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	11/19/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety requirements in 1 of 1 kitchen reviewed for kitchen sanitation.1. The facility failed to not store personal beverages in the food preparation area.2. The facility failed to ensure dented can were placed in a separate storage area.3. The facility failed to properly thaw raw meat that was observed in the sink designated for produce only. The raw meat was not under running water and had red liquid draining into the sinks drain.4. The facility failed to ensure clean cups were free of debris.These failures could place residents at risk for food contamination and food borne illnesses.Findings include:An Observation and initial tour of the kitchen on 9/22/2025 at 8:20 AM revealed a log of ground beef in a sink labeled Produce Sink only No Dishes with no running water and red liquid from under the package draining into the sink's drain. Inside the dry foods storage area were 1 of 2 apple sauce cans, 1 of 3 tuna cans, and 3 of 11 noodle soup cans that were dented. The dented cans were in the same area of the shelf as the non-dented cans were stored. There were 2 of 30 cups that were in the clean area and ready to use that had debris inside them. Underneath the prep table area was a plastic cup with a straw belonging to an employee. In an interview on 9/22/2025 at 8:29 PM with [NAME] C said that as a team all kitchen staff check all the cans in the dry food storage and place dented cans in the designated area. She said she didn't know if maybe the cook moved them yesterday. She said that dented can are not supposed to be used because the can may contain small pieces of metal that can affect the residents. [NAME] C said they have in-services every 2-3 months on different topics relating to the kitchen.In an interview on 9/22/2025 at 8:39 AM with Dietary Aide D said she had just drunk water to take her medication and left her cup under the prep table because she was in a hurry. She said she knew it was her mistake by leaving it there. The dietary aide pointed to a closet and said that is where staff keep their personal belongings and that is where she leaves her cup. She said that by leaving her cup around the food prep area can affect the residents because of cross contamination. She said monthly in-services are held and periodic spot checks are done in the kitchen.In an interview on 9/24/2025 at 1:30 PM with DM said that if meat is at room temperature pathogens can grow and cause food-borne illness. He said dirty dishware can cause illness, stomachache and other symptoms due to pathogens.In an interview on 9/24/2025 at 4:27 PM with DM said a colander is used to place meat in for thawing and in the sink under running water for 20 minutes, then placed in the refrigerator.In an interview on 9/24/2025 at 2:00 PM with Dietary Aide G said that food items such as coffee creamer tends to remain stuck to the bottom or sides of cups and that's why she uses a brush when she is washing the dishes. She said that maybe other staff didn't notice when cups still had food stuck to them and maybe didn't use a brush when they were washing the cups. She said that the brush was supposed to be used and look at the dishes to make sure all food particles are off the plates and cups. She said that if residents use dirty dishes, they can have a bacteria and cause illness. She said the important thing is to keep all residents healthy and satisfied. She said she gets training on hygiene and infection control about every six months.Record review of facility's policy: Titled, Food Storage Content Emphasis: Dry Storage: 5. Bulging or dented cans should not be placed in the storeroom for (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	use. These should be picked up by the food vendor or thrown out if necessary.Refrigeration: 12. All meats should be thawed in the refrigerator and should not be placed above other foods.Thawing foods: 1. Foods should be thawed in the refrigerator in pans, in a manner to keep other foods from being contaminated with anything that may drip from it. Ample time must be allowed for meats to thaw properly. 2. An alternative method would be to thaw foods under cool running water. If using this method, do not put foods directly in the sink. Use a colander.Record review of the Texas Food Establishment Rules 229.163 (k) 229.163 (p) (1) A food employee may drink from a closed beverage container if the container is handled to prevent contamination of : (A) the employee's hands; (B) the container; and (C) exposed foods; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.Record review of the Texas Food Establishment Rule 229.164 (o) Temperature and time control. (3) Thawing. (A) under refrigeration that maintains the food temperature at 5 degrees Celsius (41 degrees Fahrenheit) or less as specified in paragraph (6)(B)(i) of this subsection; or (B) completely submerged under running water: (i) at a water temperature of 21 degrees Celsius (70 degrees Fahrenheit) or below

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to inform residents in advance of the risks and benefits of proposed care and treatment for 1 of 5 residents (Resident #12) reviewed for resident rights.The facility failed to notify Resident #12's RP she had a Wanderguard place on 08/27/25.This failure could place residents at risk of unnecessary restriction of their freedom of movement and diminished quality of life.Findings include:Record review of Resident #12's admission sheet dated 09/23/25 reflected an [AGE] year-old female with an admit date of 08/25/25, an original admission date of 04/28/22. Her relevant diagnoses included age related physical debility (a state of generalized weakness, fatigue, and reduced physical capacity), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), and major depressive disorder (a mental disorder characterized by persistently depressed [NAME] or loss of interest in activities, causing significant impairment in daily life).Record review of Resident #12's initial MDS assessment dated [DATE] reflected the BIMS score was left blank, which indicated her cognition was severely impaired.Record review of Resident #12's initial care plan dated 08/27/25 reflected a:Problem: [Resident #12] wanders thru the hallways, and enters residents' rooms and offices risk/wanderer r/t disoriented to place, impaired safety awareness, [Resident #12] wanders aimlessly, significantly intrudes on the privacy or activities (date initiated 08/27/25)Interventions: in part included.monitor Wanderguard (management system that uses wearable bracelets components to help protect residents at risk of wandering) placement (Left) foot, (date initiated 08/27/25).Record review of Resident #12's physician's order reflected an order for a Wanderguard with an order date of 08/27/25.Record review of Resident #12's elopement/wandering