STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676181	A. BUILDING _____ B. WING _____	**07/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE HEIGHTS	**1855 W GOODWIN PLEASANTON, TX 78064**

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their written policies and procedures that prohibited and prevented abuse, neglect and exploitation of residents for 1 of 4 residents on the secure unit (Resident #1) reviewed for neglect and abuse in that: The facility did not report an injury of unknown origin within 2 hours to the State Survey Agency for Resident #1. This failure could place residents at risk for not have allegations of neglect or abuse reported to the State Agency. The findings were: Review of the facility policy titled Resident Abuse Policy dated July 2018 revealed, It is the responsibility of our team members, Community consultants, attending physicians, family members, visitors, etc. to promptly report any incident of suspected neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to community management. 4. When an alleged or suspected case of exploitation, mistreatment, neglect, injuries of an unknown source, or abuse is reported, the Community Administrator, or his/her designee, will notify the following persons or agencies per the current state/federal reporting requirements of such incident, if appropriate: a) The State licensing/certification agency responsible for surveying/licensing the Community. Review of Resident #1's face sheet, dated 7/3/2020 revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's most recent Quarterly MDS dated [DATE], revealed a BIMS score of 6 which indicated severe cognitive impairment for daily decision-making skills. Review of Resident #1's care plan, undated, revealed she had a history of [REDACTED].#1's x-ray to ribs dated 6/23/2020 revealed no fractures. Resident # 1 had another fall on 7/1/20 after the 6/23/20 x-ray. Observation on 7/3/2020 at 8:33 a.m. at a local hospital revealed Resident #1 lying in bed. Resident #1 had bruising to both eyes which were swollen. On Resident #1's outer right eye revealed stitches and a bandage above that same right eye. Further observation revealed bruising to both arms and a chest tube in place. Interview on 7/3/2020 at 8:34 a.m. with Resident #1 revealed she did not remember what happened. Interview on 7/3/2020 at 8:45 a.m. with a nurse from the local hospital revealed Resident #1 had broken ribs to her left side and a chest tube was placed on 7/2/2020 due to a hemothorax. The nurse revealed Resident #1 received stitches to her right eye and eyebrow and had a hematoma to the right eye. Interview on 7/3/2020 at 12:02 p.m. with LVN A stated Resident #1 told her she could not remember what she (Resident #1) was doing, but knew she hit her head. Interview on 7/3/2020 at 12:20 p.m. with LVN B stated Resident #1 said she knew she (Resident #1) had fallen, but did not know what she was doing. Interview on 7/3/2020 at 12:48 p.m. with the DON revealed Resident #1 was not able to tell us what happened or what she was doing other than she hit her head. Interview on 7/3/2020 at 1:51 p.m. with the Administrator revealed he was not made aware Resident #1 was unable to state what happened related to her fall on 7/1/2020. The Administrator stated if staff had told me she could not tell us what happened then I would have reported the fall.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source are reported HHSC no later than 2 hours in accordance with State law through established procedures for 1 of 4 residents (Resident #1) reviewed for abuse and neglect, in that: The facility did not report an injury of unknown origin within 2 hours to the State Survey Agency for Resident #1. This failure could place residents at risk for not having allegations of neglect or abuse reported to the State Agency. The findings were: Review of Resident #1's face sheet, dated 7/3/2020 revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's most recent Quarterly MDS dated [DATE], revealed a BIMS score of 6 which indicated severe cognitive impairment for daily decision-making skills. Review of Resident #1's care plan, undated, revealed she had a history of [REDACTED].#1's x-ray to ribs dated 6/23/2020 revealed no fractures. Resident # 1 had another fall on 7/1/20 after the 6/23/20 x-ray. Observation on 7/3/2020 at 8:33 a.m. at a local hospital revealed Resident #1 lying in bed. Resident #1 had bruising to both eyes which were swollen. On Resident #1's outer right eye revealed stitches and a bandage above that same right eye. Further observation revealed bruising to both arms and a chest tube in place. Interview on 7/3/2020 at 8:34 a.m. with Resident #1 revealed she did not remember what happened. Interview on 7/3/2020 at 8:45 a.m. with a nurse from the local hospital revealed Resident #1 had broken ribs to her left side and a chest tube was placed on 7/2/2020 due to a hemothorax. The nurse revealed Resident #1 received stitches to her right eye and eyebrow and had a hematoma to the right eye. Interview on 7/3/2020 at 12:02 p.m. with LVN A stated Resident #1 told her she could not remember what she (Resident #1) was doing, but knew she hit her head. Interview on 7/3/2020 at 12:20 p.m. with LVN B stated Resident #1 said she knew she (Resident #1) had fallen, but did not know what she was doing. Interview on 7/3/2020 at 12:48 p.m. with the DON revealed Resident #1 was not able to tell us what happened or what she was doing other than she hit her head. Interview on 7/3/2020 at 1:51 p.m. with the Administrator revealed he was not made aware Resident #1 was unable to state what happened related to her fall on 7/1/2020. The Administrator stated if staff had told me she could not tell us what happened then I would have reported the fall. Review of the facility policy titled Resident Abuse Policy dated July 2018 revealed, It is the responsibility of our team members, Community consultants, attending physicians, family members, visitors, etc. to promptly report any incident of suspected neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to community management. 4. When an alleged or suspected case of exploitation, mistreatment, neglect, injuries of an unknown source, or abuse is reported, the Community Administrator, or his/her designee, will notify the following persons or agencies per the current state/federal reporting requirements of such incident, if appropriate: a) The State licensing/certification agency responsible for surveying/licensing the Community.

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

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.