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	08/22/2024

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 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** 48278 Based on observation, interview, and record review the facility failed develop and implement a comprehensive person-centered care plan for each resident, consistent with resident needs, that includes measurable objectives and time frames to meet residents' physical needs for 2 (Resident #48 and #225) of 24 residents reviewed for comprehensive person-centered care plans. The facility failed to ensure: 1. Resident #225's care plan developed on 8/2/2024 reflected oxygen use. 2. to develop a comprehensive person-centered care plan for Resident #48 addressing the oxygen therapy. This deficient practice could place residents in the facility 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 included: 1. Record review of the Face Sheet dated 8/19/24 for Resident # 225 revealed the resident was a [AGE] year old male admitted to the facility on [DATE] with the following diagnoses: respiratory failure, sleep apnea, aortic valve stenosis (a heart valve disease in which the valve between the lower left heart chamber and the body's main artery is narrowed and doesn't open fully which reduces or blocks blood flow from the heart to the aorta and to the rest of the body), cerebrovascular disease (a condition that affects the blood vessels of the brain and cerebral circulation), type 2 diabetes mellitus, hypertension, and morbid obesity. Record review of the Doctor's Order Summary dated 8/19/24 revealed Resident # 225 was prescribed O2 at 4LPM via Nasal Cannula as needed for shortness of breath, respiratory distress, cyanosis (bluish or purplish discoloration of the skin), labored breathing related to severe aortic stenosis. Record review of the MAR dated 8/19/24 revealed an order for Resident #225 to receive O2 at 4L/MIN via nasal cannula as needed for shortness of breath, respiratory distress, cyanosis (bluish or purplish discoloration of the skin), labored breathing r/t severe aortic stenosis. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Record review of the Care Plan dated 8/2/24 for Resident #225 revealed oxygen was not care planned. Observation on 8/19/24 at 2:36 PM, revealed Resident #225 in the dining area with O2 via nasal cannula set between 2.5 and 3 LPM. Resident noted with a slight cough lasting a couple of seconds. Interview on 8/20/24 at 2:30 PM, the ADON said the MDS nurses complete the care planning for oxygenation use. She said the MDS nurses that updates care planning. She said that if it dealt with antibiotics, weights, falls or other incidents/accidents she or the DON may complete the care plans, but the bulk of it were completed by MDS. Interview on 8/20/24 at 3:25 PM, the MDS/RN verified the oxygen order for Resident #225 on PCC. She stated O2 at 4 liters per minute via nasal cannula as needed for shortness of breath, respiratory distress, cyanosis, labored breathing r/t severe aortic stenosis for Resident #225. She stated that the order was an as needed order. She stated that she was responsible for updating Resident #225's care plan. She stated that she got a list from the DON yesterday to update the oxygen care plans. She stated that the negative effect for not having the oxygen care planned was that the residents can go into hypoxia, respiratory distress, and altered mental status. Interview on 8/20/24 at 3:40 PM, the DON confirmed that Resident #225 did not have the oxygen care planed. She stated that the MDS nurses are responsible for updating the care plans. If MDS were out, then she is responsible to update the MDS. 2. Record review of Resident #48's electronic facility face sheet dated 8/22/24, revealed she was an [AGE] year-old female admitted to the facility on [DATE], original admitted [DATE] with diagnoses of Cerebral Infarction (stoke), Dementia (group of thinking and social symptoms that interferes with daily functioning) and Hypertension (high blood pressure). Record review of Resident #48's quarterly MDS assessment dated [DATE] revealed: BIMS score of 0 indicated Resident #48 cognition was severely impaired. Received Oxigen therapy while a resident. Record review of Resident #48's comprehensive person-centered care plan dated 5/30/24 revealed it did not have focus, goals, or intervention in place to address oxygen therapy. Record review of Resident #48's physician orders dated 08/16/24 for Oxygen treatment revealed Oxygen at 4L/min continuous via nasal cannula every shift for dry cough/hypoxemia. Observation on 08/19/24 at 02:36 PM Resident #48, who was non interviewable in her room was lying down, with oxygen via nasal cannula. During an interview on 08/20/24 at 03:24 PM with MDS/RN, stated she takes care of overseeing Medicaid residents, and her coworker was assigned to Medicare patients. She stated