

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.

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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 01/14/2026
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.			
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #9's admission sheet dated 10/11/2024 with an initial date of 4/26/2024 documented a [AGE] year-old female resident with diagnoses including dementia, cerebral palsy (a condition affecting a person's ability to control their muscles and movements), epilepsy, anxiety, schizoaffective disorder (a disorder that includes symptoms of both schizophrenia [such as hallucinations and delusions] and mood disorders [such as depression or mania]), bipolar disorder (a disorder of severe mood swings, including manic highs and depressive lows), and hypertension (high blood pressure). Record review of Resident #9's MDS dated [DATE] documented a BIMS score of 12 indicating moderate cognitive impairment and recorded the use of antipsychotic, antianxiety, antidepressant, diuretic, and opioid medication. Further review of the MDS revealed the assessment did not include the resident's use of anticonvulsant medication. Record review of Resident #9's order summary documented an active order for the anticonvulsant medication Depakote with an order date of 10/11/2024. Record review of Resident #9's December 2025 MAR documented the resident had been receiving Depakote as prescribed. Further review of the December MAR recorded Depakote was ordered as Depakote 125mg, Give 3 tablet by mouth three times a day for Seizures 3 tabs to equal 375mg. Record review of Resident #9's care plan with an initiation date of 5/29/2024 documented the resident requires psychotropic medications and I am at potential risk for side effects r/t my medication regimen., with a goal the resident will be/remain free of drug related complications, including movement disorder, discomfort, hypotension (low blood pressure), gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. 3. Record review of Resident #46's admission sheet dated 4/09/2025 with an original admission date of 12/21/2023 documented a [AGE] year-old male resident with diagnoses including cerebral infarction, heart disease, peripheral vascular disease, type 2 diabetes, depression, hypertension, and post-traumatic stress disorder. Record review of Resident #46's MDS assessment dated [DATE] documented a BIMS score of 15 indicating intact cognition. Further review of Resident #46's MDS revealed the assessment did not document the resident's use of antiplatelet medication. Record review of Resident #46's order summary included an active order for the antiplatelet medication Clopidogrel with an order date of 5/13/2025. Record review of Resident #46's December 2025 MAR documented the resident had been receiving Clopidogrel as prescribed. Clopidogrel was ordered as Clopidogrel 75mg, Give 75 mg by mouth one time a day. Record review of Resident #46's care plan with an initiation date of 7/29/2024 documented the resident was prescribed medication/medications that lens me to a risk for abnormal bleeding, easily bruised and/or skin issues/injury. Anti-platelet., with interventions including Inspect my skin during care and report all skin injuries as indicated. 4. Record review of Resident #68's admission sheet dated 6/12/2025 documented a [AGE] year-old female resident with diagnoses including dementia, kidney failure, type 2 diabetes mellitus, heart (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disease, hyperlipidemia (high cholesterol), and depression Record review of Resident #68's MDS assessment dated [DATE] documented a BIMS score of 12 indicating moderate cognitive impairment. Further review of MDS revealed the assessment did not include the resident's use of antiplatelet and hypoglycemic medication. Record review of Resident #68's order summary included an active order for the antiplatelet medication Aspirin with an order date of 6/12/2025 and active orders for the hypoglycemic medications Insulin Glargine with an order date of 6/19/2025 and Insulin Lispro with an order date of 6/13/2025. Record review of Resident #68's December 2025 MAR documented the resident was receiving Aspirin, Insulin Glargine, and Insulin Lispro as prescribed. Aspirin was ordered as Aspirin 81mg, Give 1 tablet by mouth one time a day. Insulin Glargine was ordered as Insulin Glargine 100 unit/mL, Inject 10 unit subcutaneously one time a day for Diabetes HOLD for BS less than 100. Insulin Lispro was ordered as Insulin Lispro 100 unit/mL, Inject as per sliding scale: If 150-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units Greater than 400 administer 12 units and notify MD, subcutaneously before meals and at bedtime for Diabetes. Record review of Resident #68's care plan with an initiation date of 6/12/2025 documented the resident was prescribed medication/medications that lends me to a risk for abnormal bleeding, easily bruised and/or skin issues/injury., with interventions including to monitor the resident for abnormal bleeding and monitor my skin for excess bruising as indicated. Further review of the care plan documented the resident has diabetes and I am at risk for: Complications associated with diabetes: Frequent Infections, Diabetic wounds, Vision Impairment, Hyper/Hypo-Glycemia, Renal Failure, Cognitive/Physical Impairment., with interventions including Administer my medications as recommended by my doctor, monitor labs as indicated. Promptly report abnormal labs results and significant clinical findings to my doctor as indicated. During an interview with the MDS LVN on 1/13/2026 at 3:28 PM, the MDS LVN stated, she gathered data for the MDS from interviews with the residents and family and information received from staff including nurses, social services, and rehab. The MDS LVN stated she made sure the MDS was complete and presented it to the MDS RN. The MDS LVN stated it was important for the assessment to be accurate, because it gave a picture of a resident and helps with care planning. The MDS LVN stated the MDS was part of a resident's care, and an accurate assessment helps with the coordination of care with other entities. During an interview with the DON on 1/14/26 at 9:10 AM, the DON stated her expectation for the MDS assessments was for them to be updated when there were changes. The DON stated medications could change all the time, and she expected them to be accurate because that was how they bill. During an interview with the MDS RN on 1/14/26 at 1:12 PM, the MDS RN stated she is the one ultimately responsible for the accuracy of the MDS. The MDS RN stated she expected her staff to enter information for the MDS correctly before they submit it to her. The MDS RN stated it was important for the MDS to be accurate, because it reflects a resident's care, what a resident receives at the facility, and how they bill. 5. Record review of the admission Record for Resident #125 documented an [AGE] year-old male admitted [DATE]. His diagnoses included cerebral infarction (stroke), Type 2 diabetes mellitus with (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unspecified diabetic retinopathy without macular edema (a form of diabetes where there are signs of eye damage and don't involve swelling in the macula), legal blindness, and peripheral vascular disease (slow progressive disorder of the blood vessels). Record review of Resident #125's MDS dated [DATE] revealed a BIMS score of 14 indicating the resident's cognition was intact. Under Section M, Skin Conditions, the following entries were made: -M0210 Unhealed Pressure Ulcers/Injuries was marked Yes - M0300 Current number of Unhealed Pressure Ulcers/Injuries at Each Stage, answers for the number of pressure ulcers was marked 0. - Section F #1 &ndash; Unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar &ndash; the number entered was 2. - Section F #2 &ndash; Number of these unstageable