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	03/21/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41095 Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the State Survey Agency for 2 of 8 Residents (Residents #1 and #2) who were reviewed for abuse, in that: 1. The facility failed to report an allegation of abuse or neglect per facility policy to the State Survey Agency (HHSC) when Resident #1 died after ingesting and choking on wet wipes. 2. The facility failed to report to the State Agency an injury of unknown origin and was suspicious of abuse/neglect for Resident #2. This deficient practice could affect any resident and could contribute to further harm or death. The findings were: 1. Record review of Resident #1's Admission Record dated [DATE] documented a [AGE] year-old male admitted to the facility [DATE] with diagnoses that included dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance (a mental disorder in which a person loses the ability to think, remember, learn, make decisions and solve problems), schizophrenia (a serious mental condition of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings and withdrawal from reality), depression (a mental condition characterized by feelings of severe despondency and dejection), neuromuscular dysfunction of bladder (a condition that occurs when the nerved controlling the bladder are damaged), and benign prostatic hyperplasia (enlarged prostate potentially squeezing the urethra and causing urinary problems). Record review of Resident #1's PPS Discharge Assessment MDS dated [DATE] revealed a BIMS score of 13 indicating he was cognitively intact. The PHQ9 score evaluating mood was 0 indicating no evidence of depression. Under Functional Abilities, Resident #1 was able to walk unassisted, transfer himself in and out of bed and to the toilet, and only required setup or clean-up assistance with ADLs. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plan dated [DATE] revealed Focus that included: - that he required a catheter and interventions were in place to provide catheter care - at risk for psycho-social issues, emotional distress or behaviors related to schizophrenia with interventions that noted behavior triggers: mood disorder, delusion and hallucinations and to keep environment calm, quiet and avoid loud noises as much as possible - Required anti-psychotic medication related to schizophrenia which included the need to monitor/document/report to MD signs and symptoms of psychotropic drug complications, altered mental status, decline in mood or behavior, hallucinations, delusions, social isolation and withdrawal . Record review of Nurses Progress Notes dated [DATE] by LVN B documented that Resident #1 was last seen at approximately 6:00 pm sitting on the side of his bed alert and oriented. CNA called for this nurse at approximately 7:10 pm. Resident lying in bed not responding to verbal stimuli, pale in color, and no pulse noted. Code Blue called. Resident was assisted to the floor by this nurse and two CNAs and CPR was initiated. 911 called by CNA at approximately 7:13 pm. CPR continued until EMS arrived .Time of death called by EMS MD at 7:48 pm. During an interview with the ADM, DON and DCO consultant on [DATE] at 2:41 pm, the ADM explained why they had not reported the death. The ADM stated that Resident #1 never had a history with anything out of the ordinary. The ADM stated Resident #1 was in the Memory Care unit since this had been recommended by the hospital since Resident #1 had been found wandering around his neighborhood naked. Also, when he was taken to activities in the general population, he would go to the doors exit seeking. The ADM and DON discussed the fact that wipes have always been available on the unit and that Resident #1 and his roommate were able to use them. The ADM stated that we have removed all the wipes and paper towels in the building and at meal times we have changed to cloth napkins. We did a full sweep of all the rooms. We also removed all the toiletries in the unit and they are now in a supply closet. The ADM stated he had asked the police officer if he suspected foul play and the answer was no. The ADM stated deaths happen for a lot of reasons so it was not unusual. The ME said they were looking into natural causes and are doing an autopsy. The DCO stated they had also done a 4 Step Assessment as part of their QAPI. During another interview with the ADM and DON on [DATE] at 9:17 am, the ADM stated that wipes are a part of the normal routine. Resident #1 could have swallowed a sock. We don't believe that we could have done anything differently to have prevented this. All the staff said they could not have done anything differently. EMS told us he (Resident #1) was actively trying to swallow the wipes - they were not packed in his mouth. There is no evidence of Resident #1 wanting to harm himself or others. 2. Record review of Resident #2's Admission Record dated [DATE] reflected an [AGE] year-old female with an initial admitted [DATE]. Relevant diagnoses included unspecified dementia (progressive disorder that impairs thought processes, such as memory, thinking, reasoning, and decision-making), cognitive communication deficit (impairment in the thought processes that can impact a person's ability to think, speak, read, and interact with others), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills), and unsteadiness on feet. Record review of Resident #2's quarterly MDS dated [DATE] reflected the resident was unable to be assessed for a BIMS score due to cognitive and communication deficits. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a confidential interview, an anonymous source (anonymous) reported concern of abuse/neglect related to an injury the resident sustained on [DATE]. The anonymous source reported that upon visiting the resident, they observed a bruise to the left lower face of the resident and a skin tear to the forearm. The anonymous source had visited the day prior ([DATE]) and neither injury was present. The anonymous source stated they notified the nursing staff of the injuries. They questioned the origin and reported the concern of neglect to the nursing staff. The anonymous source reported they were not aware of any resulting investigation and did not receive follow-up from the facility regarding the injuries. The anonymous source supplied a photograph dated [DATE] that depicted Resident #2's face and right arm. The resident had an area of purple discoloration on the left lower side of her face, extended from the lower lip to her chin. The resident also had purple and yellow discoloration on the majority surface area of the top right forearm, beginning at the back of the hand and extended to the end of the sleeve near the elbow. There appeared to be small areas of dried blood on multiple areas of the injury. The left arm was not visible in the photograph. Record review of Resident #2's progress notes reflected two relevant entries. On [DATE] at 6:00 PM, RN B entered a Change in Condition note that reported in the section positive findings reported on the resident/patient evaluation for this change in condition were . skin tear. In the section marked primary care provider feedback, the nurse entered follow facility protocol. On [DATE] at 6:56 PM, LVN EE also entered a Change in Condition note that stated resident has discoloration on left lower side of face under lip at chin. Discoloration approximately the size of a quarter. In the section marked primary care provider feedback, the nurse entered no orders at this time. Neither progress note indicated if the Abuse Coordinator or other management were notified of the injuries. In an interview on [DATE] at 11:28 am, LVN EE was asked to recall the circumstances that prompted the injury progress note. LVN EE stated she had not been notified of a fall during the nurse-to-nurse report at the start of the shift. She described the injury as nickel to quarter sized on the side of the resident's face and stated the resident didn't complain of any pain. LVN EE could not recall if the facial injury was observed during her assessment or if she was notified of the injury. LVN EE denied having suspicions of abuse/neglect during her assessment. When asked who she notified of the injury, LVN EE answered probably family and the DON. She further explained she always sends [DON] a text and the [Nurse Practitioners] a text. I think I texted [hospice nurse] as well. LVN EE was unsure if any investigation had been initiated regarding the facial injury but stated she assume[d] they did because it's proper protocol. LVN EE reported the DON entered the room after being notified of the injury and questioned the resident if anyone had hurt her. When asked about training and reporting of abuse and neglect, LVN EE responded that she notified the administrator of any suspected abuse or neglect and had received training and in-services regarding abuse and neglect from the facility . RN B did not respond to the request for an interview during the investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility incident and grievance reports did not reveal any entries for Resident #2 dated [DATE]. In an interview on [DATE] at 1:40 pm, the DON denied knowledge of any facial injury to Resident #2 occurring in December. She stated she was not notified of this injury. The DON recalled a skin tear injury in December and stated the resident would frequently flail her arms while staff were providing care and was undergoing medication adjustments which would cause distress during care. The DON stated that her expectation of staff reporting injuries or statements indicating suspicions of abuse and neglect was the Abuse Coordinator (Administrator) would be notified immediately. In an interview on [DATE] at 2:29 pm, the ADM denied knowledge of a facial injury to Resident #2. When asked if he felt that this should have been reported as possible abuse or neglect by LVN EE, the Administrator answered yes. He further stated anything to the face, obviously should be reported. The ADM explained that his expectation of staff notification of abnormal findings suggestive of abuse or neglect was immediate. Review of facility policy Abuse Guidance: Preventing, Identifying and Reporting revised [DATE], page 4 reflected [a] community owner, operator or team member who has knowledge of an allegation of or cause to believe that abuse, neglect, or exploitation has been allegedly occurred [sic] should report the suspicion or allegation of abuse, neglect, or exploitation to state authorities and may also be reported to local authorities as indicated. Report alleged or suspicions of abuse to HHSC .within the designated time frames in accordance with HHSC's PL ,d+[DATE] -are reported immediately -but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury -or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury State authorities should be notified of reports of abuse described above which alleges that 1. A resident's health or safety is in imminent danger 2. A resident has recently died because of conduct alleged in the report of abuse or neglect or other complaint 5. A resident has suffered bodily injury, because of alleged or suspicion or abuse or neglect.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512 Based on interviews and record review, the facility failed, in response to allegations of neglect, have evidence that all alleged violations were thoroughly investigated and report the results of all investigations to the administrator and to other officials in accordance with State law, including the State Survey Agency, within 5 working days of the incident for 1 of 4 (Resident #2) residents reviewed for abuse, neglect, and exploitation investigations. The facility failed to investigate an injury of unknown origin sustained by Resident #2 that was suspicious of abuse or neglect. This failure could cause diminished quality of life and place residents at risk for mistreatment. Findings included: Record review of Resident #2's face sheet dated 3/19/2025 reflected an [AGE] year-old female with an initial admitted [DATE]. Relevant diagnoses included unspecified dementia (progressive disorder that impairs thought processes, such as memory, thinking, reasoning, and decision-making), cognitive communication deficit (impairment in the thought processes that can impact a person's ability to think, speak, read, and interact with others), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills), and unsteadiness on feet. Record review of Resident #2's quarterly MDS dated [DATE] reflected the resident was unable to be assessed for a BIMS score due to cognitive and communication deficits. During a confidential interview, an anonymous source (Anonymous) reported concern of abuse/neglect related to an injury the resident sustained on December 8, 2024. The anonymous source reported that upon visiting the resident, they observed a bruise to the left lower face of the resident and a skin tear to the