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	12/10/2025

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). (continued on next page)

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

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

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free from involuntary seclusion and any physical restraint not required to treat the resident's medical symptoms for 1 of 6 (Resident #1) residents reviewed for involuntary seclusion.The facility failed to obtain a physician order, documenting the clinical criteria met for placement in the secured/locked unit, prior to Resident #1's move to the secured unit on 06/24/2025.This failure could place residents who resided on the secure unit at risk for feelings of isolation and anxiety.The findings included:Record review of Resident #1's admission Record, dated 09/22/2025, revealed a [AGE] year-old male admitted on [DATE]. Resident #1 was not listed as his own responsible party with his [family member] listed as Emergency Contact #1. Resident #1 discharged on 09/01/2025. Record review of Resident #1's Medical Diagnoses, undated and accessed 09/22/2025 at 03:37 p.m., revealed diagnoses including Alzheimer's Disease (a progressive disease that affects memory and other important mental functions), muscle wasting and atrophy (shrinking of muscle or nerve tissue), chronic kidney disease (a condition where the kidneys lose their ability to filter blood and remove wastes), and hypertension (condition of high pressure in the vessels that carry blood from the heart to the rest of the body). Record review of Resident #1's Census data, undated and accessed 09/22/2025 at 03:37 p.m., revealed Resident #1 was moved into the secure unit on 06/24/2025. Record review of Resident #1's admission MDS, dated [DATE] and signed 07/03/2025 as completed, reflected a BIMS score of 09, indicating moderate cognitive impairment. Resident #1 was documented as having not exhibited any behavioral symptoms, including wandering. Resident #1's functional abilities were documented as requiring partial/moderate assistance to set up or clean-up assistance. Record review of Resident #1's discharge MDS, dated [DATE] and signed 09/06/2025 as completed, reflected Resident #1 wandered 1 to 3 days. The timeframe for Resident #1 having wandered was not specified within the assessment, except for the date of the assessment, 09/01/2025 and the noted end date of the observation for the assessment, 09/01/2025. Resident #1's functional abilities were documented as requiring supervision or touching assistance to being independent. Record review of Standard Assessment tab on Resident #1's EMR, undated and accessed on 09/22/2025 at 03:45 p.m., did not reveal an Elopement Risk Evaluation. Assessments noted as documented from the date of admission, 06/22/2025 through to the date of transfer to the secure unit, 06/24/2025 included: - Nrsg: Admission/Readmission., dated 06/22/2025, noted as In Progress, - SS: Social Services - Admission/Readmission., dated 06/23/2025, noted as Complete, and - IDT: Care Plan Conference & Advanced Care Planning Review., dated 06/24/2025, noted as Complete. Record review of Resident #1's Nrsg: Admission/Readmission. assessment, dated 06/22/2025, revealed No was selected for .does the resident display exit seeking behavior?. The Exit Seeking Careplan section did not include noted care plan focuses or interventions.Record review of Resident #1's SS: Social Services - Admission/Readmission., dated 06/23/2025, did not reveal need for secure unit placement or noted history of behaviors, including wandering or attempted elopements. Record review of Resident #1's IDT: Care Plan Conference & Advanced Care Planning Review., dated 06/24/2025, revealed 4. Psychiatric/Psychological Status and or Behaviors selected for under C. Advanced Care Plan: Care Choices Elected; however, additional comments not provided and secure unit placement not noted as an intervention. Record review of Resident #1's Order Recap Report, dated 09/25/2025 for order dates: 06/01/2025 - 09/30/2025, reflected no orders for secure unit placement. Record review of Resident #1's care plan, undated and accessed 09/22/2025 at 03:48 p.m., did not reveal mention of secure unit placement, risk for elopement, or wandering interventions. Record review of Resident #1's progress notes, dated 06/22/2025 (day of admission) to 06/24/2025 (day of transfer to secure unit), indicated no documentation about why a room change to the secure unit was made. No progress notes were found mentioning Resident #1 had tried to elope, ask where the exit was, or had wandering behaviors. Resident #1 was unavailable for observation or interview. During an interview on 09/26/2025 at 03:06 p.m., Resident #1's family member and emergency contact #1 stated the facility notified her of Resident #1's move to the secure unit and stated the move was due to Resident #1 having been exit seeking. She revealed she did not consent to Resident #1's move and stated she did not feel the facility attempted alternate interventions such as redirecting and providing activities to Resident #1 while he settled in at the nursing home. She revealed, upon moving Resident #1 to the secure unit, the facility staff removed some of Resident #1's personal property from his initial room. She stated the family were then notified he

