STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676418	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of Bulverde	384 Harmony Hills Spring Branch, TX 78070

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that are identified in the comprehensive assessment, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 12 residents (Resident #1 and Resident #3) reviewed for comprehensive care plans, in that: 1. The facility failed to ensure Residents #1's care plan reflected using a sit-to-stand lift for Resident #1 only when holding the resident to standing position from sitting position for ADL care, including shower. 2. The facility failed to ensure Residents #3's care plan reflected the need for substantial asssitance with eating. These deficient practices place residents at risk for not receiving proper care and services due to inaccurate care plans. The findings included: 1. Record review of Resident #1's face sheet, dated [DATE], revealed Resident #1 was admitted on [DATE], readmitted on [DATE], and discharged from the facility to an acute care hospital on [DATE] with diagnoses which included: cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), Chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), obesity (excessive body fat can impair health), muscle wasting and atrophy (the decrease in size and wasting of muscle tissue), and hemiplegia (paralysis of one side of the body). Record review of Resident #1's quarterly MDS assessment, dated [DATE], revealed Resident #1's BIMS score was 1 out of 15 for severe cognitive impact with dependent coded for ADLs such as bathing/shower, bed mobility, dressing/grooming, toileting, and hygiene. Record review of Resident #1's care plan with a revision date of [DATE] revealed Bathing/Shower: I prefer to be showered ,d+[DATE] times weekly and as needed with assist of one, and transfer: total lift with two team members with large sling size. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's User Instruction Manual for Hoyer Elevate [sit-to-stand lift], undated, revealed Statement of intended use - The Hoyer Elevate [sit-to-stand lift] is suitable for patients in the sitting position only who have a degree of weight-bearing ability but require assistances to stand. During an interview with CNA A on [DATE] at 1:53 p.m. confirmed the CNA used a sit-to-stand lift with other CNAs for only making Resident #1 to stand position from a wheelchair for ADL cares such as pulling down a pants to provide a shower because Resident #1 had sitting position on the wheelchair and weight-bearing ability to one side. Further interview with the CNA confirmed she never used a sit-to-stand lift for transferring Resident #1 from a bed to chair or from chair to a bed. For transfer, CNA A used only Hoyer lift. During an interview with DOR physical therapist on [DATE] at 3:33 p.m. confirmed CNAs could use a sit-to-stand lift for Resident #1 for ADL cares because the resident had on sitting position on the wheelchair and had weight-bearing ability to one side. During an interview with DON on [DATE] at 4:30 p.m. revealed Resident #1's care plan said Transfer: total lift with two team members indicated CNAs should use only Hoyer lift when transferring Resident #1 from a bed to a chair or from a chair to a bed with other CNAs. However, CNAs could also use a sit-to-stand lift to Resident #1 for ADL cares when only Resident #1 had sitting position on the wheelchair and weight-bearing ability. Further interview with the DON confirmed Resident #1's care plan did not reflect using a sit-to-stand lift for ADL cares when only having sitting position on the wheelchair and weight-bearing ability. During an interview with MDS nurse on [DATE] at 2:21 p.m. confirmed Resident #1's care plan did not reflect the resident's current care status regarding using a sit-to-stand lift for ADL cares when only having sitting position on the wheelchair and weight-bearing ability. For staff who care Resident #1, Resident #1's care plan should have reflected the resident current care status to give correct and consistent cares. Incorrect care plan might cause incorrect care. 2. Record review of Resident #3's face sheet reflected Resident #3 was admitted on [DATE], with diagnoses which included: Multiple Sclerosis (a complex disease process that leads to damaged nerves and formation of scar tissue that disrupts or slows nerve signals and causes a variety of symptoms), Parkinson's Disease (degeneration in the part of the brain that helps coordinate movement), and fibromyalgia (chronic condition that causes pain in muscles and soft tissues all over the body), generalized muscle weakness and other lack of coordination. Record review of Resident #3's comprehensive MDS assessment, dated [DATE], reflected Resident #3's BIMS summary score was 8 out of 15, indicative of moderate cognitive impairment. Resident #3 was coded as substantial assistance for eating; total dependence for shower/bathe self. Record review of Resident #3's Care Plan reflected a focus area of self-care deficit with the following interventions: may need supervision, coaxing and encouragement during meals, revised on [DATE]; able to feed self with out physical assistance, revised on [DATE]. 73 days later on [DATE], the Care Plan was updated to reflect: set up assistance needed; then usually able to feed self but may require more physical assistance at times with 1 person assistance. Record review of New Order Form reflected Resident #3 was admitted to Hospice on [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 9:20 AM, LVN D stated Resident #3 had a Parkinson's tremor and her ability to feed herself declined. In an interview on [DATE] at 11:22 AM, the Hospice RN stated she did not believe the resident had the ability to feed herself for a very long time prior to her death [Resident #3 expired on [DATE]]. The Hospice RN stated she had to ask facility staff to get Resident #3 cleaned up on several occasions when her clothing and linens were soiled with the previous meal from hours prior. The Hospice RN was unsure of the dates these events occurred. During an interview with MDS nurse on [DATE] at 1:48 p.m. confirmed Resident #3's care plan did not reflect substantial assistance needed for eating as coded on the comprehensive MDS. The MDS Nurse stated she did not complete the annual (comprehensive) MDS assessment on Resident #3 but had reviewed the file. The MDS nurse stated that based on the Optional State Assessment (OSA), which uses a wider range of dates and included a rule of three, whereby Resident #3 fluctuated with her ability to independently feed herself. The MDS nurse stated that there were occasions where the resident exhibited ability to independently feed self, but also times where she needed substantial assistance. The MDS nurse stated that the Care Plan should have been updated to reflect this information. The MDS stated that Care Plans not accurately reflecting the actual needs of a resident could cause harm to the resident. The MDS nurse stated the comprehensive MDS assessment was coded wrong based on the assessment data from the OSA assessment. In an interview on [DATE] at 3:42 PM, the DON stated that the Care Plan can be updated as needed and in real time. The DON stated she does not do the MDS and was not sure why the MDS would be different from the Care Plan. The DON stated the Care Plan affects the Kardex, which directs the provision of care for mostly the CNAs but that the direct care nurses can review it as well. The DON stated the Care Plans are reviewed by the MDS nurses for accuracy during Care Plan Meetings. Record review of the facility's policy, titled Care plans, revised ,d+[DATE], revealed The care plan may also include the expressed preferences. The care plan in conjunction with the plan of care throughout the medical record is developed and or recommended to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 12 residents (Residents #2 and Resident #3) reviewed for the provision of routine and emergency drugs and biologicals, in that: 1. Resident #2 did not receive her morning dose of antianxiety medication (busPIRone HCL for anxiety) because of lack of communication between a nurse and a CMA regarding the resident's out on pass for appointments. 2. Resident #3 did not receive her fentanyl patch for pain relief as ordered on 1/3/2023, 2/05/2023, 3/30/2023, 4/02/2024, and 5/17/2024. These failures could place residents at risk for harm by adverse reactions and not receiving the intended therapeutic effects of their medications. The findings included: 1. Record review of Resident #2's face sheet, dated 07/18/2024, revealed Resident #2 was admitted on [DATE] and discharged from the facility on 05/13/2024 with diagnoses which included: unspecified nondisplaced fracture of sixth cervical vertebra (broken neck), neuromuscular dysfunction of bladder (lack of bladder control), multiple fracture of ribs, hypertension (high blood pressure), and anxiety. Record review of Resident #2's admission MDS assessment, dated 04/29/2024, revealed Resident #2's BIMS