forearm. Anonymous had visited the day prior (December 7, 2024) and neither injury was present. Anonymous stated that they notified the nursing staff of the injuries. They questioned the origin and reported concern of neglect to the nursing staff. Anonymous reported that they were not aware of any resulting investigation and did not receive follow-up from the facility regarding the injuries. Anonymous supplied a photograph dated 12/8/2024 that depicted Resident #2's face and right arm. Resident had an area of purple discoloration on left lower side of face, extended from lower lip to chin. Resident #2 also had purple and yellow discoloration on the majority surface area of the top right forearm, beginning at the back of the hand and extended to the end of the sleeve near the elbow. There appeared to be small areas of dried blood on multiple areas of the injury. The left arm was not visible in the photograph. Record review of Resident #2's progress notes reflected two relevant entries. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/8/2024 at 6:00 PM, RN B entered a Change in Condition note that reported in the section positive findings reported on the resident/patient evaluation for this change in condition were . skin tear. In the section marked primary care provider feedback, the nurse entered follow facility protocol. On 12/8/2024 at 6:56 PM, LVN EE also entered a Change in Condition note that stated resident has discoloration on left lower side of face under lip at chin. Discoloration approximately the size of a quarter. In the section marked primary care provider feedback, the nurse entered of no orders at this time. Neither progress note indicated if the Abuse Coordinator or other management were notified of the injuries. In an interview on 3/21/2025 at 11:28 AM, LVN EE was asked to recall the circumstances that prompted the injury progress note. LVN EE stated that she had not been notified of a fall during nurse-to-nurse report at the start of the shift. She described the injury as nickel to quarter sized on the side of resident's face and stated that resident didn't complain of any pain. LVN EE could not recall if the facial injury was observed during her assessment or if she was notified of the injury. LVN EE denied having suspicions of abuse/neglect during her assessment. When asked who she notified of the injury, LVN EE answered probably family and DON. She further explained that she always sends [DON] a text and the [Nurse Practitioners] a text. I think I texted [hospice nurse] as well. LVN EE was unsure if any investigation had been initiated regarding the facial injury but stated that she assume[d] they did because it's proper protocol. LVN EE reported that DON entered the room after being notified of the injury and questioned the resident if anyone had hurt her. When asked about training and reporting of abuse/neglect LVN EE responded that she notifies administrator of any suspected abuse/neglect and has received training and in-services regarding abuse/neglect from the facility. RN B did not respond to request for interview during investigation. Record review of facility incidents and grievances reports did not reveal any entries for Resident #2 dated 12/8/2024. In an interview on 3/21/2025 at 13:40, DON denied knowledge of any facial injury to Resident #2 occurring in December. She stated that she was not notified of this injury. DON recalled a skin tear injury in December and stated that the resident would frequently flail her arms while staff was providing care and was undergoing medication adjustments which would cause distress during care. DON stated that her expectation of staff reporting injuries or statements indicating suspicions of abuse/neglect is that the Abuse Coordinator (Administrator) will be notified immediately. In an interview on 3/21/2025 at 14:29, ADM denied knowledge of facial injury to Resident #2. When asked if he felt that this should have been reported as possible abuse/neglect by LVN EE, Administrator answered yes. He further stated that anything to the face, obviously should be reported. ADM explained that his expectation of staff notification of abnormal findings suggestive of abuse/neglect is immediate . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy Abuse Guidance: Preventing, Identifying and Reporting revised January 2024, page 5, section Investigative Procedures Related to Allegations of Abuse, Neglect of Exploitation item 2 reflected [the] Community should investigate the reported abuse. A written report of the investigation submitted [sic] to HHSC no later than the fifth working day after the initial report.

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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** 51512 Based on interviews, and record review, the facility failed to develop and implement a comprehensive care plan for 1 of 6 residents (Resident #2) reviewed for care plan revision/timing. The facility failed to ensure Resident #2's care plan addressed newly developed pressure wound for 40 days after initial assessment. The noncompliance was identified as PNC. The noncompliance began on 11/14/2024 and ended on 12/24/2024. The facility had corrected the noncompliance before the survey began. This failure put the resident at risk for declining health due to specific needs being unaddressed or unmet by lack of care planning. Findings were: Record review of Resident #2's face sheet dated 3/19/2025 reflected an [AGE] year-old female with an initial admitted [DATE]. Relevant diagnoses included unspecified dementia (progressive disorder that impairs thought processes, such as memory, thinking, reasoning, and decision-making), cognitive communication deficit (impairment in the thought processes that can impact a person's ability to think, speak, read, and interact with others), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills), and unsteadiness on feet. Record review of Resident #2's quarterly MDS dated [DATE] reflected the resident was unable to be assessed for a BIMS score due to cognitive and communication deficits. During record review of Resident #2's electronic medical record, a progress note was entered on 11/14/2024 in the form of a change in condition notification to provider regarding an observation of skin issue to the resident's left heel (discoloration to L heel round area with slight soft feel. RP aware as well as DON, Physician, skin prep applied heel floated continually [sic]. The documentation included notation of received