

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676441	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/05/2025
NAME OF PROVIDER OR SUPPLIER The Heights of Alamo		STREET ADDRESS, CITY, STATE, ZIP CODE 1214 S. Alamo Road Alamo, TX 78516	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828</p> <p>Based on observation, interview and record review, the facility failed to ensure residents had the right to be free of misappropriation of property and exploitation for 2 of 2 residents (Resident #1 and Resident #2) reviewed for misappropriation and exploitation, in that:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure the BOM asked Resident #1 and Resident #2 RP's for permission to use their spending account card. 2. The facility failed to ensure the BOM gave the AD permission to use Resident #1 and Resident #2's spending account card for other residents. 3. The facility failed to ensure the AD did not use Resident #1 and Resident #2's spending account card for unauthorized transactions on 4 occasions. As a result, Resident #1 lost \$318.64, and Resident #2 lost \$313.72 from their spending account card. <p>These failures could affect residents and their responsible party by preventing them from having access to their funds.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Record review of Resident #1's admission record, dated 04/30/25, reflected a [AGE] year-old female admitted on [DATE], an initial admitted [DATE], and an original admitted [DATE]. Her relevant diagnoses included senile degeneration of the brain (encompasses a range of neurological disorders characterized by a progressive decline in cognitive function, impacting memory, reasoning, and the ability to perform everyday activities), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and dementia (a progressive decline in mental abilities, like memory, thinking, and reasoning, that significantly impacts a person's ability to perform daily activities). Further review reflected she had a Resident Representative. <p>Record review of Resident #1's quarterly MDS assessment, dated 04/10/25 reflected a BIMS score of 00, which indicated her cognition was severely impaired.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's quarterly care plan, dated 02/17/25 reflected she had impaired thought process related to Alzheimer's disease. Her intervention in part included notify MD of any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding other, level of consciousness, mental. (date initiated 08/29/23).</p> <p>2. Record review of Resident #2's admission record, dated 04/30/25, reflected an [AGE] year-old female admitted on [DATE] and an original admitted [DATE]. Her relevant diagnoses included Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), vascular dementia (brain damage caused by multiple strokes), and cognitive communication deficit (occurs when communication problems are caused by issues with cognitive processes like attention, memory, or executive function). Further review reflected she had a Resident Representative.</p> <p>Record review of Resident #2's quarterly MDS assessment dated [DATE], reflected her BIMS score was 99, which reflected her cognition was severely impaired.</p> <p>Record review of Resident #2's quarterly care plan dated 03/17/25, reflected she had impaired cognitive function and impaired processes related to vascular dementia. Her interventions, in part included to communicate with the resident/family/caregivers regarding residents capabilities and needed as needed.</p> <p>In an interview on 04/30/25 at 11:00 a.m., the BOM said both Resident #1 and Resident #2 had received a spending account card from their medical insurance provider that ran from 01-01-24 to 12-31-24. She said each month both residents received a deposit of \$50.00 into their spending account card for them to use on over-the-counter medications and/or groceries. She said if the funds were not used, they rolled over onto the following month. The BOM said the spending account cards did not require a personal identification number when used. She said at one point (not sure when) she advised the AD that Resident #1 and Resident #2 had a spending account card that had not been used and had given her permission to use them to buy snacks for Resident #1, Resident #2, and other residents. She said both Resident #1 and Resident #2 had RPs, but she had failed to call them to get their permission to use their spending account cards. The BOM said the AD used Resident #1 and Resident #2's cards on several occasions. The BOM said at first she kept Resident #1 and Resident #2's spending account cards in a safe she kept in her office along with the receipts of what was purchased. She said at some point (not sure when) she said the AD had kept Resident #1's and Resident #2's spending cards in her office (did not remember the reason) and she had forgotten to get them back. The BOM said on 10/18/24, Resident #1's RP approached her and asked if the facility had received Resident #1's spending account card. She