STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676441	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of Alamo	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)
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. (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 0656 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, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial need that were identified in the comprehensive assessment for 1 of 3 residents (Resident #1) reviewed for comprehensive person-centered care plans. The facility failed to develop an individualized comprehensive person-centered care plan for Resident #1 by including a bedtime snack when he was NPO. This deficient practice could place residents at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs. The Findings include: The Findings include: Record review of Resident #1's admission sheet dated 11/10/25 reflected a [AGE] year-old male with an admit date of 06/16/2025 and an initial admission date of 02/13/2025. His relevant diagnoses included Huntington's disease (a progressive, fatal genetic disorder that causes the breakdown of nerve cells in the brain, leading to motor, cognitive, and emotional symptoms that worsen over time), diabetes (chronic disease where the body cannot properly regulate its blood glucose levels), muscle wasting/atrophy, muscle weakness, abnormalities of gait/mobility, lack of coordination, hypoxia (shortness of breath, rapid breathing, and a fast heart rate) and aphasia (a language disorder that impairs a person's ability to communicate, affecting their reading, writings, speaking, and understanding of others). Record review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score was left blank, which indicated his cognition was severely impaired. His MDS also reflected he had unclear speech (slurred or mumbled word), he rarely/never made himself understood, and rarely/never understood others.Record review of Resident #1's quarterly care plan dated 08/25/25 reflected a:Focus: I am at risk for nutritional deficits and/or dehydration risk r/t NPO-unable to eat or drink by mouth, requires enteral (the delivery of nutrition directly into the gastrointestinal tract through a tube) feedings for nutrition/hydration supportInterventions: in part included tube feeding Record review of Resident #1's Kardex (a desktop file system that gives a brief overview of each resident and is updated every shift) dated 11/10/25 reflected: Eating/Nutrition: NPO-nothing by mouth-see nurse for questions, I require enteral feeding support. Eating: bedtime snack In an observation on 11/10/25 at 1:43 pm, Resident #1 was observed lying in bed awake. He was on O2 via nasal cannula at 3 lpm (as ordered) and had a feeding tube with continuous feeding. RP G was at his bedside. In an interview on 11/10/25 at 1:45 pm, RP G said Resident #1 had been admitted to the facility with a feeding tube. She said Resident #1 cannot eat or drink anything by mouth. She said Resident #1 had never been fed anything by mouth while at the facility.In an interview on 11/10/25 at 4:00 pm, CNA A said she had cared for Resident #1 for five months and knew he was not able to eat or drink anything by mouth because he was fed via feeding tube. She said if she had a question regarding his plan of care, she would ask the charge nurse. She said CNAs were not allowed to touch a resident's feeding tube or to feed them via their feeding tube. She said that task belonged to nursing staff.In an interview on 11/10/25 at 4:18 pm, LVN D said Resident #1 had a feeding tube and was not allowed to eat or drink anything by mouth. He said if a CNA had any questions regarding his plan of care they would ask a charge nurse. He said CNAs were not allowed to touch a resident's feeding tube, he said that tasked belonged to nursing staff only.In an interview on 11/12/25 at 9:00 am, MDS/RN F, said it was her responsibility to ensure a resident's care plan (Kardex), and MDS were individualized and accurate. She said Resident #1 had a feeding tube and was not able to eat or drink anything by mouth. She said Resident #1's Kardex included a bedtime snack which was not an appropriate task for him because he had a feeding tube. She said the task of bedtime snack auto populated on all resident's Kardex, she said it was her responsibility to remove it for residents that were not allowed to have one. She said she failed to remove the task of bedtime snack for Resident #1 when she completed his most recent care plan. She was observed as she checked Resident #1's task of bedtime snack for the past 30 days and said the CNAs had documented NA for bedtime snack which indicated a snack was not given. MDS/RN F said there were no negative outcomes to Resident #1 having that task of a bedtime snack on his Kardex because he had not been given one. In an interview on 11/12/25 at 11:00, the DON said Resident #1 had been admitted with a feeding tube. She was observed as she checked Resident #1's Kardex and said a bedtime snack was a task that automatically populated but for him, it should have been removed because he was NPO. The DON said there were no negative outcomes to Resident #1 having his Kardex show a

