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	06/25/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Resident has the right to be informed of, and participate in, his or her treatment, including: the accurate communication and implementation of code status for 1 of 4 residents (Resident #53) reviewed resident rights and advance directives. Resident #53 had a discrepancy in code status, as evidenced by contradictory records found in the medical chart. This failure to ensure consistency in the resident code status violates their autonomy and places them at risk of receiving treatment contrary to their expressed wishes. Findings included: Record review of Resident #53's face sheet revealed an [AGE] year-old male admitted on [DATE]. Diagnoses included Senile Degeneration of the Brain (a decline in cognitive function, particularly memory and thinking skills), Dementia (progressive or persistent loss of intellectual functioning) Depression (mental health disease of high and low mood swings), Anxiety (intense, excessive, and persistent worry and fear). Record review of Quarterly MDS assessment dated [DATE] revealed BIMS (Basic Interview of Mental Status) Score of 8 indicating moderate cognitive impairment and required supervision with self-feeding, toilet hygiene, dressing, bed mobility, bathing and gait. Record review of Resident #53's medical record revealed a discrepancy was found between Resident #53 face sheet, care plan (dated 06.20.2025), OOH-DNR (dated 02.14.2025), and orders (no orders for DNR in EHR). The profile reflected Resident #53 was a full code; the care plan reflected the resident was a full code; and the Misc. Documents revealed an OOH- DNR signed by the physician dated February 2025. Resident #53's orders reflected hospice and contradictory (RN to pronounce) information for Full Code. During an interview with Resident #53 on [DATE] at 3:27 p.m., Resident #53 was asked what his wishes were if he were to stop breathing and needed CPR. He replied that he believed he would want CPR to keep on living. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Social Worker on [DATE] at 1:52 p.m., the SW was able to see and verify the discrepancy noted in Resident #53' s chart. The face sheet showed a full code, and there was a signed OOH- DNR order found in EHR under Misc. Documents . The SW was not aware if Resident #53 had an Ad Litem (someone appointed by the court to represent the interests of someone who cannot represent themselves) but verified that the two physicians who admitted Resident #53 to hospice were also the ones who signed the OOH- DNR. Resident #53 did not sign any consents to hospice or OOH-DNR. The last care plan meeting was 06.12.2025 and Resident #53 was not present . During an interview with the DON on [DATE] at 4:50 p.m., the DON stated that she did see a concern with the discrepancy and that the Social Worker would be the one to ensure that Resident #53's wishes had been updated during the care plan meeting. She understood the concerns with the discrepancy would be that his Resident #53 wishes were not followed. During an interview with the ADM on [DATE] 05:38 PM, the ADM stated he was aware of the discrepancies in the advance directives for Resident #53. That Resident #53 should be informed and make decisions regarding his treatment plan. The ADM stated that resident records should be updated at care plan meetings, and the SW was responsible for ensuring accuracy of wishes and code status. Review of the facility policy titled, The Facility Manual, revised [DATE], reflected Resident Rights, Exercise of Rights, Residents will have the right to exercise their rights as residents of the community and as citizens or residents of the United States. Residents will have the right to be free of interference, coercion, discrimination, and reprisal from the community in exercising his or her rights.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents right to request to formulate an advance directive and accurate documentation of advance directives was maintained and implemented for 1 of 4 residents (Resident #53). Resident #53's OOH-DNR was signed and in misc. documents while face sheet and care plan were listed as full code. This deficient practice could place the resident at risk of receiving care inconsistent with their wishes. The findings were: Record review of Resident #53's face sheet revealed an [AGE] year-old male admitted on [DATE]. Diagnoses included Senile Degeneration of the Brain (a decline in cognitive function, particularly memory and thinking skills), Dementia (progressive or persistent loss of intellectual functioning) Depression (mental health disease of high and low mood swings), Anxiety (intense, excessive, and persistent worry and fear). Record review of Quarterly MDS assessment dated [DATE] revealed BIMS (Basic Interview of Mental Status) Score of 8 indicating moderate cognitive impairment and required supervision with self-feeding, toilet hygiene, dressing, bed mobility, bathing and gait. Record review of Resident #53's medical record revealed a discrepancy was found between Resident #53 face sheet, care plan (dated 06.20.2025), OOH-DNR (dated 02.14.2025), and orders (no orders for DNR in EHR). The profile reflected Resident #53 was a full code; the care plan reflected the resident was a full code; and the Misc. Documents revealed an OOH- DNR signed by the physician dated February 2025. Resident #53's orders reflected hospice and contradictory (RN to pronounce) information for Full Code. During an interview with Resident #53 on [DATE] at 3:27 p.m., Resident #53 was asked what his wishes were if he were to stop breathing and needed CPR. He replied that he believed he would want CPR to keep on living. During an interview with the Social Worker on [DATE] at 1:52 p.m., the SW was able to see and verify the discrepancy noted in Resident #53' s chart. The face sheet showed a full code, and there was a signed OOH- DNR order found in EHR under Misc. Documents . The SW was not aware if Resident #53 had an Ad Litem (someone appointed by the court to represent the interests of someone who cannot represent themselves) but verified that the two physicians who admitted Resident #53 to hospice were also the ones who signed the OOH- DNR. Resident #53 did not sign any consents to hospice or OOH-DNR. The last care plan meeting was 06.12.2025 and Resident #53 was not present . (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on [DATE] at 4:50 p.m., the DON stated that she did see a concern with the discrepancy and that the Social Worker would be the one to ensure that Resident #53's wishes had been updated during the care plan meeting. She understood the concerns with the discrepancy would be that his Resident #53 wishes were not followed. During an interview with the ADM on [DATE] 05:38 PM, the ADM stated he was aware of the discrepancies in the advance directives for Resident #53. That Resident #53 should be informed and make decisions regarding his treatment plan. The ADM stated that resident records should be updated at care plan meetings, and the SW was responsible for ensuring accuracy of wishes and code status. Record review of the facility policy, Advanced Directives, reviewed [DATE], revealed, The medical record and resident's plan of care should reflect the resident's wishes as well as the physician orders in order to meet the directives described.

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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 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** Based on observation, 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 1 of 8 residents (Resident #55) reviewed for care plans. The facility failed to ensure Resident #55 was provided a pad type call light which was care planned as an intervention for the resident. This deficient practice places residents at risk for not receiving proper care and services due to not implementing care plan interventions. The findings were: Record review of Resident #55's face sheet, dated 06/23/2025, revealed he was admitted on [DATE] with diagnoses which included: muscle wasting and atrophy, not elsewhere classified, multiple sites, multiple sclerosis (a chronic, often disabling, disease of the central nervous system that affects the brain and spinal cord) , other lack of coordination, chronic pain syndrome, and muscle weakness (generalized). Record review of resident #55's Quarterly MDS assessment, dated 06/19/2025, revealed the resident's BIMS score 07 for moderate cognitive impairment. The Quarterly MDS assessment further revealed Resident #55 required substantial/maximal assistance (helper does more than half the effort) for sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer and tub/shower transfer. Record review of Resident #55's care plan, initiated date 03/19/2025, revealed Resident #55 had a focus of I use a specialized call light: Unable to push the button on the traditional call light and intervention/tasks Provide Pad type call light. During observation and interview on 06/22/2025 at 11:24 AM Resident #55 stated she had trouble with her call light. Resident #55 further stated she relied a great deal on her roommate to call when she needed something. Resident #55 was observed lying flat in the bed with the call light within reach however when she attempted to push her call light using one finger, she only pressed the side of the call light not the red button. The call light did not turn on due to resident had not manage to push the call light button. During observation and interview on 06/24/2025 at 7:28 AM revealed Resident #55 was up in her wheelchair at bedside with the over bed table in front of her and a traditional call light sitting on the side of bed within reach. Resident #55 was observed being able to this time to push the button of the call light, turning on the call light. Resident #55 stated she got shaky sometimes and had trouble with her call light. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/2025 10:15 AM the DON stated she was not aware of Resident #55 not being able to use her call light and they would get her the pad call light (call light requiring the resident only to tap). The DON further stated she was not aware it had been care planned for Resident #55 to have a pad call light. The DON stated Resident #55 had never complained to her that she was calling, and nobody was coming. The DON stated by not having the proper call light the resident would not be able to get a hold of them for what she needed. The DON stated she had personally answered her call light and was not aware the roommate was pushing the button for Resident #55. The DON stated the light outside of the room alerting staff did not tell them which bed pushed the light but, just that the room needed assistance. During an interview on 06/25/2025 11:21 AM the MDS Coordinator stated when the care plan was done back in March 2025 Resident #55 had a touch pad call light. The MDS Coordinator stated she was not sure what had happened and was not aware Resident #55 no longer had it. The MDS Coordinator stated she was not sure if Resident #55 had complained about the touch pad call light. The MDS Coordinator further stated the DON was going to put it back and it was going to stay the same. The MDS Coordinator stated she did not feel by not having the touch pad it would have been an issue because Resident #55 used the roommate many times to use the call light, and further stated Resident #55 would wheel herself out of the room to get staff and had used the call light before when it was a push call light. The MDS Coordinator stated in June 2025 when the care plan was reviewed, she was not aware Resident #55 did not have the touch pad call light. During an interview on 06/25/2025 at 5:09 PM the DON stated the care plan directed the care for the residents and by not following the care plan it could disrupt the continuity of care. The DON further stated nursing as a whole was responsible to ensure staff were aware of the care plan needs of the residents. The DON stated the staff were aware of the interventions for care or the care plan by the use of the Kardex system and the nurses had access to the view both the Kardex and the care plans. The DON was not sure if the specialized call lights were part of the Kardex. The DON further stated the Kardex was more regarding the care, but the Kardex was customizable. During an interview on 06/25/2025 5:35 PM the Administrator stated nursing was responsible for the implementation of the care plan. The Administrator stated by not following the interventions of the care plan and providing resident with the pad call light Resident #55 might not be able to alert staff to answer the call light. Record review of facility's Care Plans policy, revised date January 2023, read, Guidelines: Care Plans: The community develops a comprehensive care of each resident that includes measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan should be reflective of the identified problem or risk, a measurable outcome objective and appropriate intervention/interventions in relation to the identified problem or risk, outcome objective, and the resident's ability, needs medical condition, preventative measures. The care plan may also include 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. (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 facility's Routine Resident Care policy, revised date January 2024, read, Compliance Guidelines: Residents should receive the necessary assistance to maintain good grooming, personal/oral hygiene and safety. Steps are taken to provide that a resident's capacity for self-performance of these activities does not diminish unless circumstances of the resident's clinical condition demonstrate the decline is unavoidable. Care is taken to maintain resident safety at all times. Guidelines: #11 Team members should follow the resident plan of care and update with identified resident changes.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure medication error rates are not 5 percent or greater for 1 of 4 residents (Resident #19), reviewed for pharmacy services in that the automatic calculation of the medication error rate in the Long-Term Care Survey Process (LTCSP) after 25 opportunities with 2 errors was 8%. LVN A poured two different over the counter bulk facility medications into her bare hand to administer to Resident #19 and put the ones she did not need back into the bottle during a medication administration observation. This failure could place residents at risk of cross contamination, health complications, and illness. The findings were: Record review of Resident #19's face sheet dated 6/25/25 revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with readmission on [DATE]. Her diagnoses included unspecified protein-calorie malnutrition (the lack of sufficient energy or protein to meet the body's metabolic demands), and immunodeficiency due to conditions classified elsewhere (medical condition where an individual's immune system is weakened or not functioning optimally due to another underlying health issue). Record review of Resident #19's quarterly MDS dated [DATE] revealed the resident had a BIMS score of 1 out of 15 indicating the resident was severely cognitively impaired. Record review of Resident #19's care plan with a last reviewed date of 6/22/25 revealed a focus revised on 6/18/25 for nutritional deficits related to malnutrition. Interventions included to provide food, fluids, including supplements as ordered. Another focus initiated on 1/16/25 for chronic health conditions that included malnutrition. Interventions included to Administer medications as ordered. Record review of Resident #19's order summary dated 6/25/25 revealed an order with a start date of 12/10/24 for cyanocobalamin (Vitamin B12) Oral Tablet 1000 mcg once daily. Record review of Resident #19's order summary dated 6/25/25 revealed an order with a start date of 4/19/25 for Ferrous Sulfate (iron) tablet 325 mg once daily. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 6/24/25 at 6:36 a.m. during a medication administration observation for Resident #19, LVN A poured several cyanocobalamin (Vitamin B12) 1000mcg oral tablets from a bulk facility stock bottle (unknown amount) into her bare left hand and tilted her left hand against the bottle and put all the tablets back in the bottle except one that she had in her creased palm to administer to Resident #19. LVN A was asked if she should have poured the medication into her bare hand and or put them back in the bottle prior to her placing the contaminated vitamin B12 tablet in the medicine cup with Resident #19's other meds and she stated she should not have. LVN A discarded the bottle and the pill in her hand into the trash on the medication cart. During this same medication observation LVN A poured several iron 325mg tablets from a bulk facility stock bottle (unknown amount) into her bare left hand and tilted her left hand against the bottle and creased her palm to hold one tablet and began putting the other tablets back into the bottle and paused and then placed them all back in the bottle and discarded the bottle in the medication sharps container and asked another staff member to bring her a new bottle. LVN A stated pouring the medications into her hand and putting them back in the bottle was not a habit for her and she was nervous. LVN A stated she should not have poured the medications into her bare hand and returned them back in the bottle. LVN A stated the possible consequences of doing so could be exposing the resident to germs and contaminates the entire bottle. Review of LVN A's competencies checklist revealed she had met the medication administration competency on 2/17/25. In an attempted interview on 6/25/25 at 6:45 a.m. Resident #19 would smile when asked questions and did not respond to questions. In an interview on 6/25/25 at 10:23 a.m. the DON stated LVN A should not have put the medications in her hand nor returned them to the bulk bottle after touching them and should have used the inside of the lid to the bottle to separate them to 1 pill to administer to the resident. The DON stated the possible consequences of putting the medications in her bare hand and returning them to the bottle could be introducing bacteria. The DON stated there was not a facility policy specific to the medication error rate. Review of the facility policy on medication administration revised January 2024 indicated . 1. Follow safe sanitary practices . d. Do not touch oral medication, topical ointments, or creams .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to store medication with the expiration date on packaging in compliance with state laws and regulations for 1 of 2 medication rooms (300/400 hall) observed for medication storage. The medication room on the 300/400 hall had a box with an [NAME] boot stored without an expiration date. This failure could affect residents prescribed medications and result in less potent medications provided and could result in decreased health response or misuse of medication. The findings included: Interview and observation of medication storage room for 300/400 halls on 06/23/25 at 09:00 AM revealed the date was torn off a box with an [NAME] boot (a wet compression dressing used in the treatment of venous ulcers and dries semirigid similar to a cast) and no date was on the foil package with the [NAME] boot. The DCO took the box with the [NAME] boot and discarded it in the trash. She said she did not know why the package date was torn off that way and she did not know why it was in the medication room. The DCO said it should not have been stored that way. Interview on 6/25/2025 at 4:30PM the Administrator said expiration dates were needed on medications for nurses to know because expired medications could lose its potency and effectiveness over time. Interview on 6/25/2025 at 5:0PM the DON said it was important for medication to have expiration date so the nurse would know when not to use it. She said it was important not to use expired medication because it would not have the same benefits of what was needed to use the medication. Record review of the facility policy titled, Pharmacy Services dated February 2017 stated under Labeling of medications and biologicals: The critical elements of the drug label include: expiration dates.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen observed for kitchen sanitation. 1. The facility failed to ensure trays of prepared and poured glasses of beverages were dated and labeled. 