pressure ulcers that were present upon admission/entry or reentry &ndash; the number entered was 2. -M1040 &ndash; Other Ulcers, Wounds and Skin Problems Item B &ndash; Diabetic foot ulcer(s) was checked. Record review of Resident #125's Care Plan dated 12/02/25 revealed a focus for actual or at risk for skin impairment and noted actual sites: left heel and left 2nd toe. Record review of Resident #125's Initial Skin Issues report prepared by Treatment Nurse, RN L, with effective date of 12/2/25 and a created date of 12/9/26, revealed 6 areas of skin issues including pressure ulcer of left heel, diabetic foot ulcer on 2nd digit (toe), other skin issue on right dorsum 1st digit (great toe), pressure ulcer on right heel, pressure ulcer on sacrum (lower back), and pressure ulcer of right medial malleolus (inner ankle). During an interview with RN L on 01/12/26 at 1:00 pm, RN L stated that Resident #125 had been admitted with 6 wounds which were treated and all except 2 had been resolved. RN L stated she would provide her written skin report. During an interview with the MDS LVN on 1/13/2026 at 3:28 PM, the MDS LVN stated, she gathered data for the MDS from interviews with the residents and family and information received from staff including nurses, social services, and rehab. The MDS LVN stated she made sure the MDS was complete and presented it to the MDS RN. The MDS LVN stated it was important for the assessment to be accurate, because it gave a picture of a resident and helped with care planning. The MDS LVN stated the MDS was part of a resident's care, and an accurate assessment helps with the coordination of care with other entities. During an interview on 01/13/26 at 4:00 pm with MDS LVN, the MDS LVN stated that all but 2 of the skin conditions had been resolved by the time the last MDS assessment was completed on 12/11/25. The MDS LVN also stated that the look back period to consider answers for this area of the MDS was 7 days which would include 12/4/25 through 12/11/25. Since all 6 wounds identified in the initial skin report were still present during this time period, the MDS LVN acknowledged they should have been included on the MDS. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Comprehensive Assessments with a revision date of March 2023 noted The community uses the Resident Assessment Instrument (RAI) to develop the comprehensive resident assessment. It identifies the care, services, and treatments that each resident needs to attain or maintain his or her highest practicable mental and physical functional status., and .The RAI is the primary assessment tool used in the comprehensive assessment process., and .Each resident receives an accurate team member assessment of relevant care areas that provide team members with knowledge of each resident's status, needs, strengths, and areas of decline., and .A registered nurse conducts or coordinates the assessment. The coordinator ensures that appropriate and qualified professionals contribute to the assessment. Regardless of whether the registered nurse conducts or coordinates, he or she is responsible for certifying that the assessment has been completed. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 dated October 2025 revealed in section J0100: Pain Management scheduled pain medication regimen was defined as Pain medication order that defines dose and specific time interval for pain medication administration. In the section Coding Instructions for J0100A, Been on a Scheduled Pain Medication Regimen, the user's manual noted Code 1, yes: if the medical record contains documentation that a scheduled pain medication was received. Section N0415: High-Risk Drug Classes: Use and Indication noted Medications are an integral part of the care provided to residents of nursing homes., and Residents taking medications in these medication categories and pharmacologic classes are at risk of side effects that can adversely affect health, safety, and quality of life., and Review the resident's medical record for documentation that any of these medications were received by the resident and for the indication of their use during the 7-day look back period. and Code all high-risk drug class medications according to their pharmacological classification, not how they are being used.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 4 (Resident #4, Resident #103, Resident #26, and Resident #144) of 22 residents reviewed for accidents and hazards.1. The facility failed to ensure Resident #144 and Resident #103 did not have a disposable razor in his room.2. The facility failed to ensure Resident #4 did not have prohibited chemical and topical products stored in her room.3. The facility failed to ensure Resident #26 did not have prohibited medications and flammable products stored in his room.These failures could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health.The findings included: 1. Record review of Resident #144's face sheet date 1/13/26 reflected an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included lack of coordination, syncope and collapse (sudden, brief loss of consciousness with loss of postural tone followed by spontaneous complete recovery, fainting), and muscle weakness. Record review of Resident #144's baseline care plan dated 1/7/26 reflected that the resident was at risk for falls and had a self-care deficit with interventions that included to provide ADL care as indicated. Resident #144's baseline care plan reflected that the resident required dressing and grooming assistance with 1 person assist related to recent hospitalization that resulted in weakness and debility. Record review of Resident #103's face sheet dated 1/13/26 reflected a 79- year-old male admitted to the facility on [DATE] with diagnoses that included dementia (a chronic progressive syndrome characterized by a decline in memory, thinking, reasoning, language, and the ability to perform daily activities severe enough to interfere with independent functioning), Parkinson's disease (chronic, progressive neurodegenerative disorder characterized primarily by motor dysfunction), diabetes (a chronic metabolic disorder characterized by persistent elevated blood glucose levels cause by defects in insulin secretion, insulin action, or both), unsteadiness on feet, and abnormalities of gait and mobility. Record review of Resident #103's most recent quarterly MDS assessment dated [DATE] reflected the resident was severely cognitively impaired for daily decision-making skills and required setup or clean-up assistance with personal hygiene including shaving. Record review of Resident #103's comprehensive care plan with revision date 1/13/26 reflected the resident had a self-care deficit weakness and debility, cognitive impairment, and limited physical functioning related to stiff or limited joint range of motion, and had Parkinson's with interventions that included 1 person assist with hygiene. During an observation on 1/13/26 at 9:20 a.m., a light blue handle disposable razor was observed on Resident #144's dresser at the foot of the bed. During an observation and interview on 1/13/26 at 11:55 a.m., Resident #144 stated he was newly admitted to the facility and admitted on Thursday (1/8/26) related to a bad attack and was on the floor for over a day before somebody found him. Resident #144 was observed with a light blue handle disposable razor on the resident's dresser at the foot of the bed. Resident #144 stated the disposable (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	razor observed was provided to him by his family member two days ago. Resident #144 stated he last used the disposable razor that morning during his shower. Resident #144 stated he was not assisted with his showers and was able to go into the shower room without staff assistance. During an observation on 1/13/26 at 11:58 a.m., Resident #103 was observed with a cup at the bedside that had 5 pink handle disposable