that she was the one responsible for updating Resident's #48's care plan. She stated she got a list from DON yesterday to update the oxygen care plans. MDS/RN stated the negative effect for not having the oxygen care planned were that the residents can go into hypoxia, respiratory distress, and altered mental status. (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 08/20/24 at 03:40 PM with the DON confirmed that Resident #48 did not have the oxygen therapy care plan. She stated that MDS are responsible for updating the care plans. If MDS were out, then she will update them-. She stated they have four residents who are on oxygen. The doctor recently put her on oxygen due to cough and congestion and was told to monitor, then discontinue. Record review of the Comprehensive Person-Centered Policy dated December 2023 read in part .A comprehensive, person-centered care plan for each resident that includes measurable objectives and timeframe to meet a resident medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admissions, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care. 49301

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments, person-centered care plan to reflect the current condition for 1 of 4 residents (Resident #18) reviewed for care plan revisions. The facility failed to ensure Resident #18's care plan was updated to reflect the Oxygen order effective 07/30/2024. This failure could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included: Record review of Resident #18's face sheet dated 08/19/2024 revealed resident was an [AGE] year-old female with an admitted [DATE] and an initial admitted [DATE]. Resident #18's relevant diagnoses included: respiratory failure (difficulty to breath), vascular dementia (brain damage caused by multiple strokes), congestive heart failure (a disorder caused by a decrease in the heart's ability to pump blood), and end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids.) Record review of Resident #18's quarterly MDS assessment dated [DATE] reflected a BIMS score of 08, indicating her cognition was moderately impaired. Record review of Resident #18's physician order dated 07/30/2024 indicated O2 at 2L/Min continuous. Record review of Resident #18's quarterly comprehensive care plan dated 08/15/2024 reflected: Focus: [Resident #18] has oxygen therapy r/t ineffective gas exchange, SOB. Date initiated 05/22/2024 and revised on 05/23/2024. Intervention: oxygen settings: O2 via nasal prongs @ 4 L continuously, date initiated: 05/22/2024, date created on 03/22/2024. An observation on 08/19/2024 at 11:15 a.m., Resident #18 was sitting in her wheelchair, she was receiving oxygen therapy via nasal cannula. This surveyor observed Resident #18's oxygenator set at 3 LPM. An interview on 08/19/2024 at 11:16 a.m., Resident #18 said she required continuous oxygen therapy to help with her shortness of breath . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and observation on 08/19/2024 at 11:31 a.m., LVN C was observed checking Resident #18's oxygen setting and stated it was set at 3 LPM. He then was observed checking Resident #18's electronic medical record and said she had an oxygen order for 2 LPM via nasal cannula. LVN C said he did not think Resident #18 sustained any negative effects of not receiving the prescribed oxygen setting. LVN C said nursing staff should monitor oxygen settings one time per shift. He said his shift started at 6 a.m. and he had not yet checked Resident #18's oxygen settings. LVN C said the DON and/or ADON provided an in-service on oxygen administration at least once a year or as needed to nursing staff. An interview and observation on 08/20/2024 at 3:25 p.m. the MDS/RN was observed checking Resident #18's electronic medical record and said her care plan reflected an intervention of oxygen therapy at 2 LPM with a revision date of 08/19/2024. The MDS/RN said the DON had given her a list of residents that needed their care plan updated on 08/19/2024 afternoon and Resident #18 was one of them. The MDS/RN said she was not able to say if Resident #18 sustained any negative effects for not receiving the correct order of oxygen rate via nasal cannula because at one point she had an order for 4 LPM. The MDS/RN said it was her responsibility to update residents care plans and MDS. An interview on 08/20/2024 at 3:35 p.m., the DON said she was told by LVN C that Resident #18's oxygen setting was correct and that her care plan did not reflect the correct O2 rate. The DON said she immediately did a head-to-toe assessment on Resident #18 and concluded she was not in any type of distress. The DON said she also called Resident #18's NP to inform him Resident #18 was receiving the incorrect O2 therapy and her findings of her head-to-assessment. She said the NP did not give any new orders. The DON said she had given MDS/RN a list of residents that needed to have their care plans updated in the afternoon of 08/19/2024 and Resident #18 was one of them. The DON said negative effects of not receiving the correct O2 rate could be too much oxygen in her brain. The DON said Resident #18's care plan should be updated on the day she received the new O2 order to avoid any confusion. Record review of facility's Comprehensive Care Plans, Updating revised on 02/2022 reflected: Policy: It is the policy of this facility to notify update the comprehensive care plan when: . Notifications: b. The facility will update the comprehensive care plan after each change in condition or when there is a change with the resident's care.