2. The facility failed to ensure soup warmer with soup was returned to kitchen after meal and not left out all night. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: Observation and interview on 06/22/2025 at 9:27 AM revealed during the initial tour of the kitchen 4 trays with beverages prepared in the standing refrigerator not dated or labeled: *1 tray of 8 large glasses of milk, *1 tray of 5 large glasses of juice and water, *1 tray of 20 small glasses of orange juice and, *1 tray of 12 small glasses of milk. The [NAME] stated the trays were from breakfast and she had placed them back in the refrigerator but did not put dates on the trays. The [NAME] stated the date was, so the kitchen staff know when things are put in the refrigerator, so things would not go bad. The [NAME] was observed removing the trays of beverages from the refrigerator and placing the date on them. Observation on 06/24/2025 at 5:30 AM revealed a soup warmer on the counter in the main dining room with soup. The soup warmer did not feel warm to the touch and was not plugged in, the lid to the soup was partially opened due to ladle sticking out there was no date or label on the soup. Observation on 06/24/2025 at 5:36 AM revealed in the standing refrigerator held 6 trays thta were not dated or labeled: *One tray was observed to have 10 large glasses of tea. *Two other trays stacked on each were observed to have glasses of orange juice with the bottom tray being full and top tray almost full. *2 trays of milk stacked on one another with bottom tray full and 11 glasses on the top tray. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*A cup was observed to be sitting in the fridge that look to be chocolate milk, and * a tray with 2 dates on it for 06/22/2025 and 06/23/2025 having 2 glasses of cranberry juice, 6 glasses of milk and 1 glass of water on the tray. During an interview on 06/24/2025 at 5:39 AM the [NAME] stated the beverage trays had been placed by whoever worked last night. The [NAME] further stated the trays with the beverages should have been dated and that she had explained it to them after we came in the first day reminding the other kitchen staff. The [NAME] stated regarding the tray with the two dates was because the 06/22/2025 was not taken off and when the new date was placed. The [NAME] stated the tray of tea she stated should have been dated last night when they put it back in the refrigerator. The [NAME] stated the soup in the dining room was not brought in last night and it should have been. The [NAME] further stated the soup was put out at lunch yesterday. The [NAME] stated she was not sure how long the soup could be out but by not being brought back in to the kitchen the residents could be put at risk of being burned if they were not supervised with the soup or it could make them sick by leaving it out too long. During an interview on 06/24/2025 at 7:02 AM the Administrator stated the soup was usually brought out from the kitchen right before lunch, but there was not a set time they bring it back in to the kitchen, but it should have been after lunch. The Administrator further stated by leaving the soup out bacteria could form, and people could get sick. The Administrator stated items are to be dated and labeled to know when they might go bad. The Administrator stated the kitchen was responsible for removing the soup from the dining room and the labeling of items in the fridge. During an interview on 06/25/2025 at 11:08 AM the DM stated the kitchen the evening of 06/23/2025 should have pulled the soup from the dining room when they closed the kitchen for the night before they left. The DM stated residents could get sick from food borne illness. The DM stated the evening kitchen staff did prep the breakfast items and the beverage trays should have been labeled and dated. The DM further stated anything prepped or opened in the refrigerator should be dated and labeled, so, staff understood it was not old and to know when to pour things out. The DM stated somebody could get sick if the items were left too long in the refrigerator and not thrown out. The DM stated the person placing items in the refrigerator was responsible for labeling and dating the items. During an interview on 06/25/2025 at 5:38 PM the Administrator stated stored and refrigerated items should be labeled and dated so they know it was still okay to serve and prevent food borne illness. The Administrator further stated the kitchen as a whole was responsible for labeling and dating. Record review of in-service training dated 10/16/2024 revealed, staff had been in serviced regarding Labeling and Dating. Record review of in-service training dated 05/20/2025revealed, staff had been in serviced regarding Refrigeration & Dry Storage of Food. Review of facility's policy, Food Storage, no date, read, Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the stated, federal and US Food Codes and HACCP guidelines. Procedure: #2. Date, label and tightly seal all refrigerated foods using clean, no absorbent, covered containers that are approved for food storage.