razor blades. During an observation and interview on 1/13/26 at 1:41 p.m., Resident #103 summoned CNA F into his room and stated someone had come into his room and took his personal items that included cologne and his disposable razors. Resident #103 stated the disposable razor blades were his personal property, and he last used them to shave himself the previous evening during his shower. During an observation and interview on 1/13/26 at 1:44 p.m., with CNA F revealed Resident #144 in his room with family visiting at the bedside. Resident #144 stated, somebody came into his room and took the disposable razor that was on top of the dresser. Resident #144's family member stated he had brought the disposable razors to the resident and a second family member stated there were more disposable razors on the bottom drawer of the dresser. CNA F opened the bottom drawer of Resident #144's dresser and pulled out a disposable razor. CNA F stated that disposable razors were not allowed in the resident's room because it was considered a safety hazard and other residents could wander into the room and have access to it and could accidentally cut themselves. CNA F stated, for a resident to be able to keep a disposable razor in their room it had to be care planned. CNA F stated there was no particular staff assigned to look for or monitor for items that could potentially be a safety hazard as it was everybody's responsibility. During a follow up interview on 1/13/26 at 1:45 p.m., CNA F stated there was only one resident he knew of who was allowed to shave himself and that resident used an electric shaver. CNA F stated Resident #103 and Resident #144 were not supposed to have disposable razors in their rooms because the razors were considered an accident hazard and the residents could cut themselves. CNA F stated, in addition, the facility had residents who wandered and that person could have access to the disposable razors and potentially cut themselves. CNA F stated that residents who were capable of shaving themselves still had to have staff on standby in case there was an accident. During an interview on 1/14/26 at 9:19 a.m., the DON stated she was not aware or could not think of residents who wandered into other resident's rooms. The DON stated she was not aware of any residents who could independently shower. The DON stated, if a resident's care plan reflects the resident had a 1-person assistant, then that meant there was standby assistance by staff. The DON stated residents were allowed to have disposable razor blades in their rooms as long as it was care planned. The DON stated that residents needed to be assessed to safely use the disposable razor and it was for safety reasons. 2. Record review of Resident #4's admission record revealed a female originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included spinal stenosis of the cervical region (narrowing of the spinal canal in the neck that can compress the spinal cord and nerves causing pain, weakness, or numbness), heart failure (a chronic condition in which the heart is unable to pump blood effectively), hypertension (persistently elevated blood pressure), and diabetes mellitus (a chronic metabolic disorder characterized by elevated blood glucose levels). Record review of Resident #4's admission MDS, dated [DATE], revealed the resident's BIMS score was 15. Section GG of the MDS revealed the Resident #4 was dependent on staff for personal (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hygiene; indicating the helper did all of the effort for the activity or that two or more helpers were required. Record review of Resident #4's care plan, created on 11/20/25 and last revised on 1/1/26, revealed a self-care deficit related to spinal stenosis, dysphagia, cardiac disease, diabetes mellitus, weakness and debility, and immobility. The care plan revealed the resident required dressing and grooming with two-person assistance. Record review of Resident #4's physician orders dated 1/13/26 revealed no orders for the resident to self-administer medications or topical agents. During an observation on 1/13/26 at 11:34 a.m., a bottle of medical adhesive remover (a chemical solvent used to remove medical tape and dressings, labeled as flammable) and a bottle of pain relief cream containing lidocaine hydrochloride 4% (a topical anesthetic used to numb pain, labeled keep out of reach of children) were observed on Resident #4's bedside dresser. During an interview on 1/13/26 at 11:35 a.m. Resident #4 stated she was unsure where the adhesive remover spray came from, but she thought her family possible brought in the lidocaine ointment for her to use but she had not used it because the facility was placing lidocaine patches on her. During an interview on 1/13/26 at 11:14 a.m., LVN G stated Resident #4 was not supposed to have those items and she had not noticed them prior. LVN G removed the items and stated she would place them on the medication cart. 3. Record review of Resident #26's admission Record/Face Sheet, dated 4/29/24, revealed a [AGE] year-old male admitted with diagnoses including effusion of the left knee (abnormal accumulation of fluid within the knee joint causing swelling and pain), acute diastolic (congestive) heart failure (a condition in which the heart is unable to relax and fill properly, resulting in fluid buildup and decreased blood flow), and vascular dementia (a decline in cognitive function caused by reduced blood flow to the brain). Record review of Resident #26's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15. Section GG revealed the Resident #26 required setup or clean-up assistance for personal hygiene. Record review of Resident #26's admission/readmission care plan initiated 4/29/24 revealed the resident was at risk for self-care deficit, falls, skin concerns, pain, infection, nutritional and hydration concerns, and emotional distress related to weakness and debility. Interventions included administering medication and treatments as ordered, providing ADL care as indicated, monitoring health status, and referring concerns to nursing staff. Record review of Resident #26's physician orders, dated 1/13/26, revealed no orders for the resident to self-administer medications or topical agents. During an observation and interview on 1/12/26 at 10:44 a.m., a bottle of rubbing alcohol (a flammable antiseptic chemical) and a bottle of aerosol lidocaine spray (a topical anesthetic delivered in aerosol form) were observed on top of the dresser in plain sight. Resident #26 stated he used the lidocaine for his hand, and he could have whatever items he wanted because he had been there for some time. During an interview on 1/13/26 at 11:47 a.m. ADON G stated medications, and topical products should (continued on next page)		