orders to include apply skin prep daily as well as PRN, float heel. Further record review of this date revealed a skin & wound evaluation documented on 11/14/2024. The assessment described the wound type as pressure and stage as deep tissue injury: persistent non-blanchable deep red, maroon or purple discoloration. Record review of orders entered into the electronic medical record revealed a telephone order dated 11/14/2024 wound to left heel, apply skin prep QD & PRN as need for compromised [sic]. A written order for heel protectors was entered on a later date of 12/24/2024, reading Heel protects qd every shift for preventative measures as tolerated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's care plan revealed a care area addressing skin conditions. This focus indicated actual or at risk for skin impairment: 1.co-morbid/chronic medical conditions that lend me to risk for development/worsening. , Incontinence problems, impaired mobility. Actual: [sic]. An update was entered on 11/18/2024 of apply treatment as ordered but does not include detail regarding the treatment or area of treatment. The change in skin condition was not specifically addressed in the resident's care plan until 12/24/2024. On this date, interventions were created to include: I use therapeutic off-loading boots/heel protectors as indicated. May remove by myself at times. Off-load heels for comfort and pressure relief measures as indicated. Off load as tolerated/allowed as indicated. Further review of the electronic medical record revealed one instance of documentation of use of heel protectors/offloading heels between the documented discovery of the left heel wound on 11/14/2024 and the updated care plan on 12/24/2024. This documentation was entered in the form of a progress note that stated heel is floated from touching mattress. Documentation of the topical skin prep applied to the wound was contained within the TAR. During confidential interview on 3/20/2025 at 3:37 PM, an anonymous source (Anonymous) provided a photograph of Resident #2's left heel dated 12/8/2024. The wound was noted to cover majority of the heel area and to be pale in color to center of wound with outline of dark skin around the border. At the time the photograph was taken, the anonymous source stated the resident was not wearing heel protectors. The anonymous source described a feeling of concern at the lack of interventions for the wound and escalating these concerns to the nursing staff repeatedly but that they would do nothing about it. An interview was conducted with the DON on 3/21/2025 at 1:40 PM. The DON stated that care plans were updated in many instances, including anything that we want people to know. When asked how quickly the care plans were updated after changes were assessed, the DON explained the facility hosts care meetings every Monday in which every resident was discussed , and care plans were actively updated. The DON was asked for insight regarding the timeline of Resident #2's care plan. The DON stated skin redness would not be documented on the care plan and that may be why the care plan was not updated. The DON was asked how nursing staff would be aware of the need to use heel protectors/reduce pressure to heels if there was not an order and if the intervention was not documented in the care plan. The DON answered that this information should be communicated in verbal shift report. The facility policy titled Care Plans revised January 2023 was reviewed. This policy stated additional updates to the care plan may be done as indicated.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 41095 Based on interview, and record review, the facility failed to ensure that the resident's environment remained as free of accident hazards as possible for 1 of 23 residents (Resident #1) reviewed for accidents and supervision. The facility failed to provide that Resident # 1's environment remained as free of accident hazards as is possible when Resident #1 swallowed wet wipes, choked and expired. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 4:11 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because the facility needed to monitor the implementation of the plan of removal. The failure placed all residents at risk for serious injury, harm, and/or death. Finding include: Record review of Resident #1's Admission Record dated [DATE] documented a [AGE] year-old male admitted to the facility [DATE] with diagnoses that included dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance (a mental disorder in which a person loses the ability to think, remember, learn, make decisions and solve problems), schizophrenia (a serious mental condition of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings and withdrawal from reality), depression (a mental condition characterized by feelings of severe despondency and dejection), neuromuscular dysfunction of bladder (a condition that occurs when the nerved controlling the bladder are damaged), and benign prostatic hyperplasia (enlarged prostate potentially squeezing the urethra and causing urinary problems). Record review of Resident #1's PPS Discharge Assessment MDS dated [DATE] revealed a BIMS score of 13 indicating he was cognitively intact. The PHQ9 score evaluating mood was 0 indicating no evidence of depression. Under Functional Abilities, Resident #1 was able to walk unassisted, transfer himself in and out of bed and to the toilet, and only required setup or clean-up assistance with ADLs. Record review of Resident #1's Care Plan dated [DATE] revealed Focus that included: - that he required a catheter and interventions were in place to provide catheter care - at risk for psycho-social issues, emotional distress or behaviors related to schizophrenia with interventions that noted behavior triggers: mood disorder, delusion and hallucinations and to keep environment calm, quiet and avoid loud noises as much as possible - Required anti-psychotic medication related to schizophrenia which included the need to monitor/document/report to MD signs and symptoms of psychotropic drug complications, altered mental status, decline in mood or behavior, hallucinations, delusions, social isolation and withdrawal . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Nurses Progress Notes dated [DATE] by RN B documented that Resident #1 was last seen at approximately 6:00 pm sitting on the side of his bed alert and oriented. CNA called for this nurse at approximately 7:10 pm. Resident lying in bed not responding to verbal stimuli, pale in color, and no pulse noted. Code Blue called. Resident was assisted to the floor by this nurse and two CNAs and CPR was initiated. 