said that's what prompted the investigation into the use of Resident #1 and Resident #2's spending cards. The BOM said after their investigation, it was discovered the AD had used \$318.64 from Resident #1's spending account card and \$313.72 from Resident #2's spending account card. The BOM said prior to that incident, the facility did not have a protocol on how to manage a resident's spending account cards, and she did not know the cards could not be used for other residents or that they needed their RPs permission to use them. The BOM said Resident #1 and Resident #2 spending account cards had been mailed to the facility and were not given to their RP's. She said after the investigation, the Administrator had purchased 2 gift cards to reimburse Resident #1 and Resident #2 RP's but had not yet reimbursed them because he was waiting until after the state's investigation.</p> <p>Record review of Resident #1's receipts reflected:</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. On 05/22/24 at 12:36 p.m., a total of \$82.39 was purchased with program card.</p> <p>2. On 05/22/24 at 3:24 p.m., a total of \$85.62 was purchased with program card.</p> <p>3. On 08/16/24 at 2:14 p.m., a total of \$150.63 was purchased with program card.</p> <p>Record review of Resident #2's receipts reflected:</p> <p>1. On 05/22/24 at 3:18 p.m., a total of \$120.09 was purchased with program card.</p> <p>2. On 08/16/24 at 1:04 p.m., a total of \$193.63 was purchased with program card.</p> <p>During an observation on 04/30/25 at 1:10 p.m., Resident #2 was observed in the dining room, she required feeding assistance, her plate consisted of a pureed diet. Resident #2 had her eyes closed and was not verbal.</p> <p>During an observation on 04/30/25 at 1:30 p.m., Resident #1 was observed lying sleep in her bed.</p> <p>In an interview on 04/30/25 at 2:44 p.m., Resident #1's RP said on 10/18/24, while she visited Resident #1 at the facility, she was approached by an insurance representative who tried to recruit Resident #1 and as an incentive, the representative told her Resident #1 would qualify for a spending account card. Resident #1's RP said that's when she remembered she had already applied for Resident #1 in January 2024 but never received the spending account card. She said she approached the BOM and asked her if Resident #1's spending account card had been mailed to the facility. Resident #1's RP said the BOM told her yes, but when the BOM opened the safe she had in her office, the card was not in there. the BOM told her she needed to ask the AD if she had Resident #1's spending account card and that she would get back with her. Resident #1's RP said she had told the BOM, Resident #1 should have a large amount in the card since it had not been used, that's when she was told by the BOM that Resident #1's card had already been used to purchase snacks for Resident #1 and other residents. Resident #1's RP said later that day while still at the facility, she had bumped into the AD and asked her why she had Resident #1's spending account card, not asking her for permission to use the card and why she had purchased snacks for other residents. Resident #1's RP said the AD told her she did have the Resident #1's spending account card but did not know she needed her permission to use it and that she was not supposed be used to purchase snacks for other residents. Resident #1's RP said she observed the AD going back to her office to get Resident #1's spending account card and then gave it to her. Resident #1's RP said she was upset because the facility never called to get her permission to use Resident #1's spending account card much less to buy snacks for other residents. She said her mother suffered from senile and was not able to give consent. She said the Administrator called her days later to let her know he had completed his investigation and that the AD had been terminated. Resident #1's RP was told if she wanted to contact the local law enforcement, she could. Resident #1's RP said the Administrator had also told her she would be reimbursed the full amount that was used from Resident #1's spending account card but up until 04/30/25, she had not been reimbursed.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/30/25 at 4:47 p.m., the Administrator said the BOM had been approached by Resident #1's RP regarding Resident #1's spending account card. He said the RP found out the AD had used Resident #1's spending account card to purchase snacks for her and other residents without her permission. The Administrator said he immediately started an investigation and self-reported to State. He said he had spoken with the AD, and she had confirmed that she used Resident #1's spending account card to buy snacks for Resident #1 and other residents and that she had not called her RP to get permission to use the spending account card. He said he explained to the AD that she should not have purchased snacks/groceries for other residents. He said in reviewing Resident #1's receipts, he noticed