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview and record review, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 of 8 residents (Residents #4) reviewed for medical records. 1. The facility failed to ensure Resident #4's medication consent form was missing the nurse signature required to witness on the original medication consent for her antidepressant medication venlafaxine and the replacement consent form did not include the medication name. 2. The facility failed to ensure Resident #4's medication orders and Medication Administration Record (MAR) accurately reflected the correct route of administration, medications were documented as administered by mouth when the resident received all medications via gastrostomy tube (G-tube) (a tube surgically placed through the abdominal wall into the stomach to provide nutrition, fluids, and medications when a person cannot safely swallow). 3. The facility failed to ensure Resident #4's out-of-hospital Do Not Resuscitate (OOH DNR) document was clear and accurately completed, the physician's signature was not placed in the designated signature area. This deficient practice could place residents at risk of delayed or improper care due to inaccurate medical records. The findings include: 1. Record review of Resident #4's admission record revealed a female originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included spinal stenosis of the cervical region (narrowing of the spinal canal in the neck that can compress the spinal cord and nerves causing pain, weakness, or numbness), heart failure (a chronic condition in which the heart is unable to pump blood effectively), hypertension (persistently elevated blood pressure), encounter for surgical aftercare following surgery on the digestive system (a follow-up medical encounter for care, monitoring, and recovery after a surgical procedure involving the gastrointestinal tract). and diabetes mellitus (a chronic metabolic disorder characterized by elevated blood glucose levels). Record review of Resident #4's admission MDS, dated [DATE], revealed the resident's BIMS score was 15 (fully intact cognition). Section K revealed the resident had a feeding tube. Record review of Resident #4's care plan, created on 11/20/25 and last revised on 01/01/26, revealed the resident required a feeding tube related to dysphagia and was NPO (nothing by mouth). The care plan revealed the resident received enteral nutrition and was on EBH precautions related to the PEG tube, required the head of bed to be elevated and to avoid lying flat while feedings were running, and required staff to cue and assist with positioning. The care plan further revealed staff were to provide local care to the G-tube site as ordered, monitor for signs and symptoms of infection, and refer any feeding pump or care concerns to nursing. During a record review on 1/14/26 at 9:24 a.m. Resident #4 had a consent in the EHR for medication venlafaxine (an antidepressant medication used to treat depression, anxiety, and panic disorders by increasing levels of serotonin and norepinephrine in the brain). The consent was signed and dated by Resident #4 but was blank under the section for the person obtaining permission. During an observation, interview, and record review on 1/14/26 at 11:13 a.m. ADON C provided a different copy of Resident #4's Medication consent, dated 1/8/26. The document was blank in the section for Psychotropic Medication Prescribed, stated it was for depression, the area for the Residents information indicated she gave verbal consent, and was signed by a person obtaining the permission. ADON C stated the form should list the medication you are getting consent for so the resident was aware of what the medication was, what drug category it was in, and what they are consenting to. 2. Record review of Resident #4's active physician orders, dated 1/13/26, revealed two active orders for Venlafaxine HCl 37.5 mg for depression. One order directed to give one tablet by mouth one time a day, and a second order directed to give one tablet via PEG-tube one time a day. The orders reflect ADON C entered the orders for this medication. Record review of Resident #4's January 2026 Medication Administration Record (MAR) reflected: Duloxetine HCl 30 mg (an antidepressant used to treat depression and (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anxiety) ordered give 1 capsule by mouth one time a day for depression (01/09/26-01/11/26) and also give 1 capsule via PEG-tube one time a day for depression (beginning 01/12/26). The MAR showed the Duloxetine was administered by mouth on 1/10/26 and 1/11/26.-Lokelma 10 g oral packet (a potassium-binding medication used to treat high potassium levels) ordered give by mouth one time a day (01/09/26-01/11/26) and also give via G-tube one time a day (beginning 01/11/26). The MAR showed the lokelma was administered by mouth on 1/10/26.-Amoxicillin 500 mg (a broad-spectrum antibiotic used to treat bacterial infections) ordered give by mouth two times a day (01/10/26-01/11/26) and also give via G-tube two times a day (beginning 01/11/26). The MAR showed the amoxicillin was administered by mouth twice on 1/12/26 and once on 1/11/26.-Hydroxyzine HCl 10 mg (an antihistamine used to treat anxiety and agitation) ordered give 1 tablet by mouth every 8 hours as needed for anxiety/agitation (01/05/26-01/11/26) and also ordered give 1 tablet via G-tube every 8 hours as needed (beginning 01/11/26). The MAR showed hydroxyzine was administered on 1/5/26 and 1/9/26 by mouth.-Loperamide HCl 2 mg (an antiarrheal medication used to treat loose stools) ordered give 1 tablet by mouth every 12 hours as needed (12/24/25-01/05/26) and also ordered give 1 tablet via PEG-tube every 12 hours as needed (beginning 01/05/26).-Venlafaxine HCl 37.5 mg (an antidepressant used to treat depression) ordered give 1 tablet by mouth one time a day (01/13/26) and also ordered give 1 tablet via PEG-tube one time a day (beginning 01/14/26). The MAR reflected Venlafaxine was never administered. During an interview on 1/14/26 at 10:37 a.m. RN I stated Resident #4 always received her medication via g tube and not by mouth. RN I stated she had contacted the provider to correct the orders from by mouth to via peg tube. RN I stated although the resident never took any of the medications by mouth the orders should reflect via peg tube because the resident could aspirate if taken orally. During an interview on 1/14/26 at 11:13 a.m. ADON C stated the resident's antidepressant medication was changed from duloxetine to venlafaxine because it was easier to crush and administer via her peg tube. ADON C stated Resident #4 never received any medication orally despite what the orders showed and what was check off as administered on the MAR. ADON C stated after they deactivated the orders, they would continue to show active for that day but would be discontinued the following day. 3. Record review of Resident #4's out-of-hospital Do Not Resuscitate (OOH DNR), dated 11/21/25, revealed the resident's signature was present in Section A. The form contained a handwritten signature in the section labeled Attending Physician in the middle portion of the document. The section at the bottom of the form labeled All persons who have signed above must sign below, acknowledging that this document has been properly completed contained the resident's signature written across the line for the attending physician, and the physician signature line in that section was blank. A handwritten arrow was present in the same section for the attending physician signature to a blank line below. During an interview on 1/13/26 at 4:58 p.m. the SW stated the physicians' signature appeared to be present on the DNR in both sections required on the DNR. When this surveyor again reviewed the physician signature line remained blank. The SW stated it could be redone to look better but the DNR was still valid. During an interview on 1/14/26 at 1:42 p.m. the DON stated they did not have a policy for medical record documentation or nursing documentation. The DON stated she did not think they had a policy for consent but would check. No policies were provided.