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized for two of six residents (Resident #1 and Resident #3) reviewed for clinical records. 1. The facility failed to ensure Resident #1's medical record included an initial physician visit note when reviewed greater than 90 days (09/22/2025) after admission [DATE]). 2. The facility failed to ensure Resident #3's medical record included an initial physician visit note when reviewed greater than 90 days (09/22/2025) after admission [DATE]). 3. The facility failed to document wound care was provided to Resident #3 on three (3) occasions (Friday, 08/22/2025, Sunday, 08/24/2025, and Sunday, 08/31/2025) on Resident #3's August Treatment Administration Record (TAR). These failures could place residents at risk of not receiving the care and services needed due to inaccurate or in-complete clinical records. The findings included:1. Record review of Resident #1's admission Record, dated 09/22/2025, revealed a [AGE] year-old male admitted on [DATE]. Resident #1 was not listed as his own responsible party with his [family member] listed as Emergency Contact #1. Resident #1 discharged on 09/01/2025. Record review of Resident #1's Medical Diagnoses, undated and accessed 09/22/2025 at 03:37 p.m., revealed diagnoses including Alzheimer's Disease (a progressive disease that affects memory and other important mental functions), muscle wasting and atrophy (shrinking of muscle or nerve tissue), chronic kidney disease (a condition where the kidneys lose their ability to filter blood and remove wastes), and hypertension (condition of high pressure in the vessels that carry blood from the heart to the rest of the body). Record review of Resident #1's admission MDS, dated [DATE] and signed 07/03/2025 as completed, reflected a BIMS score of 09, indicating moderate cognitive impairment. Resident #1 was documented as having not exhibited any behavioral symptoms, including wandering. Resident #1's functional abilities were documented as requiring partial/moderate assistance to set up or clean-up assistance. Record review of Resident #1's discharge MDS, dated [DATE] and signed 09/06/2025 as completed, reflected Resident #1 wandered 1 to 3 days. Resident #1's functional abilities were documented as requiring supervision or touching assistance to being independent. Record review of Resident #1's progress notes dated 06/01/2025- 09/01/2025 did not reveal a progress note written by a physician or MD. A MD, NP Progress Notes, dated 07/26/2025 and signed by NP F was the only note noted in the progress notes written by the NP. Record review of Resident #1's MD, NP Progress Notes, dated 07/26/2025 and signed by NP F reflected Resident #1 was seen by NP F on 07/26/2025. Record review of Resident #1's EMR Misc tab on 09/25/2025 did not reveal documentation of a physician or MD note apart from referral documentation. Resident #1 was unavailable for observation or interview.During an interview on 09/26/2025 at 03:06 p.m., Resident #1's family member and emergency contact #1 stated she was unaware of and didn't know if Resident #1 had seen a physician while at the nursing facility. 2. Record review of Resident #3's admission Record, dated 09/22/2025, revealed an [AGE] year-old male admitted on [DATE]. Resident #3 was noted as on hospice. Resident #3 was not listed as his own responsible party with his [family member] listed as Emergency Contact #1. Record review of Resident #3's Medical Diagnoses, undated and accessed 09/22/2025 at 06:08 p.m., revealed diagnoses including chronic obstructive pulmonary disease (a type of progressive lung disease), dementia (a general term for impaired ability to remember, think, or make decisions), and adult failure to thrive (a condition where an older adult loses appetite, weight, and interest in activities). Record review of Resident #3's quarterly MDS, dated [DATE] and signed 06/22/2025 as completed, reflected Resident #3 had a BIMS score of 03, indicating severe cognitive impairment. Resident #3 was noted as dependent for all self-care and mobility needs, except substantial/maximal assistance with rolling left or right on the bed. He was at risk for developing pressure ulcers/injuries but documented as not having a current skin condition, including a pressure ulcer/injury. He was noted to have a pressure reducing device for his chair and for his bed.Record review of Resident #3's progress notes dated 03/08/2025- 04/21/2025 did not reveal a progress note written by a physician or MD. Record review of Resident #3's EMR Misc tab on 09/25/2025 did not reveal documentation of a physician or MD note apart from initial referral, hospice, and physician orders documentation. During an observation of Resident #3 on 09/22/2025 at 04:35 p.m., he was noted to be asleep in bed. Attempted interview with Resident #3 revealed he was not interviewable. During an observation on 09/24/2025 at 12:07 p.m., Resident #3 was noted to not be present in his room. His bed was noted to have a pressure reducing

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 laundry room reviewed for infection control. The facility failed to properly store clean resident clothing and mechanical lift slings in the facility clean laundry room.These failures could place the residents at risk of cross-contamination and development of infection.The findings included:During an observation of the clean side, noted on door of laundry room, of the nursing facility laundry room on 09/22/2025 at 04:52- 04:53 p.m., observed a bag of clean resident clothing, stored in a large clear bag with a hole in the bottom of the bag resulting in clothing spilled out and touching the laundry room floor. Observed approximately 5 mechanical lift slings hanging off the side of a trash can with straps of the slings touching the floor. During an interview on 09/26/2025 at 11:07 a.m., the LAM revealed he had been working as the manager for the facility's laundry for two weeks. He revealed the facility had been having issues with the laundry prior to his start and that he was still working to ensure all the resident clothing was cleaned and returned. He did not mention proper clothing or equipment storage for sanitation. During an interview on 09/26/2025 at 05:52 p.m., the DNS revealed the laundry services had been improving but he wouldn't say they were perfect yet. He revealed the department head for laundry was new. He did not mention proper clothing or equipment storage for sanitation. During an interview on 09/26/2025 at 07:00 p.m., the ADMIN revealed the facility had lost the prior laundry manager and had to let go of around 4-5 people in the laundry department recently due to not performing their job duties correctly. He revealed due to those changes the contracted laundry company had to send other people in to help with laundry and a new manager, the LAM, just started around 2 weeks ago. He did not mention proper clothing or equipment storage for sanitation. Requested policies for Laundry and Infection Control from the ADMIN on 09/22/2025. He provided policies titled, Routine Resident Care.Record review of policy titled, Routine Resident Care, date revised January 2023, revealed Residents should receive the necessary assistance to maintain good grooming and personal/oral hygiene.Care is taken to maintain resident safety at all times.f. Multi-patient use equipment should be cleaned/disinfected after patient use.