911 called by CNA at approximately 7:13 pm. CPR continued until EMS arrived .Time of death called by EMS MD at 7:48 pm. Record review of the EMS Report dated [DATE] revealed that during attempts to intubate Resident #1, EMS discovered a stack of wet wipes lodged in esophagus, wet wipes continued to be removed, approximately 15 wet wipes were removed . During an interview with LVN A on [DATE] at 1:12 pm, nurse reported that Resident #1 appeared to be in a good mood, participated in activities and had talked with a family member who was coming to visit. LVN A stated Resident #1 accidentally pulled out his foley so she easily reinserted it. LVN A stated Resident #1 was not complaining of pain. LVN A stated she had seen Resident #1 in the hall after that and there were no apparent signs of suicide. When asked if she had ever seen Resident #1 writing notes, LVN A stated he had asked for paper before but she had never seen him writing. LVN A was asked about the availability of wipes and she stated residents used to have access to wipes but they don't now. LVN A stated that getting rid of wipes was a plan of correction for a variety of reasons. During an interview with CNA D on [DATE] at 1:52 pm, she stated they were getting residents ready for bed. CNA D stated Resident #1 and his roommate would remind each other about going to the dining room to get their medications from the nurse. His roommate reported that he couldn't wake up Resident #1. CNA E went to check on Resident #1 and discovered he was non-responsive and got the nurse. CNA D stated she and the other CNA and the nurse got Resident #1 off the bed and onto the floor so CPR could be started until EMS arrived. CNA D stated she didn't see anything in Resident #1's mouth but later saw EMS pull something out of his mouth. CNA D stated she was in shock and never thought he would do anything like that. CNA D stated the wipes and gloves were always stored in the resident's bathrooms but now everything is either on the cart or will be locked up in a storage closet. CNA D stated staff was given an inservice by the DON about where these items will be kept. CNA D noted there are other things with which residents can hurt themselves like call light cords, miniblind cords and phones with cords - why not take those away? CNA D stated she always checked on her residents about every ,d+[DATE] minutes and makes sure the doors are open so I can see if they have fallen and they are OK. During a phone interview with CNA E on [DATE] at 2:11 pm, CNA E stated she had just seen Resident #1 earlier drinking some water. CNA E was present when EMS took the wipes out of Resident #1's throat but the wipes could not be seen prior to EMS taking them out. CNA E stated the DON inservices staff about abuse and neglect and keeping everything away from residents that are not safe. CNA E stated she worked in another facility before coming here and everything was locked up. CNA E stated that one of the girls told me Resident #1 had been seen with the bed remote cord around his neck one time. CNA E stated Resident #1 seemed fine the night before and he came out for a snack and water and was watching a movie. (continued on next page)

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	676418	A. Building B. Wing	03/21/2025

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with RN B on [DATE] at 2:20 pm, the nurse stated she had seen Resident #1 sitting on the side of his bed when she arrived at 6:00 pm for her shift. RN B stated that when she was getting ready to give out medications, his roommate told staff Resident #1 was not waking up. RN B stated, After CNA E notified me that resident was unresponsive we lowered him to the floor and began CPR. RN B stated she first tried a sternal rub and then began compressions. Another staff member used the ambu bag and it appeared that air was going in. RN B stated the EMT showed her what he had taken from Resident #1's mouth which appeared to be multiple wipes. RN B stated Resident #1 was the most alert resident in the unit and was fully aware of what was going on. RN B stated she never saw Resident #1 do anything outside the norm. RN B stated she did know that Resident #1 wrote everything down but he never showed her what he was writing. RN B stated that the DCO, DON, ADM, SW, MDS Nurse and Treatment Nurse all were present during this incident and did an inservice with staff on abuse and neglect and maintaining the safety of residents. During an interview with the ADM, DON and DCO on [DATE] at 2:41 pm, the ADM explained why they had not reported the death. The ADM stated that Resident #1 never had a history with anything out of the ordinary. The ADM stated Resident #1 was in the Memory Care unit since this had been recommended by the hospital since Resident #1 had been found wandering around his neighborhood naked. The ADM and DON discussed the fact that wipes have always been available on the unit and that Resident #1 and his roommate were able to use them. The ADM stated that we have removed all the wipes and paper towels in the building and at mealtimes we have changed to cloth napkins. We did a full sweep of all the rooms. We also removed all the toiletries in the unit and they are now in a supply closet. The DCO stated they had also done a 4 Step Assessment as part of their QAPI to review any safety concerns for residents in the Memory Care Unit. Environmental rounds were made with Maintenance Dir on [DATE] between 8:30 - 9:00 am in the Memory Care unit. All drawers and cabinets in the resident rooms were observed for wipes and gloves and all rooms had been cleared of these items. A couple of rooms were found with items that were immediately removed including 1 silicone cream tube in the bathroom and 1 small body lotion tube in a dresser drawer. During a phone interview with Dr H, psychiatrist, on [DATE] at 11:43 pm, Dr H stated he was treating Resident #1 with antidepressants. Dr H stated that when he had seen Resident #1 earlier in March, he was a little withdrawn but denied sad mood or suicidal ideations. So I treated him with a mood stabilizer. Dr H stated he had a few sessions with Resident #1 and although he was found to have cognitive impairment it was not severe enough that he would confuse wipes and snacks but added it would be hard to say for sure. Dr. H stated he did see the psychologist at quarterly meetings they held with staff and he felt if she had a concern about Resident #1 she would have informed him. During an interview with SW on [DATE] at 3:26 pm, SW stated his last BIMS score was 13 and his PHQ-9 score was 0. SW stated she was not aware that resident heard voices. SW called LVN C to her office since LVN C was over the Memory Care Unit. LVN C stated the psychologist had mentioned Resident #1 hearing voices but that the psychologist was not concerned he would be a harm to himself or others. LVN C stated his only change in behavior was that he seemed to forget he could walk and would take other residents' wheelchairs. LVN C said she reminded Resident #1 he could walk on his own so he would readily give up the wheelchair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 6:22 pm, the complainant returned my call and I informed him about our investigation. The complainant stated he could not say whether or not there was foul play involved so suggested I call the detective investigating the case. During an interview on [DATE] at 9:47 am, EMT HH reported that when EMS arrived staff were doing chest compressions and using an AED. EMT HH stated EMS took over with their life pack. EMT HH stated the EMTs noticed they were unable to get Resident #1's oxygen level so made the decision to intubate him. EMT HH said he then noticed vomit in the airway so started suctioning him. EMT HH stated he then used a scope to investigate the airway and he noticed a film. EMT HH then said he had to use his fingers to pull out a group of bath wipes. EMT HH stated the wipes were in 2 wads and did not appear to have been chewed but were rolled up and appear to have been shoved in there. EMT HH stated he looked at Resident #1's medications and didn't see anything unusual. Due to the unusual circumstances, the Crime Scene Investigator unit was called out. During a phone interview with Dr. I, psychologist, she stated the last time she saw Resident #1 he was not having suicidal ideations. Resident #1 did say he had audio hallucinations and they were critical voices like God but they were not telling him to hurt himself. Dr I said she last saw Resident #1 on February 12 and he was seated at a table and did not appear to be more depressed. Dr I stated Resident #1 would refer to himself in the third person. When surveyor asked Dr I about the fact that he frequently wrote about clouds on his papers, she said this was a delusion but not an indicator of depression. Surveyor interviewed LE L at the police department where he opened the evidence bag that had gathered about 25 pages of ,d+[DATE] x 11 paper found in Resident #1's room. On one paper he had written Resident #1 swallowed a napkin. On another paper he had written that [family member] was coming to see him. Most of the notes were very disjointed and since there were no dates on any of the papers it is unknown when they were written. LE L stated an autopsy was being done and if the solution from the wet wipes was found under Resident #1's fingernails then the conclusion would be suicide or at least self-harm. A phone interview on [DATE] at 12:40 pm with NP II revealed he had not been informed about Resident #1's death although he did see Resident #1 on behalf of the primary care physician who is also the facility Medical Director. NP II stated he would try to get a message to Dr J. During a phone interview with Dr. J on [DATE] at 2:11 pm, Dr. J stated he was aware of the death and the circumstances after being informed by the DON. Dr J stated Resident #1 was a walking and talking patient. He was in a locked unit so couldn't elope. Dr. J stated that the wipes should be in a designated area. Dr J also stated that this is very rare and he was being followed by a psychiatrist and was on medication including an anti-psychotic. Dr. J added people with schizophrenia used to be in State Hospitals but now they are in nursing homes so the psychotic behaviors have to be managed. Personnel records were reviewed for staff involved in administration of CPR including RN B, CNA D, CNA E and CNA JJ. CPR certifications and all other personnel records were current and in order. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews conducted with 25 staff members out of 96 regular staff and 31 contracted staff by surveyors on [DATE] between 8:35 am and 10:30 am and from 4:55 pm to 7:55 pm to verify they had received inservices on Abuse and Neglect, Preventing Accidents, Plan of Care/Kardex, and to ensure all wipes, gloves or personal items were locked in storage closet until use by staff with residents. The Administrator and DON were notified on [DATE] at 4:11 pm that an Immediate Jeopardy situation had been identified on [DATE] due to the above failures and were presented with an Immediate Jeopardy Template. A Plan of Removal (POR) was requested. The facility's Plan of Removal for the Immediate Jeopardy was accepted on [DATE] at 8:34 pm and reflected the following: Immediate Response: Director of Nursing Services/Assistant Director of Nursing Services/Charge Nurse immediately assessed the identified resident and initiated emergency response care. Outcome: Resident pronounced deceased post EMS emergency response care provided. Date completed: [DATE] Notifications: PCP notified Responsible party notified DNS and Admin notified Director of Clinical Operations /Director of Nursing Services/Assistant Director of Nursing Services/IDT conducted an assessment of current residents in order to validate their safety and well-being. Outcome: No negative outcomes identified. Date Completed: [DATE] Risk: All residents with cognitive impairment especially those who currently reside on the memory care unit can be affected by the deficient practice. Out of an abundance of caution the IDT Director of Nursing Services/Assistant Director of Nursing Services/Charge Nurse/Designee immediately inspected all resident room to identify and removed any items such as patient care items for added safety. Outcome: There were no negative outcomes identified. Any briefs/wipes identified in bathrooms (cabinets) were immediate removed and disposed of. Date Completed: [DATE] (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The [NAME]/Director of Nursing Services/Assistant Director of Nursing Services conducted rounds and staff interviews to identify any residents with poor cognition and who is at risk for ingesting nonfood items. Outcome: No negative outcomes identified. Date Completed: [DATE] The IDT /Director of Nursing Services/Assistant Director of Nursing Services commenced with an audit of all residents with cognitive impairment to review and update the plan of care as indicated in order to validate the plan of care for accuracy and will update as needed to ensure the appropriate intervention/interventions are noted on the plan of care/Kardex as well as accurately identified. Outcome: No negative outcomes identified. Date completed: [DATE] IDT conducted an audit of all residents with a diagnosis of schizophrenia recent change of condition concerning new onset of behaviors, worsening behaviors, or s/s of being withdrawn within the last 30 days to ensure that appropriate plan of care. Completed: Initially completed on [DATE] and on going IDT conducted an audit of all residents with a recent change of condition concerning new onset of behaviors, worsening behaviors, or s/s of being withdrawn within the last 30 days and reviewed/updated the identified residents' care plan. Completed: Initially Completed [DATE] and on going IDT conducted a depression screen for all resident identified with behavioral concerns changes in condition and all positive screens to be to the mental health provider for evaluation and treatment in order to identify any potential risks for harm to self, specifically reviewing any concerns with potential safety issues such as ingesting non-edible food items. Outcome: No negative outcomes identified. Completed: [DATE] System Response: DCO re-educated Admin/DNS/ADNS regarding: o Abuse & Neglect Preventing, Identifying, and Reporting all suspicions or allegations. o Preventing Accidents/Incidents & Fall Prevention. o Plan of Care/Kardex should be reviewed by direct care team to ensure the staff member is aware of the necessary care to be provided. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o IDT to ensure any safety concerns and appropriate interventions are noted on the plan of care and Kardex. Date Completed:[DATE] Community will ensure all staff on leave/agency staff /PRN staff are in serviced prior to working their shift. No licensed nurse, certified medication aide or certified nurse aide will assume an assignment of patient care until they have passed skills validation of accessing the Kardex. Community will ensure administrative nursing staff in the community to provide in-service/education prior team members working their assigned shift. These trainings will also be conducted with new hires. Administrator/Director of Nursing/Assistant Director of Nursing re-educated staff regarding: o Abuse & Neglect Preventing, Identifying, and Reporting all suspicions or allegations. o Preventing Accidents/Incidents & Fall Prevention. o Plan of Care/Kardex should be reviewed by direct care team to ensure the staff member is aware of the necessary care to be provided. o IDT to ensure any safety concerns and appropriate interventions are noted on the plan of care and Kardex. Going forward the identified trainings above will also be conducted with new hires accordingly. Community will ensure all staff on leave/agency/PRN staff are in serviced prior to working their shift. Community will ensure administrative nursing staff in the community to provide in-service/education prior team members working their assigned shift. These trainings will also be conducted with new hires. IDT will conduct interviews with family, review of health records and evaluate any newly admitted resident for consideration on the memory care unit in order to identify any behavioral concerns that would pose risk of harm to self by ingesting non-food items. Date implemented and ongoing: [DATE] Monitoring: The Administrator/Director of Nursing/Assistant Director of Nursing/Social Worker will make weekly random audits/rounds to validate the safety and well-being of our residents and resident rooms at random times on random halls in order to identify any safety concerns. This audit will be conducted ,d+[DATE] days a week for the next 2 months. The findings will be reviewed and reported to the QAPI committee, to validate compliance or to identify additional training needs. Date Initiated: [DATE] (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director of Nurses/Assistant Director of Nurses will review all admission/re-admission care plan and Kardex to ensure any safety risks are accurately noted on the plan of care and Kardex Will review progress notes and risk management reports to identify and safety risks / concerns. accordingly. This will take place , d+[DATE] days a week for the next 2 months. Date Initiated: [DATE] This corrective action plan 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 to establish compliance or identify additional trainings and oversight is required. The Administrator/Director of Nursing/Assistant Director of Nursing/Social Worker will complete all audits and they will be placed in a binder and kept for review by HHSC for the revisit to validate for compliance. The Administrator/Director of Nursing and Medical Director conducted a Ad Hoc QAPI meeting to review this situation, and the immediate corrective action plan implemented. The facility's POR verification was as follows: Record review with ADM and DON conducted at 5:00 pm on [DATE] to ensure assessment of residents was conducted to assure their safety and well-being. No other residents identified as being in danger of self-harm. Surveyor and Maintenance Director had conducted search of Memory Care Unit rooms on [DATE] from 8:30 am to 9:00 am to ensure all patient care items such as wipes and gloves had been removed from rooms and were secured. Record review of Plan of Care review conducted on [DATE] at 8:30 pm to ensure anyone with cognitive impairment was not at risk of ingesting non-food items. Record review of Plan of Care with all residents with cognitive impairment conducted on [DATE] at 8:30 pm to ensure accuracy of care plans. Reviewed list of residents with schizophrenia and their plan of care on [DATE] at 8:35 pm. 5 residents were listed with this disorder. Record review of 4 Step Assessment was conducted by facility staff with each resident in the facility as of [DATE] is and ongoing. Review verified with DON on [DATE] at 8:40 pm. These steps included reviewing the care plan including diagnoses and related medications, monitoring behaviors and related documentation of any changes, and determining any safety concerns as each resident room was observed. Information will be discussed in the monthly QAPI meeting. Facility did chart review for residents with behavioral concerns who are already see by psychological services and no new changes were identified. Discussed procedures and outcomes with ADM and DON on [DATE] at 8:40 pm. (continued on next page)

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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	03/21/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41095 51512 Based on observations, interviews, record review, the facility failed to maintain an infection prevention program to help prevent the development and transmission or communicable diseases and infections for 1 of 2 residents (Resident #3). The facility also failed to handle and transport linens so as to prevent the spread of infections for infection control practices. 1.The facility failed to ensure CNA FF utilized appropriate PPE when providing direct care to Resident #3, who had been identified as requiring enhanced barrier precautions. 2.The facility failed to ensure CNA M removed soiled gloves prior to exiting a room, as well as securing soiled linen in a bagged or contained method at the point of collection prior to transporting. These failures could lead to the spread of infection. Findings included: Record review of Resident #3's face sheet dated 3/20/2025 reflected an [AGE] year-old male admitted on [DATE] with diagnosis of senile degeneration of brain (a progressive disorder that impairs the thought processes, such as memory, thinking, reasoning, and decision-making). The MDS was not available for review, as the resident was newly admitted . Review of the current orders indicated an order dated 3/18/2025 for enhanced barrier precautions as well as wound care, also dated 3/18/2025, for wound to coccyx (tailbone). While in the hallway observing preparation and set-up for wound care to be performed by LVN GG on 3/19/2025 at 10:59 AM, Resident #3 was receiving incontinent care provided by CNA FF. Signage indicating EBP precautions and the PPE cart was present in the hallway near the resident's room. CNA FF was observed attempting to exit the resident's room without PPE and while wearing soiled gloves. CNA FF was redirected by LVN GG and instructed to remove gloves and utilize hand sanitizer before stepping into the hallway. CNA FF then stepped back into the resident's room and closed the door. The State Surveyor obtained permission and entered the room to observe the remainder of the incontinent care procedure. CNA FF was in the resident's restroom washing his hands and Resident #3 was resting in bed, wearing a shirt, and disposable brief. No items had been removed from the room after incontinent care, and bagged trash from the incontinent care remained in the room. The trash bag did not contain the disposable, yellow gown utilized by the facility, indicating that CNA FF had not worn a gown during the incontinent care procedure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that time, LVN GG entered the room to begin wound care. LVN GG was observed to be wearing a disposable, yellow gown. LVN GG requested CNA FF remain in the room to assist with positioning the resident during the procedure. CNA FF donned clean gloves but did not don a yellow, disposable gown. Resident #3 was assisted by CNA FF with rolling onto the right side to expose his coccyx for wound care. Wound care was performed by LVN GG, and at completion, Resident #3 was covered with a sheet and positioned for comfort by both staff members. No additional infection prevention concerns were observed during the procedure. After exiting the room at the completion of the procedure, CNA M was observed walking through the hallway at 12:12 PM holding soiled linens with gloved hands. CNA M then entered the locked area containing soiled linen. In an interview conducted on 3/20/2025 at 08:48 AM, CNA M stated she had started working at the facility five days prior with no prior experience in healthcare. CNA M stated she had not received any training from the facility regarding the handling of soiled linens. She was unsure if she had received training regarding removing soiled gloves prior to exiting a resident's room. CNA M was questioned about the use of PPE in the isolation rooms and stated they would just say gloves. They don't say anything about gowns, like nobody checks to make sure you are wearing gowns. I don't see other CNAs or nurses wearing gowns. CNA M correctly stated PPE was necessary when caring for a resident with EBP isolation precautions . An interview was conducted with LVN GG on 3/20/2025 at 1:12 PM. LVN GG confirmed that CNA FF did not wear proper PPE (disposable gown) during incontinent care or care during the observation on 3/19/2025. LVN GG reported speaking to CNA FF after the procedure to educate about the need for a gown when providing care to residents with EBP isolation precautions . The DON was interviewed on 3/21/2025 at 10:50 AM,. she reported an expectation of staff following the posted precautions when caring for a resident with transmission-based precautions, and she described training for infection control hosted upon hire and at least quarterly for all staff. When told of the observations regarding infection control, the DON explained that CNA FF was a newer employee and has required reminders about utilizing PPE. The DON also stated staff should be putting soiled linen into a bag prior to exiting the room. The DON was asked about the potential harm of staff members not following infection control procedures, and she stated that it could spread infection. The facility policy Infection Prevention and Control revised April 2024 was reviewed, and on page 8, the policy stated EBP requires the use of gown and gloves during high-contact resident care activities . On page 9, high-contact resident care activities are clarified to include providing hygiene, changing briefs, and during wound care of open wounds . A policy regarding the control of infection during general linen handling was requested from the Administrator. The Administrator explained that there was not a policy specifically addressing this issue and that the information was likely contained within the general infection control policy. The Infection Prevention and Control policy describes linen handling on page 12 for residents on isolation precautions (proper handling of laundry and linens of patients on isolation precautions ensuring linens are handled in a manner to prevent transmission of infectious agents) but does not explicitly describe the methods or procedures.