the AD had purchased a 12-pack energy drinks. He said he asked the AD about the purchase and the AD said the 12-pack energy drinks were for her personal use and had accidentally included in the items purchased with Resident #1's card. The Administrator said he immediately suspended her pending the investigation. The Administrator said during the investigation he discovered the AD had also used Resident #2's spending account card to purchase snacks for Resident #2 and other residents. He said the AD had failed to call Resident #1 and Resident #2's RP to get permission to use their spending account card. He said he had purchased two gift cards for the amount the AD had spent on Resident #1 and Resident #2's spending card to reimburse their RP's. The Administrator said he still had the gift cards because he wanted to wait until after the intake had been investigated by state. He said at the time of the incident, the facility did not have a policy on how to manage a resident's spending account cards. He said he had included Resident #2 in his investigation but had not self-reported the incident to state nor had informed her RP. The Administrator said the BOM had been responsible for giving the AD permission to use Resident #1 and Resident #2's spending account cards and had failed to call their RP's. He said after his investigation, the AD had been terminated, the BOM had received a written write-up, the allegation of misappropriation had been confirmed and the facility had created a policy related to the resident's spending account cards effective 10/29/24 (he said which was good for the remained of 2024 only). The Administrator said he had not contacted the local law enforcement because the facility's policy did not indicate to do so but had advised Resident #1's RP she could call herself. The Administrator said all staff had been in-serviced on the topic of abuse, neglect, neglect and exploitation on 10/18/24.</p> <p>In a telephone interview on 05/01/25 at 3:49 p.m., Resident #2's RP said she had received a telephone call from the Administrator on 05/01/25 to let her know the former AD had used Resident #2's spending account card without her permission and had purchased snacks for Resident #2 and other residents. The RP said the administrator told her he had already investigated the incident, and the AD had been terminated but had forgotten to call her to let her know when he concluded the investigation. She said the Administrator told her he would be reimbursed the entire amount the AD used from Resident #2's spending account card. The RP said she had wished she had been notified before the purchases since Resident #2 was not verbal and would not be able to say what she wanted. The RP said the Administrator gave her the option to contact law enforcement if she wanted to pursue charges. The RP said she was not going to press charges.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/04/25 at 7:50 p.m., the AD (former) said the BOM had informed her that Resident #1 and Resident #2 had been allowed spending cards from their insurance. She said the BOM had given her permission to use Resident #1 and Resident #2's spending account cards to buy snacks for them and other residents. She said she was never told she needed to get Resident #1 and Resident #2 RP's permission before using their spending account cards. The AD said she used Resident #1 and Resident #2's spending account card on several occasions to buy snacks for them and other residents but did not remember the amount used. She said all the food items bought were for Resident #1, Resident #2, and other residents except for one time she accidentally included a 12-pack energy drink when buying groceries for Resident #1. The AD said she had immediately told the BOM about it and told her she wanted to reimburse Resident #1's spending account card but that the BOM told her she did not know how to reimburse monies back into the spending account cards and that she would get back to her. She said at the beginning of the year, the BOM kept Resident #1 and Resident #2's spending account cards in a safe in her office but sometime before the BOM went on vacation (not sure of the date) she told her to keep the spending account cards in her office in case she needed them while she was out. The AD said on 10/18/24, the Administrator approached her and asked her if she had used Resident #1 and Resident #2's spending card for other residents, if she had purchased a 12-pack energy drink, and if she had asked their RP's for permission to use their card. The AD said she told the Administrator the BOM had given her permission to use Resident #1 and Resident #2's spending account cards to buy snacks/groceries for them and other residents. The AD said she also told the Administrator that she had purchased a 12-pack energy drink for her personal use with Resident #1's spending account card by accident. The AD said she told the Administrator she had immediately notified the BOM of the purchase and her intention to reimburse Resident #1's spending account card but that the BOM told her she did not know how to reimburse monies back into the spending account cards. The AD said she was terminated because she had not requested permission from Resident #1 and Resident #2 RP's, because she had used Resident #1 and Resident #2's spending account card for other residents and because she had purchased a 12-pack energy drink with Resident #1's spending account card.