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	06/25/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medical records were kept in accordance with professional standards and practices and were complete and accurately documented for 1 of 4 residents (Resident #53) reviewed for accuracy of records. The facility failed to ensure Resident #53 expressed Full Code status and the code status documented in the electronic medical record, placing the resident at risk of receiving improper treatment. These failures could place residents at risk for improper care due to inaccurate records. Findings included: Record review of Resident #53's face sheet revealed an [AGE] year-old male admitted on [DATE]. Diagnoses included Senile Degeneration of the Brain (a decline in cognitive function, particularly memory and thinking skills), Dementia (progressive or persistent loss of intellectual functioning) Depression (mental health disease of high and low mood swings), Anxiety (intense, excessive, and persistent worry and fear). Record review of Quarterly MDS assessment dated [DATE] revealed BIMS (Basic Interview of Mental Status) Score of 8 indicating moderate cognitive impairment and required supervision with self-feeding, toilet hygiene, dressing, bed mobility, bathing and gait. During a record review on [DATE] at 11:42am of Misc. Documents section of the clinical record indicated Resident #53 had an OOH- DNR signed by physician dated February 2025. During an interview with Resident #53 on [DATE] at 3:27 p.m., Resident #53 stated he believed he would want CPR to keep on living. During an interview and observation with the social worker on [DATE] at 1:52 p.m., the SW confirmed the discrepancy noted in the chart. The SW was not aware if Resident #53 had an Ad Litem (someone appointed by the court to represent the interests of someone who cannot represent themselves) but verified that the two physicians who admitted Resident #53 to hospice were also the ones who signed the OOH- DNR. Resident #53 did not sign any consents to Hospice or OOH-DNR. The last Care Plan meeting was 06.12. 2025 and Resident #53 was not present. During an interview with the DON on [DATE] at 4:50 p.m., the DON stated there was a concern with the discrepancy in Resident #53s records and the social worker would be the one to ensure his wishes had been updated during the care plan meeting. She stated the discrepancy would be that Resident #53's wishes were not followed. During an interview with the ADM on [DATE] 05:38 PM, the ADM stated he was aware of the discrepancies in advance directives for Resident #53. He stated Resident #53 should be informed and make decisions regarding his treatment plan. ADM stated Resident Records should be updated at care plan meetings and SW was responsible for ensuring accuracy of wishes and code status. (continued on next page)

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	06/25/2025

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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(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 - Few	Record review of the facility policy, Resident Rights, reviewed [DATE], revealed, Residents have the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect their well-being.

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	06/25/2025

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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(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. 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 4 residents (Resident #19) reviewed for infection control. LVN A poured two different over the counter bulk facility medications into her bare hand to administer to Resident #19 and put the pills she did not need back into the bottle during a medication administration observation. This failure could place residents at risk of cross contamination, health complications, and illness. The findings were: In an observation and interview on 6/24/25 at 6:36 a.m. during a medication administration observation for Resident #19, LVN A poured several cyanocobalamin (Vitamin B12) 1000mcg oral tablets from a bulk facility stock bottle (unknown amount) into her bare left hand and tilted her left hand against the bottle and put all the tablets back in the bottle except one that she had in her creased palm to administer to Resident #19. LVN A stated she should not have poured the medications into her bare hands and put the remainder medication back into the bottle. LVN A discarded the bottle and the pill in her hand in the trash on the medication cart. LVN A poured several iron 325mg tablets from a bulk facility stock bottle (unknown amount) into her bare left hand and tilted her left hand against the bottle and creased her palm to hold one tablet and began putting the other tablets back into the bottle, she paused, and placed all pills back in the bottle and discarded the bottle in the medication sharps container and asked another staff member to bring her a new bottle. LVN A stated pouring the medications into her hand and putting them back in the bottle was not a habit for her and she was nervous. LVN A stated she should not have poured the medications into her bare hand and returned them back in the bottle. LVN A stated the possible consequences of doing so could be exposing the resident to germs and contaminates the entire bottle. In an interview on 6/25/25 at 10:23 a.m. the DON stated LVN A should not have put the medications in her hand nor returned them to the bulk bottle after touching them and should have used the inside of the lid to the bottle to separate them to 1 pill to administer to the resident. The DON stated the possible consequences of putting the medications in her bare hand and returning them to the bottle could be introducing bacteria. The DON stated there was not a facility policy specific to the medication error rate. Review of LVN A's competencies checklist revealed she had met the medication administration competency and infection control practices on 2/17/25. Review of the facility policy on medication administration revised January 2024 indicated . 1. Follow safe sanitary practices . d. Do not touch oral medication, topical ointments, or creams .