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 5 of 6 residents (Resident #7, Residents #97, Resident#34. Resident #144 and Resident #4) reviewed for infection control.1. The facility failed to ensure CNA D sanitized the pulse oximeter used between Resident #7 and Resident #97.2. The facility failed to ensure MA E sanitized the blood pressure cuff used between Resident #34 and Resident #144.3. The facility failed to ensure Resident #4's wound bed did not come in contact with a used bed sheet after it was cleaned while RN L was performing wound care. 4. The facility failed to ensure CNA J and CNA K did not hold Resident #4's catheter above bladder level. These failures could place residents at risk for cross contamination and infection. The findings included: 1. Record review of Resident #7's face sheet dated 1/13/26 reflected an [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included respiratory bronchiolitis interstitial lung disease, heart failure, and respiratory failure. Record review of Resident #7's comprehensive care plan with revision date 1/2/26 reflected Resident #7 was at risk of experiencing shortness of breath and required oxygen therapy related to ineffective gas exchange with interventions that included monitoring for signs and symptoms of respiratory distress and report to the physician as needed respirations and pulse oximetry. Record review of Resident #97's face sheet dated 1/13/26 reflected a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included morbid obesity due to excess calories, hyperlipidemia, and respiratory disorders. Record review of Resident #97's comprehensive care plan with revision date 12/16/25 reflected the resident was at risk for significant infections and/or current infections related to compromised medical condition with interventions that included to monitor vital signs as indicated. Resident #97's comprehensive care plan reflected the resident was at risk of experiencing shortness of breath. During an observation on 1/13/26 at 8:19 a.m., CNA D entered Resident #7's room and obtained an oxygen saturation reading with the pulse oximeter. CNA D exited the room, documented his finding on a sheet of paper and re-entered the same room and obtained Resident #97's oxygen saturation with the same pulse oximeter used on Resident #7. CNA D documented his finding on the sheet of paper and walked down the hall to deliver the sheet of paper to an unidentified male nurse. 2. Observation on 1/13/26 at 8:29 a.m. during the medication pass, revealed MA E placed the wrist blood pressure cuff around her left wrist and prepared medications for Resident #34. MA E removed the wrist blood pressure cuff from her left arm and placed it on Resident #34's right wrist. MA E did not sanitize the wrist blood pressure cuff prior to placing it on Resident #34's right wrist. MA E, after obtaining Resident #34's blood pressure, removed the wrist blood pressure cuff and placed it on the medication cart counter. MA E then prepared Resident #144's medications and took the wrist blood pressure cuff and placed it on Resident #144's left wrist. MA E did not sanitize the wrist blood pressure cuff after using it on Resident #34 or before using it on Resident #144. During an interview on 1/13/26 at 9:20 a.m., MA E stated, the wrist blood pressure cuff she used was her own personal equipment and used it throughout the shift. MA E stated she never thought about (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sanitizing the wrist blood pressure cuff between residents and was not sure how to do it. MA E stated, I guess it (blood pressure cuff) would be cleaned between residents because of cross contamination. MA E stated, if there was cross contamination, the resident could get an infection or pass on an infection to somebody else. During an interview on 1/13/26 at 9:26 a.m., CNA D stated he had obtained oxygen saturations on Resident #7 and Resident #97. CNA D stated that the pulse oximeter used was his personal equipment that he used throughout the shift. CNA D stated he used a sanitizing wipe to disinfect the pulse oximeter after he used it on Resident #7 and before he used it on Resident #97. CNA D obtained the package of wipes he stated he used to sanitize the pulse oximeter from Resident #7 and Resident #97's room and presented a package of wet wipes use for incontinence care. CNA D stated the wipes were used for incontinence care and he should have been using the micro kill disinfectant wipes to clean the pulse oximeter instead. CNA D exited the resident room and went down the hall and presented a container marked, Germicidal Alcohol Wipes. CNA D stated, the germicidal wipes were supposed to be used to properly disinfect the pulse oximeter, otherwise there was a risk of cross contamination, and an infection could occur between the residents. CNA D stated he had received infection control in-service training approximately 2 to 3 weeks ago. During an interview on 1/14/26 at 9:14 a.m., the DON stated it was her expectation that medical equipment, such as pulse oximeters and blood pressure cuffs, should be disinfected prior to use and between residents to prevent cross contamination and to prevent an infection. The DON stated that incontinent wipes should not be used to clean medical equipment. Record review of the facility document titled Cleaning and Disinfecting Non-Critical Resident-Care Items with revision date June 2011 revealed in part, .The purpose of this procedure is to provide guidelines for disinfection of non-critical resident-care items.Non-critical items are those that come in contact with intact skin but not mucous membranes.Non-critical resident-care items include.blood pressure cuffs.Reusable items are cleaned and disinfected or sterilized between residents.low-level disinfectants for non-critical items include.ethyl or isopropyl alcohol.phenolic germicidal detergents. 3. Record review of Resident #4's admission record revealed a female originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included spinal stenosis of the cervical region (narrowing of the spinal canal in the neck that can compress the spinal cord and nerves causing pain, weakness, or numbness), heart failure (a chronic condition in which the heart is unable to pump blood effectively), hypertension (persistently elevated blood pressure), encounter for surgical aftercare following surgery on the digestive system (a follow-up medical encounter for care, monitoring, and recovery after a surgical procedure involving the gastrointestinal tract). and diabetes mellitus (a chronic metabolic disorder characterized by elevated blood glucose levels). Record review of Resident #4's admission MDS, dated [DATE], revealed the resident's BIMS score was 15 (fully intact cognition). Section H revealed the resident had a indwelling catheter. Record review of Resident #4's care plan, created on 11/20/25 and last revised on 01/01/26, revealed the resident had actual or at risk for skin impairment with a pressure injury to the sacrum and a surgical wound to the right shoulder. The care plan revealed the resident was to receive skin treatments as ordered, use pressure relieving devices and a therapeutic pressure reducing mattress, and remain free from complications related to skin injury. The care plan further revealed the resident was at risk for infection related to a compromised medical condition and was to be monitored for signs and symptoms of infection. The care plan revealed the resident required a urinary catheter and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was at risk for catheter related injury and infection, and staff were to provide catheter care each shift and as indicated, check tubing for kinks, and maintain catheter safety. Record review of Resident #4's active physician orders, dated 12/22/25, revealed orders for an 18 French Foley catheter with a 10 cc balloon to be changed monthly and as needed, an order for the Foley catheter to be changed every night shift starting on the 15th and ending on the 15th of each month, and an order for Foley catheter care with perineal wipes and/or soap and water every shift. Record review of Resident #4's active wound care orders, dated 01/06/26, revealed an order to cleanse the sacral wound with wound cleanser or normal saline, pat dry, apply Medihoney (a medical-grade honey product used to promote wound healing and prevent bacterial growth), cover with calcium alginate (an absorbent dressing derived from seaweed used to manage wound drainage and support healing), and secure with a dry dressing every day shift for the sacrum (the triangular bone at the base of the spine, located between the hip bones, that forms the back part of the pelvis) and buttocks. During an observation on 1/13/26 at 9:58 a.m., RN L, wearing clean gloves, was observed cleansing Resident #4's sacral wound bed