STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676350	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of Tomball	27840 Johnson Road Tomball, TX 77375

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 (CR#1) of 5 residents reviewed for quality of care. The facility failed to ensure that CR#1 did not develop a pressure ulcer from date of admission, 3/6/25 through date of discharge, 3/19/25. An Immediate Jeopardy (IJ) was identified on 05/09/2025 at 7:18 pm. While the IJ was removed on 05/12/2025 at 12:15 pm, the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm that is not immediate threat due to the facility's need to evaluate the effectiveness of the corrective systems/plan of correction. Findings include: Review of CR#1's face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included Type 2 Diabetes Mellitus(a group disease that result in too much sugar in the blood), Heart disease(Damage or disease in the heart's major blood vessels), Hypertension(A condition in which the force of the blood against the artery walls is too high) , Hyperlipidemia(an elevated level of lipids like cholesterol and triglycerides-in your blood), and Osteoporosis(a medical condition in which the bones become brittle and fragile from loss of tissue, typically as a result of hormonal changes, or deficiency of calcium or vitamin D. Review of CR# 1's Quarterly MDS (Minimum Data Set) assessment dated [DATE], section C reflected a BIMS (Brief Interview for Mental Status) score of 12. Review of CR #1's care plan dated 03/09/2025 reflected CR #1 was care planned for skin care issues and to prevent skin breakdown. He was to be changed, kept dry, and barrier cream was to be applied to prevent skin breakdown. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of CR #1 progress note dated 03/06/2025 reflected that upon admission, a head-to-toe assessment was completed and ROM bilaterally in upper extremities and lower extremities. His skin was intact except for a dressing on the right hip from surgery and bruising on both hands. As a precaution wound care was notified to assess the resident again in order to ensure he did not have any other skin issues. Review of CR #1's Skin and Wound evaluation dated 03/13/2025 reflected that CR #1 had obtained a pressure ulcer at the facility. It was unstageable: obscured full thickness skin and tissue loss. The assessment stated that wound bed had eschar and slough present, no odor, moderate drainage was present, peri wound was pink in color, and normal temperature. Wound measurements area: 3.4 cm, length 6.3 cm, Width 2.0 cm. Nurse practitioner was notified, and she gave verbal orders to begin treating the wound. Review of CR #1's SBAR dated 03/13/25 reflected the CNA informed the wound care nurse of a wound to the coccyx area of CR#1. The wound care nurse assessed CR#1 and reported the findings to the wound care Doctor. The wound care Doctor gave orders to treat CR#1 wound. Review of CR #1's progress note dated 03/13/25 reflected that the following note was written by LVN-A: CNA notified writer that after a shower she noticed an open area on resident bottom, full skin assessment completed, writer noted a unstageable pressure wound to the coccyx, Doctor notified, treatment orders given. Review of CR #1's progress note dated 03/19/2025 reflected Resident wife and son returned and packed all resident belongings. When nurse asked resident wife about the appointment, she just kept walking and did not respond. Nurse checked room and noticed all resident belonging were gone. Nurse notified social worker. Resident's wife and son were noted loading resident into vehicle with all belongings. When asked was everything ok and could we assist them with anything, they responded, no we are leaving. Resident's son was given an AMA form by social worker, and he refused to sign document. Review of CR #1's of care plans/initial MDS dated [DATE] reflected CR #1 had poor physical functioning, was not able to reposition himself in bed, required 2-person assistance for repositioning, and was incontinent of bladder and/or bowel. Review of CR #1's hospital record dated 03/19/2025 reflected that CR#1 was taken to the hospital after he left AMA from the facility. Review of CR#1 BRADEN assessment dated [DATE] reflected CR #1 was at risk for pressure sores. In an interview on 04/15/2025 at 12:25 PM, LVN-A stated that CR #1 was admitted into the facility on [DATE] with a right hip incision only. LVN-A also stated that on 03/13/25 she was notified that CR #1 had obtained a wound on his sacrum while in house. LVN-A stated that she called the wound care doctor and she was given verbal orders to start treatment. LVN-A was asked what could have caused the wound and she stated that she did not know. LVN-A was asked if a like of none positioning, and not changing a resident in time could cause a wound and LVN-A said it's possible. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/24/25 at 10:16 am, RN-A stated that on 03/06/2025 that she did a head-to-toe assessment on CR #1 and that the only issue that he had was an incision to his right hip. RN-A stated that if there had been a wound on CR #1 sacrum that she would have noted and that she would have called the wound care nurse and the Doctor right away. RN-A also stated that the only way CR #1 could have obtained a wound was by him not being positioned as needed. In an interview on 04/24/25 at 10:23 am, the DON stated that when a resident came into the facility, a head-to-toe assessment is conducted, and if there are any issues with skin breakdown, the wound care nurse and the wound care doctor is notified right away, an air mattress will be ordered, and pictures are taken of the wound. The DON also stated that repositioning residents is another way to prevent wounds. In an interview on 02/06/25 at 11:17 pm, the Administrator stated that when a resident is admitted into the facility, upon admission, a head-to-toe assessment is conducted to make sure that the resident does not have any wounds or any other issues. He stated if there is a wound, the wound care nurse and the wound care doctor is notified so that treatment is started right away. The Administrator also stated that an air mattress would be ordered to help with the wound, repositioning helps in healing the wound, and the family will be notified. In an interview on 04/24/25 at 11:46 am, The Wound Care Doctor stated that she gave LVN-A verbal orders on 03/13/25 to treat CR t#1. The wound Care Doctor stated that she gave verbal orders to treat CR #1 with calcium alginate, and air mattress. The Wound Care Doctor also stated that she is at the facility once a week and that she told the Wound Care Nurse to make sure that CR#1 was on the schedule for next week so that he could be reexamined. In an interview on 05/08/25 at 12:25pm, the Wound Care Doctor stated that CR#1's wounds were unavoidable, because of his age, uncontrollable diabetes, hypertension, hyperlipidemia, and heart disease. She also stated that residents with hip issues don't like to be turned nor do they move themselves because of the pain from the hip. In an interview on 05/09/25 at 4:04pm, the Wound Care Doctor stated that the precautions the facility had in place to prevent the pressure ulcer for CR #1 were sufficient. Precautions in place were to keep CR #1 dry, use barrier cream, pressure reducing mattress and repositioning the resident every two hours or more if needed. She stated that the facility sent her a picture of the wound after she had left the facility, and in her medical opinion, the wound was not serious enough for her to go back to the facility to debride the wound nor was it serious enough to send the resident out to the hospital. The Wound Care Doctor statede that she told the Wound Care Nurse to add CR#1 to the schedule to be examined next week. In an interview on 05/09/25 at 4:10 pm, the DON stated that the precautions the facility had in place to prevent the pressure ulcer for CR #1 were sufficient and was in accordance with the facility. The precautions in place was to keep CR #1 dry, use barrier cream, pressure reducing mattress and repositioning the resident every two hours or more if needed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Skin and Wound Prevention and Management policy dated 03/14/2019 reflected A community treatment protocols and formularies are based upon current standards of practice and developed by a community's clinical team and medical director. The community adopts protocols for prevention, identification, assessment, and management of skin conditions, wounds, and pressure ulcer injuries. The Administrator and DON were notified on 05/09/2025 at 7:18 p.m., an Immediate Jeopardy situation (IJ) was identified due to the above failures. The Administrator was provided the IJ template on 05/09/2025 and a Plan or Removal (POR) was requested. The Plan of Removal was accepted on 05/10/25. Abatement Plan for [facility] Plan of Removal F686 - The facility failed to ensure CR#1 received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Immediate Response: Resident CR #1 on 3/13/2025 an unstageable was identified on the coccyx and discharged AMA on 3/19/2025. Director of Nursing Services/Assistant Director of Nursing Services/Charge Nurses completed skin assessments on all residents currently in the community to validate skin condition, treatment orders, preventative measures in place and care plans were reflective of their current skin condition. There were no negative outcomes identified with the 100% skin audit. The results of this audit will be placed in the binder for review with revisit from HHSC. Date completed: 5/10/2025 Director of Nursing Services/Assistant Director of