</p> <p>Record review of the facility's Statement of Resident Rights policy implemented on February 2017 and revised in January 2023 reflected:</p> <p>Compliance Guidelines:</p> <p>The community should educate, encourage, and honor the rights of those we serve. Further, the community should assist a resident/patient to fully exercise their rights as applicable. Residents/Patients do not give up their rights when entering a [NAME] Community.</p> <p>Resident/Patient Rights include: 3.The right to be free from abuse and exploitation.</p> <p>Record review of the facility's policy on Abuse Guidance: Preventing, Identifying and Reporting policy implemented on February 2017 and revised in January 2024 reflected:</p> <p>Compliance Guidelines:</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Every resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Residents should not be subjected to abuse by anyone, including, but not limited to, community team members, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. It is the responsibility of our team members, community consultants, attending physicians, family members, visitors, etcetera. To promptly report any incident, I was suspected neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to community management.</p> <p>Seven Elements of ANE .Prevention-The Administrator/Abuse Coordinator has the overall responsibility for the coordination and implementation of the ANE prevention and reporting program.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828</p> <p>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 1 of 2 Residents (Resident #2) who were reviewed for misappropriation of property, in that:</p> <p>The facility failed to report when the AD used Resident #2's Spending Account Card without her permission to purchase food items for Resident #2 and other residents.</p> <p>This failure could place residents at increased risk for potential abuse to unreported allegations of misappropriation of property.</p> <p>The findings were:</p> <p>Record review of Resident #2's admission record, dated 04/30/25, reflected an [AGE] year-old female admitted on [DATE] and an original admitted [DATE]. Her relevant diagnoses included Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), vascular dementia (brain damage caused by multiple strokes), and cognitive communication deficit (occurs when communication problems are caused by issues with cognitive processes like attention, memory, or executive function).</p> <p>Record review of Resident #2's quarterly MDS assessment dated [DATE], reflected her BIMS score was 99, which reflected her cognition was severely impaired. Further review reflected Resident #2 had a legal guardian.</p> <p>Record review of Resident #2's quarterly care plan dated 03/17/25, reflected she had impaired cognitive function and impaired processes related to vascular dementia. Her interventions, in part included to communicate with the resident/family/caregivers regarding residents capabilities and needed as needed.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/30/25 at 11:00 a.m., the BOM said Resident #2's spending account card had also been used by the AD without getting permission from her RP and had been used to purchase food items for other residents. The BOM said Resident #2 had received a spending account card from her medical insurance provider that ran from 01/24 to 12/24. She said each month Resident #2 would get deposited \$50.00 into her card for her to use on over-the-counter medications and/or groceries. She said if the funds were not used, they would roll over onto the following month. The BOM said at one point (not sure when) she advised the AD that Resident #2 had a spending account card that had not been used and she had given the AD permission to use them to buy snacks for Resident #2 and other residents. She said Resident #2 had an RP, but she had failed to call RP to get permission to use the spending account card. The BOM said the AD had used Resident #2's card on several occasions. The BOM said she kept Resident #2's spending account card in a safe she kept in her office along with the receipts of what was purchased but at one point she said the AD kept Resident #2's spending cards in her office (did not remember the reason) and she had forgotten to get it back. The BOM said on 10/18/24, the Administrator investigated an allegation of misappropriation of property for another resident and it was discovered AD had also used Resident #2's spending account card and had been included in his investigation. She said after their investigation, it was determined the amount the amount used on Resident #2's spending account card was \$313.72.