from the center outward. RN L removed her gloves, performed hand hygiene, donned new gloves, and blotted the wound bed with dry gauze when slight bleeding was noted. RN L then removed her gloves, performed hand hygiene, and donned new gloves again. While RN L was performing wound care, CNA J was observed assisting to hold the resident in a side-lying position. CNA J began to allow the resident to roll backward, and the resident's wound bed came into contact with the bed sheet. RN L then asked CNA J if there was a clean sheet available. CNA J pointed to the bedside table and stated a clean sheet was available to change out. The resident's wound bed remained in contact with the bed sheet at that time. RN L then instructed CNA J to reposition the resident to allow full access to the wound bed. RN L applied Medihoney to the wound bed and secured the dressing. The wound bed was not cleansed again after it had come into contact with the bed sheet. During an interview on 1/13/26 at 10:15 a.m., RN L stated she did not notice the wound bed had come into contact with the bed sheet during wound care. RN L then stated she cleaned the wound bed after it touched the sheet. When asked what should occur if a wound bed touches a bed sheet, RN L stated the sheet would be considered contaminated and the wound bed should be cleansed again because it places the resident at risk for infection. During an interview on 1/14/26 at 9:05 a.m., the DON stated RN L had informed her that the surveyor questioned the wound bed touching the bed sheet during wound care. The DON stated RN L reported she was not aware the wound bed had touched the sheet and stated she had cleaned the wound bed. The DON stated if a wound bed comes into contact with a bed sheet, staff were expected to cleanse the wound bed again because it places the resident at risk for infection if not. Record review of the facility document titled Charge Nurse Proficiency Check Offs for RN L, dated 01/15/2025, revealed she was evaluated and signed off as competent in wound care, G-tube medication administration, hand hygiene, PPE donning and doffing, and infection control related skills. Record review of the Wound Care Competency checklist for RN L, dated 01/15/2025, revealed required steps included: maintaining a clean field, cleansing the wound from inner to outer, removing soiled dressings, applying topical medications as ordered, applying dressings, and restarting the procedure if any area became contaminated. The checklist further required staff to maintain a clean field and to start over if any area was contaminated (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an observation on 1/13/26 at 10:05 a.m., CNA J and CNA K were observed providing incontinent care and catheter care to Resident #4. After care was completed, the aides repositioned the resident in bed and moved the catheter bag and drainage tubing from the right side of the bed back to the left side where it had been prior to care. CNA K was observed holding the catheter tubing arm's length in the air while standing at the bedside to hand it to CNA J. The resident was lying flat in bed at that time. During an interview on 1/13/26 at 11:47 a.m., CNA J and CNA K stated they did not notice they had held the catheter bag and tubing above the resident's bladder during care. CNA J stated the catheter bag and tubing should not be raised above the bladder because it can become contaminated. CNA K stated she was not aware of the reason the catheter bag and tubing should not be raised above bladder level. Both CNAs stated they had received training on catheter care. Record review of the facility catheter care skills checklist for CNA J, dated 10/21/2025, revealed she was evaluated and signed off as competent in female catheter care. The checklist specifically required staff to keep the drainage bag below the level of the bladder during care and repositioning to avoid contamination and backflow. Record review of the facility catheter care skills checklist for CNA K, dated 10/22/2025, revealed she was evaluated and signed off as competent in female catheter care. The checklist specifically required staff to keep the drainage bag below the level of the bladder during care and repositioning to avoid contamination and backflow. During an interview on 1/14/26 at 8:59 a.m. the DON stated staff should not hold a catheter bag above the level of the resident's bladder because it could put urine back into someone's bladder, potentially place the resident at risk of infection. Record review of the facility policy titled Skin and Wound Prevention and Management, dated 3/14/19 and revised January 2023, revealed, the community will ensure that a resident admitting into the community will [be] evaluated and identify the associated risks that may result in skin breakdown. The policy further stated staff were to apply treatments as ordered and prevent exposure of wounds to contaminated surfaces. Record review of the facility policy titled Infection Prevention and Control, dated 3/13/19 and revised April 2024, revealed staff were to follow standard precautions, perform hand hygiene between tasks. The policy stated staff were to prevent cross contamination during resident care and to follow standard precautions, contact precautions, isolation precautions and enhanced barrier precautions. standard precautions apply to all residents. hand hygiene shall be performed before and after resident contact. Record review of the facility policy titled Incontinence and Catheterization Assessment and Evaluation, implemented 2017 and revised January 2023, revealed, the community employs standard infection control practices in managing catheters and associated drainage system. The policy further stated, the community strives to keep the resident catheter clean to minimize bacterial migration into the urethra and bladder. the community takes measures to maintain free urine flow through any indwelling catheter.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the resident had the right to formulate an advance directive and determine the choice to receive or not receive cardiopulmonary resuscitation (CPR) for 1 (Resident #26) of 8 residents reviewed for resident rights. The facility failed to ensure Resident #26's out-of-hospital Do Not Resuscitate (OOH DNR) was complete and valid for use in an emergency. This failure could result in failure to honor the resident's wishes during a medical emergency. Findings included: Record review of Resident #26's admission Record/Face Sheet, dated [DATE], revealed a [AGE] year-old male admitted with diagnoses including effusion of the left knee (abnormal accumulation of fluid within the knee joint causing swelling and pain), acute diastolic (congestive) heart failure (a condition in which the heart is unable to relax and fill properly, resulting in fluid buildup and decreased blood flow), and vascular dementia (a decline in cognitive function caused by reduced blood flow to the brain). The admission record revealed the resident's advance directive was DNR. Record review of Resident #26's Quarterly MDS assessment, dated [DATE], revealed the resident's BIMS score was 15, indicating the resident's cognition was intact for daily decision making. Record review of Resident #26's comprehensive care plan, initiated [DATE], revealed a focus area for advance directives. The care plan stated, Code status DNR - Do Not Resuscitate. Honor my advance directives, care wishes, and code status will be respected and honored as indicated. Record review of Resident #26's physician order summary, dated [DATE], revealed an order for DNR with an order date of [DATE] and no end date. Record review of Resident #26's OOH DNR, dated [DATE], revealed the document was signed by the resident and notarized. The document did not contain a physician's signature. During an interview on [DATE] at 4:40 p.m., the DON stated all resident DNRs were located in the electronic