & Drinking: I am able to feed my self and drink without physical assistance. May need to prepare my tray/foods and drinks.; initiated 02/13/25. Record review of Resident #2's OT Discharge summary, dated [DATE]-[DATE], reflected Resident #2 needed partial/moderate assistance when performing eating tasks. Interview and observation on 11/04/25 at 12:38 PM, LVN B was sitting at the table with Resident #1 and Resident #2. She was currently helping Resident #1 eat. She revealed both of these residents needed help getting fed. Interview on 11/05/25 at 02:25 PM, CNA A revealed some days Resident #1 will feed herself and staff will help at the end of the meal. She revealed sometimes staff needed to help Resident #1 with her meal the whole mealtime. She revealed the staff knew what resident needed assistance by keeping an eye on the residents in the dining room, but CNAs also used the Kardex (a section in residents' medical record that told the CNAs what to do for resident care) to find out about resident care. Interview on 11/05/25 at 02:53 PM, LVN B revealed both Resident #1 and Resident #2 needed help getting fed at mealtimes. She revealed she knew a resident needed help with eating based on observations at mealtimes and did not need a care plan to know this. Interview on 11/06/25 at 11:52 AM, SLP revealed he worked with Resident #1 and not Resident #2. He revealed Resident #1 needed help with eating at mealtimes. He revealed it was important for Resident #1 to receive help at mealtimes so she could receive proper nutrition, and it would be a safety issue if she did not receive help. Interviews on 11/06/25 at 01:01 PM, MDS nurse C and MDS nurse D revealed multiple staff were able to update resident care plans because it could be challenging for MDS nurses to be able to document everything necessary for resident care in their respective care plans. They revealed they oversaw that the care plans were up to date but might miss some updates. MDS nurse C revealed Resident #1 would sometimes feed herself, but other days Resident #1 needed help with eating. MDS nurse C further revealed Resident #2 also needed help eating and their care plans needed to be updated. MDS nurse D revealed updating care plans were important because it was the residents' plan of care and a blueprint. Interview on 11/06/2025 at 01:27 PM, the ADON revealed Resident #1 and Resident #2 needed help when being fed and the nursing staff looked at care plans to know this about resident care. Interview on 11/06/25 at 04:35 PM the DON and ADM revealed it</p>		