</p> <p>In an interview on 04/30/25 at 4:47 p.m., the Administrator said that on 10/18/24, he had investigated an allegation of misappropriation of property that included Resident #2. He said it was determined that the BOM had given the AD permission to use Resident #2's spending account card without her AR's permission and to use it to purchase food items for other residents also. He said the AD had been suspended on 10/18/24 and later terminated on 10/28/24. The Administrator said the BOM had received a disciplinary action on 10/28/24, all staff had been in-serviced on the topic of ANE on 10/18/24. The Administrator said he had confirmed the allegation of misappropriation of property on Resident #2 but had forgotten to report it to state and had not called her RP to let her know of the allegation and findings.</p> <p>In a telephone interview on 05/01/25 at 3:49 p.m., Resident #2's RP said she received a telephone call from the Administrator on 05/01/25 to let her know that on 10/28/24, the former AD had been terminated because she had used Resident #2's spending account card without her (RP's) permission and because the AD had used Resident #2's spending account card to purchase snacks/groceries for other residents. Resident #2's RP said the Administrator told her he had forgotten to call her when he first learned of the incident and when he had concluded his investigation. Resident #2's RP said the Administrator told her he had purchased a gift card with the amount the AD had used from Resident #2's spending account card and that it would be mailed to her since she lived out of state. Resident #2's RP said she had wished she had been notified before the purchases since Resident #2 was not verbal and would not be able to say what she wanted.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/04/25 at 7:50 p.m., the AD (former) said the BOM had informed her that Resident #2 had been allowed a spending card from her insurance and had given her permission to use her card to buy snacks for her and other residents. She said the BOM never told her she needed to get Resident #2's RP permission before using her spending account card. She said she used Resident #2's spending account card on several occasions to buy snacks for her and other residents but did not remember the amount used. She said at the beginning of the year, the BOM kept Resident #2's spending account cards in a safe in her office but sometime before the BOM went on vacation (sometime in the summer of 2024) she told her to keep the spending account cards in her office. The AD said on 10/18/24, the Administrator approached her and questioned about using Resident #2's spending card for her and other residents. She said she told the Administrator the BOM had given her permission to use the card for Resident #2 and other residents. She said the Administrator told her she was not supposed to have used Resident #2's card for other residents and suspended her pending the investigation. She said on 10/28/24, she had been terminated.</p> <p>Record review of the facility's policy on Abuse Guidance: Preventing, Identifying and Reporting policy implemented on February 2017 and revised in January 2024 reflected:</p> <p>Compliance Guidelines:</p> <p>Every resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Residents should not be subjected to abuse by anyone, including, but not limited to, community team members, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. It is the responsibility of our team members, community consultants, attending physicians, family members, visitors, etcetera. To promptly report any incident, I was suspected neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to community management.</p> <p>Seven Elements of ANE .Reporting/Response-All alleged/suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities are individual as may be required by law and per the current state/federal reporting requirements.</p> <p>Reporting Allegations or Suspicions of Abuse:</p> <p>Allegations of, incidents of or suspicions of abuse or neglect are reportable to state authorities in accordance with HHSC's PL 19-17 .Report alleged or suspicions of abuse to HHSC by email reporting or via TULIP reporting within the designated time frames in accordance with HHSC's PL- 1917, not later than 24 hours if the events that cause the allegation do not involve abuse and no not result in serious bodily injury.</p>		

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NAME OF PROVIDER OR SUPPLIER The Heights of Alamo		STREET ADDRESS, CITY, STATE, ZIP CODE 1214 S. Alamo Road Alamo, TX 78516	