health record under the miscellaneous tab unless they were pending signatures and waiting to be scanned. The DON stated the Social Worker (SW) was in charge of DNR paperwork. The DON stated the facility would honor a DNR pending the physician's signature, as long as the form was filled out. The DON stated emergency medical services honored a DNR in the past without a physician's signature. During an interview on [DATE] at 4:58 p.m., the SW stated Resident #26's DNR was in the electronic health record. After reviewing the OOH DNR, the SW stated the DNR appeared to be pending the physician's signature. The SW stated she would check the physician's folder to see if the form was waiting for signature. The SW stated she may have attempted to have the medical director sign the form and placed it back in the physician's folder. The SW stated she would have to verify if she emailed the physician, requesting signature. The SW stated there was a verbal order from the physician for Resident #26 to be a DNR. The SW stated she was unsure if emergency medical services would honor a DNR without a physician's signature. She stated nursing staff were the ones who responded to codes. Record review of the facility's policy titled Advanced Directives, dated February 2017 and revised [DATE], revealed, Every resident has the right to formulate an advance directive and to refuse treatment. The community will determine the existence of an advance directive at the time of admission. Prior to or upon admission, the community will provide the resident with information about the resident's right to formulate an advance directive. A copy of the advance directive and subsequent revisions will be included in the resident's medical record. The nurse should then obtain a physician's order for appropriate care decision in order to initiate and implement the preferred treatment wishes expressed. The IDT should honor the care decision expressed and initiate the advance directive by initiating the Out of Hospital Do Not Resuscitate (OOH DNR) form and should obtain the medical provider/physician's signature as per the OOH DNR form instructions. The medical record and resident plan of care should reflect the resident's wishes as well as the physician orders in order to meet the directives described.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for 1 of 2 residents (Resident #148) reviewed for dialysis: The facility did not maintain communication, coordination, and collaboration with the dialysis facility for Resident #148. This failure could affect residents who received dialysis treatments and place them at risk for complications and not receiving proper care and treatment to meet their needs. The findings included: Record review of Resident #148's face sheet dated 1/14/26 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included end stage renal disease (permanent stage or chronic kidney disease in which the kidneys have lost nearly all their ability to function), diabetes (chronic metabolic disorder characterized by elevated blood glucose due to insufficient insulin production), chronic viral hepatitis C (long-term infection of the liver cause by the hepatitis C virus leading to ongoing liver inflammation and damage), heart failure, and dependence on renal dialysis (medical treatment that replaces some functions of the kidneys). Record review of Resident #148's Order Summary Report dated 1/14/26 reflected the following:- Dialysis to be done at dialysis clinic Monday, Wednesday, and Friday at 10:15 a.m., with order date 1/11/26 and no end date. Record review of Resident #148's initial/baseline care plan dated 1/12/26 reflected the resident had end stage kidney disease and required dialysis treatments with interventions that included to coordinate transportation to and from dialysis treatments, monitor/document/report to the physician any signs or symptoms of infection to access site, such as redness, swelling, warmth, or drainage and remove post dialysis bandage if indicated and monitor for signs and symptoms of bleeding. Record review of the Pre-Dialysis Assessment document presented to the Surveyor by Resident #148, dated 1/12/26 revealed the following:- Patient's Infection Control Status: No know (sic) exposure & asymptomatic was noted- Exposed to: N/A was noted- Does the patient have one or more of the following conditions that would warrant precaution or isolation: N/A was noted- Current Vitals: B/P 177/89, P 78, T 98, R 18, O2 95- Pain Level 0- Fistula Location: Left Arm- Post Dialysis Assessment: Wet Weight Kg 64.7, Dry Weight 55.2 Kg- Post Dialysis Vitals: B/P 161/83, Pulse 79, Temp. 97.5, Resp. 17, O2 Sats. N/A- DIALYSIS NURSE: signed by Dialysis Clinic RN Record review of the Pre-Dialysis Assessment document presented to the Surveyor by RN B, dated 1/12/26 revealed the following:- Patient's Infection Control Status: No know (sic) exposure & asymptomatic was noted- Exposed to section and Does the patient have one or more of the following conditions that would warrant precaution or isolation had a diagonal line over it- Current Vitals: B/P 156/80, P 84, T 98.4, R 20, O2 94 Room air- Fistula Location: Left arm- Post Dialysis Assessment was blank- Post Dialysis Vitals: B/P 142/76, Pulse 78, Temp. 98.1, Resp. 18, O2 Sats. 95 RA- DIALYSIS NURSE section was blank During an observation and interview on 1/13/26 at 4:45 p.m., Resident #148 stated he had recently admitted to the facility on Saturday (1/10/26) but had been receiving dialysis treatments for the past 2 1/2 years. Resident #148 revealed and was observed with the dialysis port located on the left upper arm. Resident #148 stated he had scheduled dialysis treatments every Monday, Wednesday, and Friday. Resident #148 stated he last went to dialysis on Monday, 1/12/26. Resident #148 stated he was provided with a sack lunch and in the sack lunch he found a folded-up piece of paper. Resident #148 stated he did not know what the document in the sack lunch was and believed he had either lost it or thrown it away. Resident #148 stated he was not told what to do with the folded-up piece of paper, but if I had been asked to give it to somebody I would have done that. Resident #148 reached into the small trash bin observed at the bedside and pulled out a folded-up piece of paper and handed it to the Surveyor. Resident #148 presented the Surveyor with a document titled, Pre-Dialysis Assessment which included the resident's name, dated 1/12/26, a set of current vital signs, and a set of post-dialysis vital signs with the wet weight (64.7 Kg) and dry weight (55.2 Kg), signed by the dialysis clinic RN. Resident #148 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER The Heights on Huebner		STREET ADDRESS, CITY, STATE, ZIP CODE 10127 Huebner Rd San Antonio, TX 78240	
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	took back the Pre-Dialysis Assessment document, folded it back up, and placed it on the nightstand. During an interview on 1/13/26 at 4:58 p.m., RN A stated she worked the day shift on 1/12/26 and prepared the Pre-Dialysis Assessment document for Resident #148, and because it was the first time the resident was sent to dialysis from their facility, the resident did not have a dialysis binder, so RN A stated she placed the Pre-Dialysis Assessment document in Resident #148's sack lunch. RN A stated she was responsible for inputting the current vitals on the form, and then the resident was supposed to give the document to the dialysis clinic staff, and then the dialysis clinic staff filled out their portion and then the document was sent back to the facility with the resident. RN A stated she was not on duty when Resident #148 returned from dialysis and could not recall who was on duty after her. RN A stated the post dialysis assessment vital signs section of the Pre-Dialysis Assessment document was supposed to be filled in by the facility nurse when the resident returned. RN A stated, once the document was completed, it was placed in a basket at the nurse's station for the medical records staff to pick up and scan into the resident's electronic record. During an interview on 1/13/26 at 5:04 p.m., the DON stated the Pre-Dialysis Assessment document should be completed by the facility nurse before the resident was sent to dialysis. The DON stated the Pre-Dialysis Assessment document was sent with the resident and the dialysis clinic was supposed to fill in their portion of the document. The DON stated the document was supposed to be returned to the facility with the resident, and the document either stayed in the resident's binder, or it gets picked up by medical records and was scanned into the resident's electronic record. The DON stated, the purpose of the Pre-Dialysis Assessment document was to obtain pre-dialysis and post-dialysis weights and to record information regarding any issues with the treatment, to see how well the resident tolerated the treatment, and if the resident received medications while at the dialysis clinic. The DON stated the Pre-Dialysis Assessment document for Resident #148 could not be located but RN B, who was responsible for medical records, was trying to locate the document and would provide to the Surveyor when found. During an observation and interview on 1/13/26 at 5:14 p.m., RN B presented the Surveyor with Resident #148's Pre-Dialysis Assessment document dated 1/12/26. RN B stated the document was missing information that was supposed to be provided by the dialysis clinic staff. The Pre-Dialysis Assessment document presented by RN B and the document provided to the Surveyor by Resident #148 did not match. RN B was asked if the Pre-Dialysis Assessment document he presented to the Surveyor was the original document from 1/12/26, and RN B stated, yes. RN B stated the information provided on the Pre-Dialysis Assessment form was crucial because it showed any issues encountered during the dialysis treatment which included a drop in blood pressure. RN B stated he was responsible for checking the Pre-Dialysis Assessment document for completeness and accuracy before it was scanned into the electronic record and should be checked usually the following day. During an interview on 1/13/26 at 5:27 p.m., ADON C stated she placed a call to the dialysis clinic and was able to obtain the dry weight for Resident #148. ADON C stated the Pre-Dialysis Assessment document was important because information provided on the document determined if the resident was stable when he left the facility prior to treatment and the dialysis clinic was supposed to provide the resident's weights and any issues seen during treatment or any additional orders or restrictions, such as fluid restriction. ADON C stated, once the document was brought back to the facility, it was placed in a box at the nurse's station, and then RN B would pick up the document and scan it into the electronic record. ADON C stated, RN B was responsible for ensuring the document was completed, and if there was any missing information, RN B would either make a call to the dialysis clinic or inform the floor nurse to obtain the information before scanning the document into the record. ADON C stated, we can't scan it (Pre-Dialysis Assessment document) until it's filled out. During a follow-up interview on 1/14/26 at 8:53 a.m., the DON stated the facility did not have a policy regarding documenting post dialysis vitals on the Pre-Dialysis Assessment document, but stated vitals obtained by the nurse were documented in the electronic record. Record review of the facility document titled, Hemodialysis - Care of Residents with revision date January (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2023 reflected in part, .Compliance Guidelines.The community provided residents with safe, accurate, and appropriate care, assessments, and interventions to maintain or improve resident outcomes.Overview.Hemodialysis is a process of cleansing the blood of accumulated waste products, it is used for residents with end-stage renal failure.Pre-Treatment.Coordinate with the dialysis treatment center.		

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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 all drugs and biologicals were stored in accordance with currently accepted professional principles for 1 of 1 emergency care cart reviewed for storage of drugs. The facility failed to ensure the emergency cart did not have expired tracheostomy kits. This deficient practice could place residents at risk of adverse reactions. The findings included: During an observation and interview on [DATE] beginning at 10:40 a.m. with RN B revealed inspection of the emergency cart was observed with two packages of Tracheostomy Clean and Care Kits. One kit had an expiration date of [DATE] and the other had an expiration date of 12/2024. RN B stated he was responsible for ensuring the emergency cart was stocked and was checked by him every day. RN B stated there should not be any expired items in the emergency cart. The DON approached the Surveyor and RN B during the inspection at 10:50 a.m. and stated if items were to be taken from the emergency cart during an emergency, the nurse would be checking the expiration date of the item prior to use. RN B stated, if a nurse needed to take supplies from the emergency cart during an emergency, they would be checking for expiration dates. During a follow up interview requested by RN B on [DATE] at 2:50 p.m., he stated, the emergency cart that was inspected did not have any medications in it and the facility did not have any residents in the facility with tracheostomies currently. Record review of the AED and Crash Cart Inspection Log for [DATE] reflected in part, Daily Inspection: Nurse to validate supplies are available on crash cart and Nurse to initial that the Crash Cart has been inspected and is ready for emergency use. Review of the Crash Cart Inspection Log reflected the daily inspection and nurse initials were documented daily from [DATE], to [DATE], which indicated the cart had been checked as indicated. Record review of the facility document titled Pharmacy Services: Provision of Medications and Biologicals with revision date [DATE] reflected in part, . The community provides routine and emergency medications and biologicals to its residents or obtains them under an agreement. The community maintains an emergency medication kit.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food for 1 of 1 kitchen in accordance with professional standards for food service safety. 1. A bag of celery stalks was opened and undated in the refrigerator 2. A bag of sliced ham was opened in the refrigerator. 3. A bag of cereal was opened in the pantry. These failures could place residents who consume meals and snacks from the kitchen at risk for food borne illness. The findings included: During an observation of the facility kitchen on 01/11/2026 at 9:20 AM, a bag of celery was discovered opened and undated in the refrigerator, a bag of sliced ham was discovered opened in the refrigerator, and a bag of cereal was discovered opened in the pantry. During an interview with the Dietary Manager on 01/11/2026 at 10:45 AM, the Dietary Manager stated she would have staff remove undated and unsealed items from the refrigerator and pantry. The Dietary Manager further stated if items were undated or unsealed, they could be expired, and freshness could not be guaranteed. During an interview with the Dietitian on 01/11/2026 at 12:15 PM, the Dietitian stated it was important for food items to be dated and sealed to keep things from expiring. Record review of the facility policy titled Food Storage, dated 2018 noted To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines., and 1. Dry storage rooms d. To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated., and 2. Refrigerators d. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage.		