Nursing Services/Charge Nurses /Regional Director of Clinical Operations reviewed clinical records for all residents currently with pressure ulcers to validate preventative measures in place to ensure they are receiving necessary treatment services to promote healing and prevent infection of pressure ulcer as ordered by physician and documented in care plan. Audit completed by the Regional DCO. All care plans have appropriate interventions in place There were no negative outcomes identified with our 3 residents who currently reside in the community and have pressure ulcers. The results of this audit will be placed in the binder for review with revisit from HHSC. Date completed: 5/10/2025 (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director of Nursing Services/Assistant Director of Nursing Services/Charge Nurses reviewed all residents who currently reside in the community to ensure person centered plan of care to include development of a pressure ulcer and interventions to be taken. Audit completed by the Regional DCO. All care plans have appropriate interventions in place. There were no negative outcomes identified. The results of this audit will be placed in the binder for review with revisit from HHSC. Date completed:5/10/2025 Director of Nursing Services/Assistant Director of Nursing Services in-serviced licensed nurses regarding: Skin assessment completed upon admission, readmission, weekly and as needed, Implementing the admission plan of care problem, goal, interventions for skin concerns, identified wounds and risk for skin injury. To include following physician orders regarding all wound care and wound care consultations, documentation process for identified skin wounds, Notifications of new wounds, changes, or deterioration of wounds and resolved wounds to MD, resident representative, and DON, Communication with IDT of all wounds. Low air loss mattress will be used with stage 3 and 4 pressure injuries and/or as clinically indicated. Date completed:5/10/2025 Director of Nursing Services/Assistant Director of Nursing Services/Charge Nurses re- all direct care team members on prevention of pressure injuries and reporting of changes in condition to the charge nurse immediately. Date completed: 5/10/2025 Director of Nursing/Assistant Director of Nursing Services conducted education on Abuse Neglect/ Residents Rights out of an abundance of caution to all direct care team members and licensed nurses. Date completed: 5/10/2025 Director of Nursing / Assistant Director of Nursing will ensure all licensed nursing staff will be re-educated to include anyone on leave/PRN staff will be in serviced prior to working the next shift. DON/ADON will ensure administrative nursing staff in the community will provide in-service/education prior to team members working their assigned shift. The trainings will also be conducted with new hires. Risk Response: Residents who are at risk for skin breakdown have the potential to be affected by the deficient practice. Director of Nursing / ADON will ensure all licensed nursing staff will be re-educated to include anyone on leave/agency/PRN staff will be in serviced prior to working the next shift. DON/ADON will ensure administrative nursing staff in the community will provide in-service/education prior to team members working their assigned shift. The trainings will also be conducted with new hires. Systemic Response: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director of Nursing Services/Assistant Director of Nursing Services/Charge Nurses completed skin assessments on all residents currently in the community to validate skin condition, treatment orders, preventative measures in place and care plans were reflective of their current skin condition. There were no negative outcomes identified with the 100% skin audit. The results of this audit will be placed in the binder for review with revisit from HHSC. Date completed: 5/10/2025 Director of Nursing Services/Assistant Director of Nursing Services/Charge Nurses /Regional Director of Clinical Operations reviewed clinical records for all residents currently with pressure ulcers to validate preventative measures in place to ensure they are receiving necessary treatment services to promote healing and prevent infection of pressure ulcer as ordered by physician and documented in care plan. Audit completed by the Regional DCO. All care plans have appropriate interventions in place. There were no negative outcomes noted with our 3 residents who currently reside in the community and have pressure ulcers. The results of this audit will be placed in the binder for review with revisit from HHSC. Date completed: 5/10/2025 Director of Nursing Services/Assistant Director of Nursing Services/Charge Nurses reviewed all residents with pressure ulcers to ensure person centered plan of care to include development of a pressure