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care received such care consistent with professional standards of practice for 3 of 4 residents (Resident #225, Resident #18, and Resident 48) reviewed for respiratory care. The facility failed to ensure: 1. Resident #225 received oxygen at the prescribed rate. Resident #225 received oxygen at a rate less than prescribed. 2. Resident #18's oxygen was administered at 3 Lpm instead of 2 Lpm via nasal cannula as ordered by physician. 3. Resident #48 's oxygen was administered at 3.5 Liters Per Minute instead of 4 Liters Per Minute via nasal cannula as ordered by the physician. This failure could place residents who receive respiratory care at risk of developing respiratory complications and a decreased qualify of care. The findings included: 1. Record review of the Face Sheet dated 8/19/24 for Resident # 225 revealed the resident was a [AGE] year old male admitted to the facility on [DATE] with the following diagnoses: respiratory failure, sleep Apnea, aortic valve stenosis (a heart valve disease in which the valve between the lower left heart chamber and the body's main artery is narrowed and doesn't open fully which reduces or blocks blood flow from the heart to the aorta and to the rest of the body), cerebrovascular disease (a condition that affects the blood vessels of the brain and cerebral circulation), type 2 diabetes mellitus, and hypertension. Record review of the Care Plan dated 8/2/24 for Resident #225 revealed oxygen was not care planned. Record review of the Doctor's Order Summary dated 8/19/24 revealed Resident # 225 was prescribed O2 at 4LPM via Nasal Cannula as needed shortness of breath, respiratory distress, cyanosis, labored breathing related to severe aortic stenosis. Record review of the MAR dated 8/19/24 revealed an order for Resident #225 to receive O2 at 4L/MIN via nasal cannula as needed for shortness of breath, respiratory distress, cyanosis (bluish or purplish discoloration of the skin), labored breathing r/t severe aortic stenosis. Observation and interview on 8/19/24 at 2:36 PM, Resident #225 was in the dining area with O2 via nasal cannula set between 2.5 and 3 LPM. Resident was noted with a slight cough lasting a couple of seconds. Resident did not have other symptoms. Resident #225 was asked if he felt ok by this surveyor, and he nodded yes. He nodded no when this surveyor asked if he had shortness of breath or difficulty breathing. (continued on next page)

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	455625	A. Building B. Wing	08/22/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 8/19/24 at 2:55 PM, LVN B confirmed Resident #225's order reflected O2 at 4 LPM via nasal cannula as needed. She said that all nurses were responsible for ensuring O2 rates were set correctly. LVN B assessed Resident #225's flow rate and she said it was at 3 LPM. LVN B said that if a resident is receiving less oxygen than prescribed by the MD, the resident could desaturate (have a low blood oxygen saturation). LVN B stated that it was her responsibility to check oxygen rates when she comes on shift. LVN B said that she did not check Resident #225's oxygen rate this morning. Interview on 8/20/24 at 2:30 PM, the ADON said that training for oxygen administration was shared between herself, the DON, and respiratory. The ADON said during training, they instruct nurses how to check the level of the oxygen by ensuring that the ball was in the center of the line. The ADON said a resident could have respiratory distress if receiving less than ordered by the MD, but that they could also experience nothing adverse. Interview on 8/20/24 at 3:40 PM, the DON stated that the charge nurse was responsible for checking the O2 setting every shift and as needed. The DON said that they have four residents who are on oxygen. The DON said that she, the ADON, and the MDS/RN check the oxygen residents early in the morning before 5:30 am. The DON said that they check the setting and if the equipment has been changed. She said that their respiratory therapist came about a month ago to train staff and that she comes every 6 months to give us a training. The DON said that they also train and in service clinical staff quarterly. She said that staff was trained on how to do a respiratory assessment and O 2 saturations. She said that they also take a course, and that they train the licensed staff. She stated the negative outcome of oxygen setting not being correct was the resident can have altered mental status. The DON completed an assessment on Resident #225 and said that he was not supposed to be wearing the oxygen and that the doctor mentioned he needed to start using his lungs. 