score was 15 out of 15 for cognitively intact with two person assistances coded for ADLs such as bathing/shower, bed mobility, dressing/grooming, toileting, and hygiene. Record review of Resident #2's physician orders, dated 04/29/2024, revealed busPIRone HCL oral tablet 5 mg (Buspirone HCL) give one tablet by mouth two times a day for Anxiety. Record review of Resident #2's MAR, dated from 05/01/2024 to 05/31/2024, revealed busPIRone HCL oral tablet 5 mg (Buspirone HCL) give one tablet by mouth two times a day for Anxiety, scheduled QD-M (every day morning) and EE-E (every day early evening), and marked not given to only morning dose on 05/07/2024 and 05/08/2024 because the resident was out on pass. Further record review the MAR revealed Follow up appointment on 05/07/2024 at 8:10 am for orthopedic hand and follow up appointment on 05/08/2024 at 8:20 am for trauma surgery clinic. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CMA B on 07/18/2024 at 3:41 p.m. confirmed CMA B did not give only morning dose of Buspirone HCL 5 mg one tablet for anxiety to Resident #2 on 05/07/2024 and 05/08/2024 because Resident #2 left already the facility for the appointments when CMA B entered to the resident's room to give the medication around 9 am. The CMA B stated she could give medications scheduled QD-M (every day morning) from 6 am to 10 am. However, because the CMA B started first passing medications from 200 hall on 05/07/2024 and 05/08/2024 around 6:30 am, when the CMA B entered to Resident #2's room (room [ROOM NUMBER]) to give morning dose of the medication around 9 am, Resident #2 was not in the facility. Further interview with the CMA B stated 100 hall nurses did not say anything about the resident's appointments to the CMA B. If 100 hall nurses had said Resident #2's appointments to the CMA B, CMA B could have given morning dose of Buspirone HCL to the resident first before the resident left the facility for the appointments. During an interview with LVN C on 07/18/2024 at 5:05 p.m. stated Resident #2 left the faciity on [DATE] and 05/08/2024 around 7:30 am for the appointments, and LVN C did not remember if or not she had communications to the CMA B about Resident #2's appointments. Further interview with LVN C confirmed LVN C should have had communications to CMA B regarding Resident #2's appointments, so CMA B could have given Resident #2's morning dose of Buspirone HCL to the resident first before the resident left for the appointments. Resident #2 did not receive the morning doses of the medication due to lack of communications. During an interview with DON on 07/22/2024 at 2:21 p.m. confirmed LVN C should have had communications with CMA B about Resident #2's appointments, so Resident #2 should have received her morning dose of Buspirone HCL 5 mg for anxiety before the resident left the facility for her appointments. Lack of communication caused missed doses to Resident #2, and the resident might have anxiety. 2. Record review of Resident #3's face sheet reflected Resident #3 was admitted on [DATE], with diagnoses which included: Multiple Sclerosis (a complex disease process that leads to damaged nerves and formation of scar tissue that disrupts or slows nerve signals and causes a variety of symptoms), Parkinson's Disease (degeneration in the part of the brain that helps coordinate movement), and fibromyalgia (chronic condition that causes pain in muscles and soft tissues all over the body), generalized muscle weakness and other lack of coordination. Record review of Resident #3's comprehensive MDS assessment, dated 03/27/2024, reflected Resident #3's BIMS summary score was 8 out of 15, indicative of moderate cognitive impairment. Undersection J Health Conditions - Pain Management, Resident #3 was coded as having received scheduled pain medication regimen. Record review of Resident #3's Care Plan reflected a focus area of risk for experiencing discomfort or pain related to .poor health, muscle spasms, fibromyalgia, MS, and bone/joint disorder initiated 1/27/2022; with the following interventions: administer medications to relieve pain as recommended by my doctor, initiated on 1/27/2022. Additional focus area of End-of-Life Care: Hospice initiated 2/16/2024; with the following associated interventions: administer my medications and treatments as recommended by my doctor, initiated 8/15/2023. Record review of New Order Form reflected Resident #3 was admitted to Hospice on 2/15/2024. In addition, fentanyl; patch, 12 micrograms every 72 hours was ordered for chronic pain on 2/15/2024 . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's MAR for January 2024 reflected on 1/03/2024 the 3:29 PM application of the Fentanyl Patch was coded as Other: Nurse Notified. Record review of Progress Note, authored by LVN E, dated 1/3/2024 reflected that the fentanyl patch was not available, physician and pharmacy notified. Record review of Resident #3's MAR for February 2024 reflected on 2/05/2024 the 3:29 PM application of the fentanyl patch was coded as Other: Nurse Verbally Informed, by LVN I. Entries for the application of the fentanyl patch on 2/08/2024, 2/14/2024 were blank. Record review of Resident #3's MAR for March 2024 reflected entry for the application of the fentanyl patch on 3/30/2024 was blank. Record review of Progress Note, authored by LVN H, dated 3/30/2024 at 1:53 PM, reflected, resident c[omplains]/o[f] pain, gave PRN main meds x2 with some relief . Tried to reposition resident to make comfortable. At present time in bed eyes closed, and call light is [sic] reach. Record review of Resident #3's MAR for April 2024 reflected entry for the application of the fentanyl patch on 4/02/2024 was blank. Record review of Progress Note, authored by RN F, dated 4/2/2024 at 4:20 PM, reflected, resident without fentanyl patch to replace as ordered. Hospice notified and spoke [sic] nurse who stated medication would arrive this night or early morning. Record review of Resident #3's MAR for May 2024 reflected entry for the application of the fentanyl patch on 5/17/2024 was code as Other: Nurse Verbally Informed, by LVN G. Entries for hydromorphone for 5/17/2024 reflected administration at all scheduled times. No PRNs for pain relief administered that day. Record review of screenshot of text message received from Hospice RN, time stamped 2:40 PM [dated 5/17/2024 as per subsequent interview], reflected Resident #3 out of hydromorphine [sp]; following message time stamped 6:27 PM reflected [visitor] here saying resident is crying out in pain. Record review of Progress Note authored by LVN G on 5/17/2024 at 5:02 PM reflected, resident is out of fentanyl patches and was due for a change this evening. Also low on hydromorphine [sp]. Spoke with Hospice, and Nurse [redacted] for refills .pending signatures for triplicate for refill. In an interview on 7/19/2024 at 9:20 AM, LVN D stated that medications were to be reordered with enough time before the last available dose for the refill to arrive at the facility. LVN D stated that it would depend on the how frequently the resident required the medication. LVN D stated, ideally the fentanyl patch should be reordered on the next to last patch, allowing 6 days for delivery, since a new patched is placed every 3 days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/19/2024 at 10:52 AM, the DON stated that a refill request was sent to [Pharmacy] on 5/17/2024 and it was received that same evening. The DON stated that she believed the Resident always received some type of pain relief medication. The DON stated that she believed the fentanyl patch was placed each time it was due, but receiving it may have been after the time listed on the MAR. The DON stated she believed the resident would get the fentanyl patch by late evening or no later than the over night hours on the day it was due . The DON stated that the medications needed to be re-ordered with a 3 day lead time to ensure that the medications were available for the next dose. In an interview 7/19/2024 at 11:22 AM, the Hospice RN stated that she would visit Resident #3 weekly, an unnamed Hospice LVN would visit twice a week. Hospice RN stated that the facility would contact Hospice for refills of the pain management medications when they were out. The Hospice RN stated that this became such a repetitive event that she would inquire at each visit to physically see the medications on hand prior to her exit to ensure plenty of medication was available. Record review of the facility policy, titled Mediation Administration, revised 01/2024, revealed . 6. Administer medications as ordered by the physician. Routine medications shall be administered according to the established medication administration schedule for the community and The nurse/med aid/med tech may use their discretion to alter medication/treatment administration times within the liberalized time window to accommodate patient needs such as activities participation (bathing, activities, visitation with friends and family, therapy, dining for instance), rest and adjusting for unexpected patient events.