ulcer and interventions to be taken. The results of this audit will be placed in the binder for review with revisit from HHSC. Date completed: 5/10 /2025 Director of Nursing Services/Assistant Director of Nursing Services in-serviced licensed nurses regarding: Skin assessment completed upon admission, readmission, weekly and as needed, Implementing the admission plan of care problem, goal, interventions for skin concerns, identified wounds and risk for skin injury. To include following physician orders regarding all wound care and wound care consultations, Documentation process for identified skin wounds, Notifications of new wounds, changes, or deterioration of wounds and resolved wounds to MD, resident representative, and DON, Communication with IDT of all wounds. Low air loss mattress will be used with stage 3 and 4 pressure injuries and/or as clinical indicated. Date completed:5/10/2025 Director of Nursing Services/Assistant Director of Nursing Services/Charge Nurses re-educated all direct care team members on prevention of pressure injuries and reporting of changes in condition to the charge nurse immediately. Date completed: 5/10/2025 Director of Nursing/Assistant Director of Nursing Services conducted education on Abuse Neglect/ Residents Rights out of an abundance of caution to all direct care team members and licensed nurses. Date completed: 5/10/2025 (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director of Nursing / ADON will ensure all licensed nursing staff will be re-educated to include anyone on leave/PRN staff will be in serviced prior to working the next shift. DON/ADON will ensure administrative nursing staff in the community will provide in-service/education prior to team members working their assigned shift. The trainings will also be conducted with new hires. Monitoring Response: The Director of Nursing/ Assistant Director of Nursing will conduct random weekly (1-7 days per week) audit of new admissions, readmissions, residents with pressure ulcers, and resident at risk to develop pressure ulcers to ensure appropriate interventions are in in place to prevent and treat and pressure ulcers. Director of Nursing/Assistant Director of Nursing will conduct daily reviews during clinical start-up meetings (1-7days per week) review of progress notes, SBARs and nursing 24-hour report to ensure that appropriate interventions are in place as well as any additional follow up has been assigned. Director of Nursing/Assistant Director of Nursing will perform random audits with team members to validate knowledge of reporting of changes in condition 1-7 days a week. These plans will remain in place for the next 2 months to ensure compliance or to identify any further training needs. Findings of those observations will be reported to the QAPI committee during monthly meeting for the next 2 months and documented in the QAPI minutes. All information from this response plan will be placed in a binder or binders for review with the visit from HHSC. IDT and Medical Director conducted an Ad Hoc QAPI to review issue and community's response plan in place. Monitoring the POR on 05/10/2025 thru 05/12/2025: Review of Residents #2 and #3's skin assessments dated, 05/10/2025 reflected that both residents currently in the community validated skin condition, treatment orders, preventative measures were in place and care plans reflected their current skin condition. There were no negative outcomes identified with the 100% skin audit. Review of Residents person-centered plan of cares which included development of a pressure ulcer and interventions dated 05/10/2025 reflected that nurses reviewed all residents who resided in the community. Review of in-service dated 05/10/2025 reflected that in-services were conducted regarding skin assessments were completed upon admission, readmission, weekly and as needed, Implementing the admission plan of care problem, goal, interventions for skin concerns, identified wounds and risk for skin injury. To include following physician orders regarding all wound care and wound care consultations, documentation process for identified skin wounds, Notifications of new wounds, changes, or deterioration of wounds and resolved wounds to MD, resident representative, and DON, Communication with IDT of all wounds. Low air loss mattress will be used with stage 3 and 4 pressure injuries and/or as clinically indicated. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of in-service document dated 05/10/2025 reflected that facility staff were educated on Abuse/Neglect pertaining to residents. The staff were educated on who to report abuse/neglect to, types of abuse/neglect, and they were educated on examples of Abuse/Neglect. Review of in-service document dated 05/10/2025 reflected that all facility staff were in-serviced on residents who are at risk for skin breakdown have the potential to be affected by the deficient practice. Review of facility staff in-service document dated, 05/10/2025 reflected that facility staff were in-serviced on Resident Rights. In an interview on 05/10/2025 at 5:00 PM, with the four CNAs, four LVN, and four RN revealed that they were in-serviced on identifying, reporting, treating, and preventing pressure ulcers. The staff stated that they understand the importance of identifying, reporting, treating and preventing pressure ulcers. In an interview on 05/10/2025 at 5:00 PM, ten CNA revealed they were in-serviced on reporting skin care issues to their charge nurse immediately if they identified a resident with skin care issues. In an interview on 05/10/2025 at 5:30 PM, CNAs, LVN, and RN revealed they were in-serviced on residents who were at risk for skin breakdown and had the potential to be affected by the deficient practice. In an interview on 05/12/2025 at 9:30 AM, the DON and ADON stated that their response to F-686-IJ- was to complete skin assessments on all residents currently in the community to validate skin condition, treatment orders, preventative measures in place and care plans were reflective of their current skin condition. There were no negative outcomes identified with the 100% skin audit. In an interview on 05/12/2025 at 9:50 AM, the DON and ADON stated that their response to F-686-IJ- reviewed clinical records for all residents currently with pressure ulcers to validate preventative measures in place to ensure they are receiving necessary treatment services to promote healing and prevent infection of pressure ulcer as ordered by physician and documented in care plan. In an interview on 05/12/2025 at 10:00 AM, DON and ADON stated that they reviewed all residents with pressure ulcers to ensure person centered plans of care to included development of a pressure ulcer and interventions to be taken. In an interview on 05/12/2025 at 10:10 AM, DON and ADON stated that they in serviced licensed nurses regarding: Skin assessment completed upon admission, readmission, weekly and as needed, Implementing the admission plan of care problem, goal, interventions for skin concerns, identified wounds and risk for skin injury. To include following physician orders regarding all wound care and wound care consultations, Documentation process for identified skin wounds, (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 05/12/2025 at 11:30 AM DON and ADON stated that their response to F-686-IJ- was to random weekly (1-7 days per week) audit of new admissions, readmissions, residents with pressure ulcers, and resident at risk to develop pressure ulcers to ensure. Conduct daily reviews during clinical start-up meetings (1-7days per week) review of progress notes, SBARs and nursing 24-hour report to ensure that appropriate interventions are in place as well as any additional follow up has been assigned and conduct daily reviews during clinical start-up meetings (1-7days per week) review of progress notes, SBARs and nursing 24-hour report to ensure that appropriate interventions are in place as well as any additional follow up has been assigned. Staff that report s/s of abuse, types of abuse, neglect, report have not witnessed, have not heard of, or had any report regarding abuse or neglect and would report it to their charge nurse/abuse coordinator and feel safe reporting. We would separate residents if in an altercation, allow them to vent, and use calm voice. In the event staff member were seen performing abuse or neglect, The staff member would be asked to leave the area and would not be allowed to continue to work during that shift. The below was able to verbalize type of abuse and signs and symptoms of abuse. Report the last in-services about abuse, neglect, exploitation was within the last 2-3 days. Staff that can report signs and symptoms of change of condition and skin breakdown. Signs and symptoms that would be reportable are change in mental status, bruises, agitation, urine smell, skin breakdown would be redness possible bogginess under red area, rash. Report that they can locate care area needs for resident and POC of PCC and are able to document all areas of skin breakdown and if resident declines barrier cream, repositioning, assistance with being turned every two hours. CNA state they would report all changes to their charge nurse. Nurses state when the CNA's report any concerns, they themselves inquire as to the who, what, where, when, will go and assess resident when needed, make report to family doctor, DON, Administrator as needed. Report the last in-services about change of condition and wound assessment, reporting, prevention, and documentation was within the last 2-3 days. The Administrator was informed the Immediate Jeopardy was removed on 05/12/2025 at 12:15pm. The facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems.