

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER The Heights of Bulverde		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 8 residents (Resident #1) whose assessments were reviewed. The facility failed to indicate Resident #1's had an indwelling urinary catheter on her Quarterly MDS dated [DATE]. This failure could place residents at risk for inadequate care due to inaccurate assessments. The findings included: Record review of Resident #1's admission Record, dated 10/04/2025, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included high blood pressure, diabetes (chronic elevated levels of blood sugar which can affect other organs and bodily tissues), Parkinson's disease (progressive neurological disorder that affects, movement, balance and coordination), hypothyroidism (low blood levels of thyroid hormones) and systemic Lupus Erythematosus (a chronic autoimmune disease where the body's immune system attacks healthy tissues and organs, causing damage). Record review of Resident #1's Quarterly MDS assessment, dated 09/23/2025, revealed the resident's BIMS score was 15 out of 15, indication her cognitive skills for daily decision making were not impaired, and it was not marked the resident had an indwelling urinary catheter. Record review of Resident #1's care plans dated 10/05/2025, revealed a care plan for the focus area of At risk for infection or recurrent/chronic infection related to compromised medical condition: foley cath, initiated 05/23/2025 and revised on 10/04/2025. Record review of Resident #1's electronic clinical record Physician's Order Summary Report dated 10/04/2025 revealed an order to admit Resident #1 to Hospice A dated 06/20/2025 with no discontinue date, and another order to admit to Hospice B dated 8/21/25 with diagnoses of Parkinson's disease; and there was no order for an indwelling urinary catheter. Record review of Resident #1's electronic clinical record under the Miscellaneous section revealed a New Order Form dated 06/30/2025 with a handwritten order from Hospice A Physician I to Place Foley [urinary] cath [catheter] for [urinary] retention and an order for an antibiotic (Cipro 500 mg) to be administered by mouth twice a day for 10 days for diagnosis of Urinary Tract Infection, and was signed by Hospice A Physician I. Record review of Resident #1's electronic clinical record under the Miscellaneous section revealed a Hospice A Meeting Review note, dated 07/01/2025, which noted on 06/30/2025 Resident #1 was complaining of symptoms of urinary retention. Resident #1 wanted an in-and-out catheter which was placed and left for urinary retention. Resident #1 had over 1 L [Liter] of urine retention. Her urine was cloudy. Cipro 500 mg bid [twice a day] x 10 days started. Record review of Resident #1's Hospice A Nursing Clinical Notes, dated 07/02/2025, 07/07/2025, and 07/10/2025 revealed Resident #1 had an indwelling urinary catheter. Record review of Resident #1's Hospice B admission Orders, dated 08/19/2025, revealed she was admitted with hospice diagnosis of Parkinson's disease, and an order for the indwelling urinary catheter was not listed. Record review of Resident #1's Hospice B Facility and Hospice Delineation of Duties Plan of Care, dated 08/19/2025, revealed both Hospice B and the facility were responsible to provide indwelling urinary catheter care, insertion, and change the catheter. Record review of Resident #1's Hospice B Plan of Care, dated 8/19/2025, revealed the resident was admitted for hospice services; the aide was responsible to provide urinary catheter care such as emptying the drainage bag, performing pericare, and notify if the bag was leaking; and the skilled nurse was responsible to assess the function of the indwelling urinary catheter and drainage system; and supplies Hospice B would provide included indwelling urinary catheter and drainage bag. Under the Order Section of the Hospice B Plan of Care was Resident #1 may have an indwelling urinary catheter that was to be changed every 30 days and as needed. Record review of Resident #1's nurses' note dated 09/14/2025 by LVN J revealed Hospice B was contacted due to the urinary catheter leaking, the hospice nurse came into the facility, a new catheter was inserted which was patent and draining urine which Resident #1 tolerated. In an interview on 10/04/2025 at 3:43 PM, RN A stated Resident #1 had an indwelling urinary catheter. Observation on 10/04/2025 at 3:58 PM revealed Resident #1 was in bed with an indwelling urinary catheter collection bag hung on the resident's bed frame with clear yellow urine. In a further interview on 10/04/2025 at 4:19 PM, RN A stated Resident #1 had the indwelling urinary catheter since she was admitted to hospice care because of urinary retention. RN A said initially an in-and-out catheter was done but Resident #1 still retained urine, so an indwelling urinary catheter was inserted. In an interview on 10/04/2205 at 4:22 PM, RN A reviewed Resident #1's physician's orders in the electronic clinical record, stated she did not see an order for the indwelling urinary catheter and said, I guess it's not in there. In an interview on</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible, for 1 of 3 residents (Resident #1) reviewed for urinary catheters. The facility failed to ensure Resident #1's Hospice A Physician I's handwritten order for the indwelling urinary catheter that had been in place for 95 days was on the electronic physician orders; and did not document when urinary catheter care was provided or if the urinary catheter had been replaced every 30 days as ordered by Hospice B. This failure could place residents at risk for a decline in their health status. The findings included: Record review of Resident #1's admission Record, dated 10/04/2025, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included high blood pressure, diabetes (chronic elevated levels of blood sugar which can affect other organs and bodily tissues), Parkinson's disease (progressive neurological disorder that affects, movement, balance and coordination), hypothyroidism (low blood levels of thyroid hormones) and systemic Lupus Erythematosus (a chronic autoimmune disease where the body's immune system attacks healthy tissues and organs, causing damage). Record review of Resident #1's Quarterly MDS assessment, dated 09/23/2025, revealed the resident's BIMS score was 15 out of 15, indication her cognitive skills for daily decision making were not impaired, and it was not marked the resident had an indwelling urinary catheter. Record review of Resident #1's care plans dated 10/05/2025, revealed a care plan for the focus area of At risk for infection or recurrent/chronic infection related to compromised medical condition: foley cath, initiated 05/23/2025 and revised on 10/04/2025. Record review of Resident #1's electronic clinical record Physician's Order Summary Report dated 10/04/2025 revealed an order to admit Resident #1 to Hospice A dated 06/20/2025 with no discontinue date, and another order to admit to Hospice B dated 8/21/25 with diagnoses of Parkinson's disease; and there was no order for an indwelling urinary catheter. Record review of Resident #1's electronic clinical record under the Miscellaneous section revealed a New Order Form dated 06/30/2025 with a handwritten order from Hospice A Physician I to Place Foley [urinary] cath [catheter] for [urinary] retention and an order for an antibiotic (Cipro 500 mg) to be administered by mouth twice a day for 10 days for diagnosis of Urinary Tract Infection, and was signed by Hospice A Physician I. Record review of Resident #1's electronic clinical record under the Miscellaneous section revealed a Hospice A Meeting Review note, dated 07/01/2025, which noted on 06/30/2025 Resident #1 was complaining of symptoms of urinary retention. Resident #1 wanted an in-and-out catheter which was placed and left for urinary retention. Resident #1 had over 1 L [Liter] of urine retention. Her urine was cloudy. Cipro 500 mg bid [twice a day] x 10 days started. Record review of Resident #1's Hospice A Nursing Clinical Notes, dated 07/02/2025, 07/07/2025, and 07/10/2025 revealed Resident #1 had an indwelling urinary catheter. Record review of Resident #1's Hospice B admission Orders, dated 08/19/2025, revealed she was admitted with hospice diagnosis of Parkinson's disease, and an order for the indwelling urinary catheter was not listed. Record review of Resident #1's Hospice B Facility and Hospice Delineation of Duties Plan of Care, dated 08/19/2025, revealed both Hospice B and the facility were responsible to provide indwelling urinary catheter care, insertion, and change the catheter. Record review of Resident #1's Hospice B Plan of Care, dated 8/19/2025, revealed the resident was admitted for hospice services; the aide was responsible to provide urinary catheter care such as emptying the drainage bag, performing pericare, and notify if the bag was leaking; and the skilled nurse was responsible to assess the function of the indwelling urinary catheter and drainage system; and supplies Hospice B would provide included indwelling urinary catheter and drainage bag. Under the Order Section of the Hospice B Plan of Care was Resident #1 may have an indwelling urinary catheter that was to be changed every 30 days and as needed. Record review of Resident #1's July 2025 MAR/TAR revealed Resident #1 received the antibiotic Cipro 500 mg twice a day by mouth for 10 days and there was no documentation of indwelling urinary catheter care or if the indwelling urinary catheter had been replaced. Record review of Resident #1's August 2025 MAR/TAR revealed there was no documentation of an indwelling urinary catheter care or if the indwelling urinary catheter had been replaced. Record review of Resident #1's September 2025 MAR/TAR revealed there was no documentation of an indwelling urinary catheter care or if the indwelling urinary catheter had been replaced. Record review of Resident #1's October 2025 MAR/TAR revealed there was no documentation of an indwelling urinary catheter care from 10/01/2025</p>		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 1 of 8 residents (Resident #1) reviewed for clinical records. The facility failed to ensure Resident #1's electronic clinical record had Hospice A Physician I's handwritten order for the indwelling urinary catheter, that had been in place for 95 days and did not discontinue the order for Hospice A when the resident admitted to Hospice B. This failure could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. The findings included: Record review of Resident #1's admission Record, dated 10/04/2025, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included high blood pressure, diabetes (chronic elevated levels of blood sugar which can affect other organs and bodily tissues), Parkinson's disease (progressive neurological disorder that affects, movement, balance and coordination), hypothyroidism (low blood levels of thyroid hormones) and systemic Lupus Erythematosus (a chronic autoimmune disease where the body's immune system attacks healthy tissues and organs, causing damage). Record review of Resident #1's Quarterly MDS assessment, dated 09/23/2025, revealed the resident's BIMS score was 15 out of 15, indication her cognitive skills for daily decision making were not impaired, and it was not marked the resident had an indwelling urinary catheter. 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Record review of Resident #1's nurses' note dated 09/14/2025 by LVN J revealed Hospice B was contacted due to the urinary catheter leaking, the hospice nurse came into the facility, a new catheter was inserted which was patent and draining urine which Resident #1 tolerated. Record review of Resident #1's nurses' note dated 10/03/2025, created on 10/04/2025 at 4:24 PM by RN A revealed Hospice B nurse came into facility per resident request to replace foley [indwelling urinary catheter]. Foley 16fr [size of catheter inserted] was placed successfully by hospice nurse. In an interview on 10/04/2025 at 3:43 PM, RN A stated Resident #1 had an indwelling urinary catheter. Observation on 10/04/2025 at 3:58 PM revealed Resident #1 was in bed</p>		