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761</p> <p>Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 4 residents (Resident #3) reviewed for accidents and supervision, in that:</p> <p>The facility failed to ensure Resident #3 received adequate supervision to prevent him from falling off the bed fracturing his right distal femur on 07/30/2024.</p> <p>An Immediate Jeopardy was identified on 05/02/2025. The Immediate Jeopardy template was provided to the facility on [DATE] at 06:55 PM. The Immediate Jeopardy was removed on 05/04/2025 at 05:00 PM. The IJ was lowered to isolated with no actual harm with a potential for more than minimal harm.</p> <p>This deficient practice placed all resident as risk of injuries, such as falls, fractures, and death due to improper supervision.</p> <p>The findings included:</p> <p>Record review of Resident #3's admission record dated 05/02/2025 reflected a [AGE] year-old male originally admitted to the facility on [DATE]. His diagnoses included paraplegia (a condition characterized by partial or complete paralysis of both lower limbs, typically affecting the legs, feet, and hips caused by damage to the spinal cord in the thoracic or lumbar regions), chronic kidney disease, Stage 5, dependence on renal dialysis, heart failure, hypertension (high blood pressure), and type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>Record review of Resident #3's quarterly MDS dated [DATE] reflected a BIMS score of 15, indicating Resident #3 was cognitively intact. Resident #3 had adequate hearing, understood others, was understood by others, was always incontinent of bladder, continence of bowel was not rated due to the ileostomy (a surgical procedure where the end of the last part of the small intestine was brought out through an opening in the abdomen, creating an artificial opening). The MDS Section GG reflected, Toilet hygiene: Dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity Or, the assistance of 2 or more helpers is required for the resident to complete the activity).</p> <p>Record review of Resident #3's 05/20/2024 Care Plan revealed:</p> <p>FOCUS: o I have a Self Care deficit r/t impaired mobility, multiple comorbidities, disease process. At times I require more staff support than others based on comorbidities Date Initiated: 01/08/2024 Created on: 05/25/2022 Revision on: 01/08/2024</p> <p>GOAL: o I will maintain or improve my ability to participate in my care with ADLs through my next review date. Date Initiated: 05/25/2022 Created on: 05/25/2022 Revision on: 10/10/2022 Target Date: 05/20/2024</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>INTERVENTIONS/TASKS: . o Toileting/Incontinent Care x 2 person assistance Date Initiated: 05/25/2022 Created on: 05/25/2022 NSG CNA .</p> <p>Record review of Resident #3's Progress Notes written by RN D, dated 07/30/24 at 02:56 AM, CNA notified SN that resident had witnessed fall sliding off bed legs first upon performing perineal care. I grabbed the side rail as they were changing and i just started sliding off, maybe I must have grabbed it too fast. Upon entering room resident was at bedside floor bed was at lowest position, resident was seated in seated position slated to his left side. Resident was assessed for any injuries skin intact. Resident denied experiencing any pain prior to having nursing personnel pick him up from ground. Stating I'm fine mija, just put me back in bed.</p> <p>Record review of Resident #3's Progress Notes dated 08/07/2024 at 11:39 AM written by LVN C revealed, resident has swelling, redness, warm to the touch, and pain to the right knee. NP notified. Orders given for x-ray to right knee.</p> <p>Record review of Resident #3's x-ray results of right knee, dated 08/07/24 at 01:57 PM, revealed an acute-appearing fracture of the distal shaft of the right femur (a bone break due to a sudden traumatic event of the lower thigh bone above the knee). Impression: There is an acute-appearing fracture as described above. -There is osteopenia (a loss of bone density that occurs when the body does not make new bone as quickly as it reabsorbs old bone).</p> <p>Record review of Resident #3's Progress Notes written by NP E, dated 08/07/2024 at 03:04 PM, Resident #3 states he is feeling well, but does c/o some discomfort to right knee. Xray of right knee shows acute distal fx of femur. Xray shows osteopenia. New order to send to ER to eval and tx.</p> <p>Record review of Resident #3's Progress Notes written by RN F, dated 08/07/2024 at 04:32 PM, SBAR Summary for Providers Situation : The Change In Condition/s reported on this CIC Evaluation are/were: Trauma (fall related or other). With response from NP E to send out to ER.</p> <p>Record review of Resident #3's Preliminary Hospital Report dated 08/08/24, revealed Resident #3 was brought to the ER from the nursing facility with right lower extremity pain and edema (swelling), after sustaining a fall from bed. X-ray showed mildly displaced right distal femur fracture, with small joint effusion (when excess fluid builds up l or around a joint, causing swelling) and intermuscular hematomas (a bruise between muscle layers) at fracture site. Orthopedics was consulted and took patient for surgery today (08/08/24). Patient is being admitted for further evaluation and treatment.