2. Record review of Resident #18's face sheet dated 08/19/2024 revealed resident was an [AGE] year-old female with an admitted [DATE] and an initial admitted [DATE]. Resident #18's relevant diagnoses included: respiratory failure (difficulty to breath), vascular dementia (brain damage caused by multiple strokes), congestive heart failure (An older term for heart failure, a disorder caused by a decrease in the heart's ability to pump blood. Congestive heart failure referred specifically to the type of heart failure associated with the accumulation of excess fluid in the lungs or extremities). Record review of Resident #18's quarterly MD'S assessment dated [DATE] reflected a BIMS score of 08, indicating her cognition was moderately impaired. Record review of Resident #18's physician order dated 07/30/2024 O 2 at 2/Min continuous. Record review of Resident #18's quarterly comprehensive care plan dated 08/15/2024 reflected: Focus: [Resident #18] has oxygen therapy R/T ineffective gas exchange, SOB. Date initiated 05/22/2024 and revised on 05/23/2024. Intervention: oxygen settings: O 2 via nasal prongs @ 4 AL continuously, date initiated: 05/22/2024, date created on 03/22/2024. An observation on 08/19/2024 at 11:15 a.m., Resident #18 was sitting in her wheelchair, she was receiving oxygen therapy via nasal annular. This surveyor observed Resident #18's oxygenate set at 3 LP. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 08/19/2024 at 11:16 a.m., Resident #18 said she required continuous oxygen therapy to help with her shortness of breath. An interview and observation on 08/19/2024 at 11:31 a.m., [NAME] AC was observed checking Resident #18's oxygen setting and stated it was set at 3 LP. He then was observed checking Resident #18's electronic medical record and said she had an oxygen order for 2 LP via nasal annular. [NAME] AC said he didn't think Resident #18 sustained any negative effects of not receiving the prescribed oxygen setting. [NAME] AC said nursing staff should monitor oxygen settings one time per shift. He said his shift started at 6 a.m. and he had not yet checked Resident #18's oxygen setting. [NAME] AC said the DON and/or ADN provide in-service on oxygen administration at least once a year or as needed to nursing staff. An interview and observation on 08/20/2024 at 3:25 p.m. the MD'S/RN was observed checking Resident #18's electronic medical record and said her care plan reflected an intervention of oxygen therapy at 2 LP with a revision date of 08/19/2024. MD'S/RN said the DON had given her a list of residents that needed their care plan updated on 08/19/2024 afternoon and Resident #18 was one of them. MD'S/RN was not able to say if Resident #18 sustained any negative effects for not receiving the correct order of oxygen rate via nasal cannula. MDS/RN said it was her responsibility to update residents care plans and MDS. An interview on 08/20/2024 at 3:35 p.m. the DON said she was told by LVN C that Resident #18's oxygen setting was receiving the correct O2 and that her care plan did not reflect the correct O2 rate. The DON said she immediately did a head-to-toe assessment on Resident #18 and concluded she was not in any type of distress. The DON said she also called Resident #18's NP to inform him Resident #18 was receiving the incorrect O2 therapy and her findings of her head-to-assessment. She said the NP did not give any new orders. The DON said she had given MDS/RN a list of residents that needed to have their care plans updated in the afternoon of 08/19/2024 and Resident #18 was one of them. The DON said negative effects of not receiving the correct O2 rate could be too much oxygen in her brain. The DON said nursing staff are supposed to check a resident's oxygen setting one time every shift and they can do it anytime during their shift. The DON said she and the ADON conduct in-service on oxygen administration one a year or as needed. 3. Record review of Resident #48's electronic facility face sheet dated 8/22/24, revealed she was an [AGE] year-old female admitted to the facility on [DATE], original admitted [DATE] with diagnoses of Cerebral Infarction, Dysphagia Gastrostomy status, Muscle weakness, Dementia (group of thinking and social symptoms that interferes with daily functioning), Parkinson's Disease, and Hypertension (high blood pressure). Record review of Resident #48's quarterly MDS assessment dated [DATE] revealed she scored a 0 on her BIMS score indicating her cognition was severely impaired. Record review of Resident #48's comprehensive person-centered care plan dated 5/30/24 revealed it did not have focus, goals, or intervention in place to address oxygen therapy. Record review of Resident #48's physician orders for Oxygen treatment revealed Oxygen at 4L/min continuous via nasal cannula every shift for dry cough/hypoxemia. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/19/24 at 02:36 PM Resident #48, revealed the oxygen setting on the oxygen concentration machine to be at 3.5L/min. During an interview and observation on 08/19/24 at 02:53 PM with LVN B, stated she was the nurse for Resident #48. She walked with the surveyor to Resident #48's room and verified oxygen setting at 3.5 Liters. She stated she was responsible for checking the oxygen setting. She stated she switched out the humidifier this morning and it must have moved. She stated she checks oxygen setting every time she goes in the room. She confirmed that Resident #48 oxygen setting physician order was written for 4 liters. LVN B stated the ADON or DON check the oxygen settings as well. She stated that they had already done rounds when she got here this morning at around 6:40 am. She stated the negative effect was that Resident #48 can desaturate. She stated in-services for oxygen and nebulizers are done every quarterly. During an interview on 08/20/24 at 03:40 PM with DON, stated the charge nurse was responsible for checking the oxygen setting every shift and as needed. She stated that she, along with the ADON, and MDS/RN check the resident's oxygen early in the morning before 5:30 am. They are checking the oxygen setting and if the equipment has been changed. They check them daily. The doctor recently put her on oxygen due to cough and congestion and was told to monitor, then discontinue. She did an assessment on Resident #48. The respiratory therapist came about a month ago to train staff. The respiratory therapist comes every six months to give them training. They also train and in service clinical staff quarterly. They were trained on how to do a respiratory assessment and oxygen saturation. She stated they have four residents who are on oxygen. She stated the negative outcome of the oxygen setting not being correct was the resident can have altered mental status. Record review of the Oxygen Administration policy date revised 7/2019 revealed: Policy It is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency measure until the order can be obtained. Purpose The purpose of the oxygen therapy is to provide sufficient oxygen to the blood stream and tissues. Procedure 10. Turn the unit on to the desired flow rate, and assess equipment for proper functioning: . 13. Reassess oxygen flowmeter for correct liter flow. 48278 49301

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301 Based on observations, interviews, and record reviews the facility failed to ensure that nurses were able to demonstrate competency in skills and techniques to provide nursing and related services for 1 of 2 residents (Resident #48) by 1 of 2 nurses (LVN A) reviewed for competent staff, in that: LVN A failed to check G-tube residual prior to administering medication for Resident #48. This failure could place residents at risk for not receiving nursing services by adequately trained and licensed nurses and could result in a decline in health. The findings included: Record review of Resident #48's electronic face sheet dated 8/21/2024 reflected she was admitted to the facility on [DATE] with the following diagnoses: moderate protein-calorie malnutrition, dysphagia (swallowing difficulties), and gastrostomy status (an opening into the stomach from the abdominal wall and a tube is inserted to allow air and fluid to leave the stomach and can be used to give drugs and liquids, including liquid food to the patient) and other lack of coordination. Record review of Resident #48's quarterly MDS assessment dated [DATE] reflected her cognitive skills for daily decision making were severely impaired and that she is rarely/never understood. She was dependent on staff with all her with ADL's. She had a swallowing disorder and a feeding tube for nutritional approaches. Record review of Resident #48's comprehensive person-centered care plan dated 05/30/2024 reflected Resident #48 required tube feeding r/t resisting eating, weight loss, NPO (nothing by mouth) diet. Interventions included: Check for tube placement and gastric contents/residual volume per facility protocol and record. Hold feed if greater than 150ML re-instill and notify MD for additional orders. Date Initiated: 08/20/2024. Record review of Resident #48's order summary dated 8/21/24 reflected the following order: Donepezil HCl Oral Tablet 5 MG (Donepezil Hydrochloride) Give 1 tablet via G-Tube one time a day for Alzheimer's. Record review of Resident #48's MAR dated 8/21/24 reflected the following order: Donepezil HCl Oral Tablet 5 MG (Donepezil Hydrochloride) Give 1 tablet via G-Tube one time a day for Alzheimer's. Order Date: 05/11/2023 2334. On 8/20/24 at 3:31 PM observation of Med Pass of LVN A revealed she did not check for residual prior to administering medication. (continued on next page)

