STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455625	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta Vista Rehabilitation and Healthcare	510 Paredes Line Rd Brownsville, TX 78521

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 interview and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 of 5 residents (Resident #1) reviewed for administration. The facility failed to ensure LVN A documented accurate nursing progress notes for Resident # 1 after the TPN was discontinued. This failure could affect residents whose records are maintained by the facility and could place them at risk for errors in care and treatment. The findings included:Record review of Resident #1's admission record, dated 5/01/2026, reflected a [AGE] year-old female originally admitted to the facility on [DATE]. Resident #1's diagnoses include adult failure to thrive (decline in an older person's physical, mental, or social health), gastrostomy status (the presence of a surgically created opening between the abdominal wall and the stomach, used for long-term feeding, medication or stomach decompression), dysphagia (difficulty swallowing), and diabetes mellitus (chronic condition where blood sugar levels are too high because the body either does not produce enough insulin or cannot effectively use the insulin it makes). Record review of Resident #1's MDS assessment dated [DATE] reflected a BIMS score of 07 which indicated severe cognitive impairment. Section K- Swallowing/Nutritional Status indicated, parenteral/IV feeding while a resident and feeding tube while a resident. Record review of Resident #1's discharge MDS assessment dated [DATE] reflected Section K- Swallowing/Nutritional Status indicated, the resident had a feeding tube at discharge. Record review of Resident #1's nursing progress notes, dated 4/11/2026 at 11:36 p.m., by LVN B, reflected an order by the physician to discontinue the TPN after the last bag was empty. Record review of Resident #1's nursing progress notes, dated 4/15/2026 at 7:24 p.m., by LVN A, reflected nutrition note: continues on TPN at 40cc/hr. Record review of Resident #1's medication administration record, dated 4/1/2026 through 4/30/2026, indicated last TPN administered was on 4/12/2026 at 9:17 a.m. In an interview on 5/01/2026 at 11:20 a.m., LVN A stated he had documented the TPN because he had assumed Resident #1 was still receiving it. He said he had not seen Resident #1 prior to documenting the TPN. LVN A said a negative outcome of not accurately documenting could cause over-hydration or fluid overload for the resident. In an interview on 5/01/2026 at 2:28 p.m., LVN B stated she had received an order from the physician to discontinue the TPN for Resident #1, once the current bag was completed. She said she hung the last bag of TPN on 4/12/2026 at 9:17 a.m. She said the bag TPN finished on 4/13/2026 at 9 a.m. and was no longer administered to Resident #1. She said the bag of TPN was administered on 4/12/26 because Resident #1's family member requested that the TPN continue infusing until lab reports were available. LVN B called the physician and informed him of the family member's request. She said the physician gave an order to continue infusing TPN for Resident #1 until lab reports were ready. LVN B said lab results were reported on 4/12/2026 and the TPN was discontinued once the bag was finished. In an interview on 5/01/2026 at 3:07 p.m., LVN C stated she had received report from LVN B on 4/12/26, to discontinue TPN once the bag was finished. She said during the second shift, the TPN was still infusing, and it was reported to the third shift nurse to discontinue TPN when it finished. She said that on 4/13/2026, Resident #1 (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was no longer receiving TPN. LVN C said the nursing progress notes were pre-populated and that it was the nurse's responsibility to make any changes as needed to reflect accuracy in documentation. In an interview on 5/01/2026 at 6:26 p.m., the DON stated Resident #1 resided across from her office and would have discarded any empty IV medication seen hanging. She said an in-service on documentation had been started and that the facility's software system had been updated two months ago. She said she had been providing the staff with reminders to be vigilant about their documentation. The DON said there was no negative effect for Resident #1 because it was only documentation. Record review of the facility's policy titled Documentation of Cares Given, dated 01/2026, reflected Procedure: 5. A complete account of the resident's care treatment, response to care, signs, symptoms, etc., as well as the progress of the resident's care. No further verbiage was identified in the facility's policy regarding accurate documentation.