</p> <p>Record review of facility's reported incident report dated 08/08/25 revealed, Resident #3's fractured right distal femur was reported as Injury of Unknown Origin.</p> <p>In an interview on 05/01/25 at 03:40 PM, Resident #3 stated he fractured his leg last August (2024) and he remembered it. Resident #3 stated he slipped from the bed when the CNA was changing his diaper. He said he knew he was falling but could not stop it. He said the nurse went in to check him and his hips and back were hurting. Resident #3 stated that his knee started hurting a day later. He said he was given something for pain.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 05/02/25 at 10:20 AM, Resident #3 stated one CNA was doing the diaper change when he fell and fractured his right knee last July (2024). Resident stated the CNA turned him and pushed too far and he could not stay in the bed. He said he fell even though he grabbed the side rail and tried to stay in the bed. Resident #3 said the next day he told the nurse that he had pain to his right knee. Resident #3 stated he did not think the CNA meant for him to fall.</p> <p>In an interview on 05/02/25 at 10:37 AM, The DON stated Resident #3 was now coded a 2 person assist, but back when the fall happened, he was coded a 1-2 person assist. She said he was now a 2 person assist due to safety reasons. The DON stated CNA B was the CNA performing care at the time of Resident #3's fall from the bed. This was verified with the July 2024 schedule. The DON stated CNA B no longer worked at the facility.</p> <p>In an attempted telephone interview on 05/02/25 at 12:23 PM, with CNA B, the call would not go through. The telephone number had been disconnected. Surveyor was unable to leave voicemail.</p> <p>In an interview on 05/02/25 at 12:52 PM, LVN C stated she notified NP E of x-ray results of Resident #3 on 08/07/24. LVN C stated Resident #3 fell during night shift (07/30/24) and she reported the x-ray results to the NP. LVN C stated she was not the one who had completed the initial assessment on Resident #3 after his fall last year. LVN C stated she had completed the assessment on Resident #3 when his leg was red and warm to touch about a week after the fall (08/07/24). She said Resident #3 was a paraplegic and had no feeling to his legs so he would not have felt pain. LVN C stated she could not remember much about it because it was so long ago. LVN C stated they all could check the care plan to find out how many are needed to assist a resident for ADLs. She said the CNAs could look on their tablets (Kardex) to find the information. LVN C stated they have been in-serviced all the time on abuse/neglect. She said the last in-service they had on abuse/neglect was a couple days ago.</p> <p>In an interview on 05/02/25 at 01:14 PM, RN D stated she had assessed Resident #3 after his fall on 07/30/24. RN D stated CNA B had been working on Resident #3's hall on 07/30/24 and was with him when he fell out of bed. RN D stated CNA B was changing Resident #3. RN D stated CNA B and the Resident #3 told her he grabbed the rail too fast and fell. RN D stated later in the shift, she notified the doctor the resident was having lower back discomfort and x-rays were ordered. RN D stated she assumed discomfort because the resident had no feeling to the lower part of his body. RN D stated Resident #3 had not complained of knee or leg pain, but he was a paraplegic and could not feel his legs. RN D stated she reported the fall to the DON, NP E, and RP. She said when she assessed Resident #3 at the time of the fall, there was no redness or swelling to the lower extremities. RN D stated abuse/neglect in-services occurred all the time. She said the last one was two days ago (04/30/25). She said the charge nurse was to monitor CNAs and she was a charge nurse. She said she had not seen CNA B go into Resident #3's room that night to do incontinent care. RN D stated it was right after shift change and she was still in report when CNA B went into Resident #3's room. RN D stated they could find whether a resident was a one- or a two-person assist by reading the admission assessment. RN D stated she was not sure whether Resident #3 was a 1- or a 2-person assist.</p> <p>In an interview on 05/02/25 at 05:10 PM, the Administrator stated the DON was notified of Resident #3's fall on 07/30/24, but he was not notified until after the fracture was found (08/08/24) by x-ray. He said at the time of the fall, staff were in-serviced on A/N and the DON had added bordered mattress with cover to the care plan for an intervention after the fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Observation of incontinent care on 05/04/25 at 04:20 PM for Resident #2 (Resident #2 was a 2-person assist for incontinent care per Care Plan and MDS). CNA G and CNA H performed incontinent care on Resident #2. CNA G reviewed Kardex for level of care prior to entering Resident #2's room. No deficiencies noted for incontinent care.</p> <p>Record review of the facility's Falls Prevention Guideline policy dated March 28, 2022 Revised 1/2024, revealed:</p> <p>Purpose:</p> <p>To establish a process that identifies risk and establishes interventions to mitigate the occurrence of falls.