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	455625	A. Building B. Wing	08/22/2024

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 3:40 PM interviewed LVN A and she said that she had not check for residual for resident #48 prior to administering the medication, she checked for placement using her stethoscope and syringe with air. She said that the orders do not say to check for residual prior to medication administration. She said that the orders only showed to check for residual prior to feeding. On 8/21/24 at 8:40 am interviewed RN (PRN). She said that prior to administering medications via g-tube for a resident, she always checked for residual by aspirating gastric contents using a syringe. She said that if residual was more than 150 mL, she must hold medication and notify MD for further orders. She said that if they did not checked residuals, a resident may have too much residual and may vomit up the medications and make them ineffective. On 8/21/24 at 8:50 am interviewed DON. She said that nurses must check for residual prior to administering medications via g-tube. If less than 150 mL, residual is returned. If greater than 150 mL, hold medication and notify MD for further orders. The DON said that nurses were trained and checked off on that skill upon hire and annually. She said that they recently had an in-service in June 2024. Record review of Skills competency checklist - Enteral Med Pass dated 6/14/24 revealed LVN A was evaluated and checked off on the skills needed to complete enteral med pass to include: 21. Checks tube placement by auscultation and aspiration and 23. Checks gastric residual and notifies physician appropriately if any abnormalities. Record review of the facility's Medication Administration via Feeding Tube policy revised 12/2023 revealed: Policy It is the policy of this facility to ensure that medications administered via feeding tube are administered safely and accurately. A physician's order is required for the administration of any medication via feeding tube. Guidelines 12. Check for correct placement of feeding tube prior to administration of medication. Procedure 12. Check for proper placement of the feeding tube.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards or food service safety for 1 of 3 mini refrigerators reviewed for sanitation in that: The facility failed to ensure the food items in Resident # 39's mini refrigerator were labeled and dated. This failure could place residents at risk of foodborne illnesses. The findings included: Record review of Resident #39's face sheet dated August 20, 2024, reflected resident was an [AGE] year-old male with an admitted [DATE] and an initial date of 04/11/2018. Resident #39's relevant diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), dementia (a loss of brain function that worsens over time and affects memory, thinking, behavior, and language), and end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids.) Record review of Resident #39's quarterly MDS assessment dated [DATE] reflected he had a BIMS score of 05, which indicated his cognition was severely impaired. An observation on 08/20/2024 at 9:00 a.m., Resident #39 had a mini refrigerator on his side of the room. With his permission, this surveyor opened the mini refrigerator and observed one squared plastic container with a red lid that contained a brown substance. The clear container was not labeled or dated. Also in the mini refrigerator were 12 mini round containers with a green and red substance in them that were not labeled or dated. In an interview on 08/20/2024 at 9:10 a.m., Resident #39 said he was a dialysis patient and one of the things he liked to eat after dialysis were beans. He identified the brown substance in the squared clear container with a red lid as beans and salsa in the mini round containers. He said his daughter brought them on August 19, 2024 (evening). Resident #39 said nursing staff would often check inside his mini refrigerator. In an interview on 08/21/2024 at 1:50 p.m., the Dietary Manager said there were 3 residents in the facility who had mini refrigerators in their rooms. The Dietary Manager said he was pretty sure when a family member brought outside food, it would first be given to the resident's charge nurse to determine if it was something the resident could eat. He said if the food was approved then it would be taken to the resident to consume. The Dietary Manager said the resident's charge nurse was supposed to label and date all outside food. The Dietary Manager said all food should be labeled and dated to prevent any illnesses. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/21/2024 at 1:59 p.m., the front Receptionist said if a family member brought in outside food, she would take the food to the resident's charge nurse. She said once she took the food items to the resident's charge nurse they would take over. The front Receptionist said the facility did not keep a log of outside food brought in by family members. An interview and observation on 08/21/2024 at 2:05 p.m., LVN C, said if a family member brought in any outside food, the front Receptionist would take it to the resident's charge nurse. He said the Charge Nurse responsibility were to check if the outside food was within the resident's diet plan. If approved, LVN C said the Charge Nurse would label and date the food and take it to the resident. He said the resident was allowed 8 hours to eat any outside food or it would be disposed. LVN C said the purpose of labeling the food was for the facility to have control in preventing stomach infections. An interview on 08/21/2024 at 2:13 p.m., the DON said when a family member brought in outside food, the front Receptionist would take the food and hand it over to the resident's charge nurse. She said the Charge Nurse would check what it was and would make sure it was within the resident's diet plan. She said if it's something the resident can eat, then the food was taken to the resident. She said it as at that time that the outside food should be labeled and dated by the Charge Nurse. The DON said the facility also has angel rounds. She said each hall was assigned a person to make daily rounds to the residents in that hall and one of the things they were supposed to check for were to make sure any outside food (in the room or mini refrigerator) were labeled and dated. The DON said during the angel rounds, any food that was found in the resident's room/mini refrigerator that was not labeled or dated should be discarded to avoid any illnesses. The DON said Resident #39's angel was the Business Office Coordinator. An interview on 08/21/24 at 2:49 p.m., the Business office Coordinator said she was in charge of Resident #39's hall and would conduct angel rounds every day before 11:00 a.m. She said one of her responsibilities during an angel rounds would be to check their rooms for any outside food. She said if any outside food were found in the room or in their mini refrigerator, she would make sure it was labeled and dated and if it wasn't she would dispose it. She said on Monday, August 19, 2024, she said she checked Resident #39's mini refrigerator and did not see any outside food. She said on Tuesday, August 20, 2024, she saw one clear container with a red lid that was not labeled or dated. She said she intended to put a label and date it but got occupied. She said she saw it again on Wednesday, August 21, 2024, and thought to myself I needed to throw out the beans but forgot about it. She said on Tuesday August 20, 2024, she called Resident #39's daughter and asked her if she had brought in any outside food (beans), and she said yes that she had brought them in the evening of Monday, August 19, 2024. The Business Office Coordinator said the purpose of labeling and dating all outside food was to prevent the food from going bad and causing upset stomach. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/21/2024 at 3:05 p.m., the Administrator said when a family member bought in any outside food they would check in with the Front Receptionist and the front receptionist would take the food the resident's charge nurse. She said the Charge Nurse would check the resident's diet to see if it were something the resident could eat. She said if the Charge Nurse approved it, the outside food would be taken to the resident. The Administrator said if the resident did not finish the food, the CNAs would ask the Charge Nurse to label and date it. The Administrator said during the angel rounds they should check inside the refrigerator to make all food was labeled and dated. She said if any food was found not labeled or dated it should be discarded. She said, normally the food in the refrigerator was kept for 72 hours or sooner. The Administrator said the negative effects of food not labeled and dated would be that the facility would not know how long the food had been sitting there. Record review of the facility's Food Brought by Family or Visitor revised on 10/2007 reflected: Policy: It is the policy of this facility that food(s) brought to a resident by family/visitor must be inspected before being provided to the resident . 5. Non-perishable foods permitted to be retained in the resident's room must be stored in plastic containers with tight-fitting lids, except fresh fruit. Perishable foods must be destroyed daily.