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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. (continued on next page)

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F 0842 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 interviews and record reviews, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 3 residents (Resident #2) reviewed for accuracy of records. The facility failed to ensure LVN C signed off Bisacodyl 10 mg PRN via rectal 1 dose on 10/03/25 after it was administered to Resident #2.This failure could place residents at risk of not receiving appropriate care through inadequate documentation resulting in deterioration in condition, exacerbation of disease process, overmedication, and increased risk of harm or injury. The Findings included: Record review of Resident #2's admission record dated 11/13/25 reflected a [AGE] year-old female with an admit date of 09/29/25 and an initial admission date of 09/15/25. Her relevant diagnoses included end stage renal disease (the final stage of chronic kidney disease, where the kidneys have severe damage and can no longer function well enough to sustain life), dependence on renal dialysis (patient has permanent kidney failure and relies on dialysis procedure or kidney transplant to sustain life), and constipation (having fewer than three bowel movements a week, with stools that are hard, dry, and difficult to pass). Record review of Resident #2's quarterly MDS assessment dated [DATE] reflected a BIMS score of 10, which indicated her cognition was moderately impaired. Record review of Resident #2's quarterly care plan dated 09/15/25 reflected a: Focus- I have chronic health conditions & comorbidities conditions that have affected my physical function and may affect my quality of life.constipation Interventions- in part included administer my medications, treatments, respiratory treatment/therapy, and diet as recommended by physician. Provide care as tolerated and needed. Record review of Resident #2's change in condition dated 10/03/25, authored by LVN D reflected: Situation: The change in condition, symptoms, or signs observed and evaluated is/are: constipation or impaction. Things that make the condition or symptom worse are: Resident complaining of constipation and wanting relief. This condition, symptom, or sign has occurred before: yes. Review and notify: primary care clinician notified: yes, date: 10/03/25, time: 11:00 am. Recommendations of Primary Clinicians: administer Bisacodyl PRN via rectal X 1 dose. Record review of Resident #2's eMAR for the month of October 2025 did not reflected an order for bisacodyl PRN via rectal x1 dose therefore, not signed off after being administered on10/03/25. Record review of Resident #2's Bowel Task report for 10/03/25 reflected she had a bowel movement at 1:43 pm. In an interview on 11/12/25 at 9:18 am, LVN D said on 10/03/25, RN E had informed him that Resident #2 had been flagged on their daily reports indicating she had not had a bowel movement in several days. He said he immediately sent CNA H to go check on Resident #2 and asked her if she felt she was constipated or had any discomfort. LVN D said CNA H had later gone back to him and told him that Resident #2 had requested medication for her constipation. LVN D said he called Resident #2's NP and he had prescribed a PRN 1 x medication (Bisacodyl/suppository) for relief. He said he instructed CNA H to accompany him to administer the suppository. LVN D said the medication Bisacodyl was successful and Resident #2 had a bowel movement minutes later. LVN D said as soon as Resident #2's NP ordered the Bisacodyl, he had completed an order and signed it off on her 10/2025 eMAR after it was administered. LVN D there were no negative outcomes to Resident #3 for not inputting an order for Bisacodyl and signing off on it after it was administered because he insisted he had done both. In an interview on 11/12/25 at 10:00 am, RN E said the facility received daily reports on residents that were flagged for not having a bowel movement in three days. RN E said on 10/03/25 while she reviewed those reports she noticed that Resident #2 had been flagged for not having a bowel movement in 3 days and discussed it with LVN D. RN E said as she reviewed Resident #2's eMAR that she did not see an order for the medication Bisacodyl and since there was no order, it did not populate on Resident #2's 10/2025 eMAR. RN E said the facility's protocol would have been that as soon as LVN D received the order for Bisacodyl, he should have inputted an order and then it would have automatically populated on Resident #2's eMAR. RN E said, since LVN D did not create an order for Bisacodyl, it was not populate on Resident #2's eMAR and not alerted to sign off on it. RN E said there were no negative outcomes to Resident #2 not having the medication Bisacodyl listed and signed off on her 10/2025 eMAR because she had confirmed with CNA H and LVN D that it had been administered. She said the medication had been written on Resident #2's Change in Condition. In an interview on 11/12/25 at 11:45 am, the DON said the facility's protocol for a nursing staff would have been that as soon as they receive an order to input it on the resident's electronic medical record. Once it was inputted as an order, it would populate on the