</p> <p>This was determined to be an IJ and the Administrator was provided the IJ template on 05/03/25 at 06:55 PM.</p> <p>The following Plan of Removal submitted by the facility was accepted on 05/03/25 at 01:45 PM.</p> <p>POR reflected:</p> <ul style="list-style-type: none"> -QAPI / IDT meeting to be held in regard to IJ; -Random audit by facility of 6 CNAs performing incontinent care; -Incontinent Care observation; - Audit of ADLs care/appropriate level of care; -Interviews, by facility, with staff and interviewable residents completed on A/N; -Audit of all 2-person assist resident's care plan/Kardex and MDS for incontinent care were showing 2-person assist. -In-services to be conducted with staff on Abuse/Neglect, fall prevention, Kardex/Care Plan; <p>Topic: Plan of Care/Kardex - Staff were educated on the CNA to confirm with charge nurse at the beginning of shift any changes in ADL level of assistance and validate by viewing the Kardex. CNA and charge nurse to communicate changes with incoming shift during end of shift report to ensure that the staff member understands the level of care to be provided and adhered to.</p> <p>Topic: Abuse/Neglect Preventing, Identifying, and Reporting - Staff were educated on abuse/neglect preventing, identifying, and reporting all suspicions or allegations immediately to the administrator.</p> <p>Topic: Preventing Accidents/Incidents and Fall Prevention - Staff to ensure care was provided in a safe manner in accordance with the plan of care/Kardex. Staff to respond to a fall urgently, assessing, and notifying.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Immediate Corrective Action Response:</p> <p>Record review of QAPI / IDT meeting held with signatures for IJ. Date completed 05/03/25.</p> <p>Record review on 05/03/25 at 02:45 PM of random audit by facility of 6 CNAs performing incontinent care with all 6 CNAs using correct level of assistance. Date completed 05/03/25.</p> <p>Record review on 05/03/25 at 02:50 PM of incontinent Care observation by facility with CNA I completed by facility. Date completed 05/03/25.</p> <p>Record review on 05/03/25 at 03:02 PM of ADLs care/appropriate level of care audit completed by facility on 05/02/25 - 05/03/25 for all residents by facility was completed and verified. Date completed 05/03/25.</p> <p>Record review on 05/02/25 - 05/03/25 of interviews, by facility, with staff and interviewable residents completed on A/N. No resident or staff reported abuse or neglect. Date completed 05/03/25.</p> <p>Record review on 05/03/25 at 03:10 PM surveyor audited all 2-person assist resident's care plan/Kardex and MDS for incontinent care were showing 2-person assist. 36 / 36 residents verified for correctness.</p> <p>Record review of facility's in-services revealed the following in-services were conducted with staff:</p> <p>Topic: Plan of Care/Kardex - Staff were educated on the CNA to confirm with charge nurse at the beginning of shift any changes in ADL level of assistance and validate by viewing the Kardex. CNA and charge nurse to communicate changes with incoming shift during end of shift report to ensure that the staff member understands the level of care to be provided and adhered to.</p> <p>Topic: Abuse/Neglect Preventing, Identifying, and Reporting - Staff were educated on abuse/neglect preventing, identifying, and reporting all suspicions or allegations immediately to the administrator.</p> <p>Topic: Preventing Accidents/Incidents and Fall Prevention - Staff to ensure care was provided in a safe manner in accordance with the plan of care/Kardex. Staff to respond to a fall urgently, assessing, and notifying.</p> <p>During interviews on 05/03/2025 at 04:00 PM through 05/04/25 at 03:23 PM CNAs G, H, I, J, K, L, O, P, R, V, X, Y, Z, CC, GG, II, KK, and three NAs in Training L, Q, and JJ said they had been in-serviced on the topics of the Plan of Care/Kardex, Abuse/Neglect Preventing, Identifying, and Reporting, and Preventing Accidents/Incidents and Fall Prevention.</p> <p>During interviews on 05/03/2025 at 04:00 PM through 05/04/25 at 03:23 PM LVNs M, N, S, T, U, W, AA, BB, DD, EE, FF, and HH said they had been in-serviced on the topics of the Plan of Care/Kardex, Abuse/Neglect Preventing, Identifying, and Reporting, and Preventing Accidents/Incidents and Fall Prevention.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During interviews on 05/03/2025 at 04:00 PM through 05/04/25 at 03:23 PM RN F, DON, and Administrator said they had been in-serviced on the topics of the Plan of Care/Kardex, Abuse/Neglect Preventing, Identifying, and Reporting, and Preventing Accidents/Incidents and Fall Prevention.</p> <p>The Administrator was notified on 05/04/2025 at 5:00 PM that the IJ had been removed. While the IJ was removed, the facility remained out of compliance at a level of no actual harm that was not immediate jeopardy at a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems.</p>		