evaluation dated 09/04/25 reflected a score of 11 which indicated she was a high risk for elopement.During an observation and interview on 09/22/25 at 9:33 am, Resident #12 was observed lying in bed awake. She had both her legs exposed and on her left ankle she had a Wanderguard. Resident #12 was not interviewable, she kept repeating words. Record review on 09/22/25 at 4:10 pm, of Resident #12's electronic medical record did not indicate her RP had been notified a Wanderguard was placed on her on 08/27/25.In an interview and observation on 09/23/25 at 4:00 pm, the DON said the facility did not require a consent form for a Wanderguard because it was not considered a restraint. The DON said the resident's RP needed to be notified that a Wanderguard would be placed on the resident. She was observed as she checked Resident's electronic medical record and said she could not find a progress note that indicated Resident #12's RP had been notified. Record review of the facility's Wandering Residents-Wanderguard policy (not dated) reflected:Policy: it is the policy of this facility to allow each resident as much physical freedom as safely possible in order to maintain the resident's optimum functions.Procedure:5. The family/responsible party shall be notified of the risk for wandering and that the Wanderguard has been placed on the resident.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 5 (Resident #12) residents reviewed for accuracy of assessments.The facility failed to ensure Resident #12 was coded as having wandering behavior and a wander alarm on her MDS assessment dated [DATE].This failure could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being.Findings included:Record review of Resident #12's admission sheet dated 09/23/25 reflected an [AGE] year-old female with an admit date of 08/25/25, an original admission date of 04/28/22. Her relevant diagnoses included age related physical debility (a state of generalized weakness, fatigue, and reduced physical capacity), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), and major depressive disorder (a mental disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).Record review of Resident #12's initial MDS assessment dated [DATE] reflected the BIMS score was left blank, which indicated her cognition was severely impaired. Further review reflected that she was not coded as having any wandering behaviors or a wander alarm.Record review of Resident #12's initial care plan dated 08/27/25 reflected a :Problem: [Resident #12] wanders thru the hallways, and enters residents' rooms and offices risk/wanderer r/t disoriented to place, impaired safety awareness, [Resident #12] wanders aimlessly, significantly intrudes on the privacy or activities (date initiated 08/27/25)Interventions: in part included.monitor Wanderguard placement (a wander management system that uses wearable bracelets and to help protect residents at risk of wandering) (Left) foot, (date initiated 08/27/25).Record review of Resident #12's physician's order reflected an order for a Wanderguard with an order date of 08/27/25.Record review of Resident #12's elopement/wandering evaluation dated 09/04/25 reflected a score of 11 which indicated she was a high risk for elopement.During an observation on 09/22/25 at 9:33 am, Resident #12 was observed lying in bed awake, she had both her legs uncovered and on her left ankle she had a Wanderguard.In an interview on 09/22/25 at 9:34 am, Resident #12 was not interviewable.In an interview and observation on 09/23/2025 at 3:00 PM, the MDS Coordinator said Resident #12 had a Wanderguard effective 08/27/25. She said the Wanderguard was considered an alarm device. She was observed reviewing Resident #12's MDS assessment and said she must had forgotten to code her as having a Wanderguard and wandering behaviors on her MDS assessment. She was not able to say what a negative outcome was to Resident #12 for not having her MDS assessment indicate she had Wanderguard and wandering behaviors.An interview on 09/23/25 at 3:45 pm, the DON said Resident #12's MDS assessment should have been coded as having wandering behaviors and wore a Wanderguard. The DON said there were no negative outcomes to Resident #12 not having her MDS assessment indicate she wore a Wanderguard.Record review of the facility's Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.19.9.1, October 2024 reflected:Section P: Restraints and Alarms:Item Rationale: Health-related Quality of life:An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarms, or elopement/wandering devices. n Record review of the facility's Resident Assessment policy, dated 01.2022; 12.2023 reflected:Policy:It is the policy of this facility that resident's will be assessed, and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident's preferences and goals of care, functional status, and strengths and needs will be identified.Procedure: Comprehensive Assessment: includes the completion of the MDS (Minimum Data Set) as well as the CAA (Care Area Assessment) process, followed by development and/or review of the comprehensive care plan. Comprehensive MDS (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment include Admission, Annual, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment. An accurate Comprehensive Assessment will be made of the resident's needs, strengths, goals, life history and preferences, using the RAI (Resident Assessment Instrument) and will include at least the following:Mood and behavior patternsSpecial treatments and procedures

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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** Based on interview and record review, the facility failed to develop and a comprehensive care plan for each resident, with the resident's rights, that includes measurable short-term and long-term objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 6 residents (Resident # 4) reviewed for care plans that: The facility failed to ensure Resident # 4's care plan included her triggers for a diagnosis of Post Traumatic Stress Disorder (PTSD). This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings include the following: Review of Resident # 4's admission Record dated 9/24/2025, revealed she was a [AGE] year-old female admitted to the facility on [DATE], with a diagnoses including Type 2 Diabetes Mellitus (a chronic condition that affects how the body uses glucose {sugar} for energy), Hypertension (high blood pressure), Schizophrenia (brain disorder where a person's thoughts, feelings, and behavior are disputed, making it hard to understand reality), and Post-Traumatic Stress Disorder (a mental health condition that develops after experiencing or witnessing a traumatic event, such as a natural disaster, war, or violent crime). Record of Resident # 4's quarterly MDS assessment, dated 7/28/2025, revealed: She had a mental status score of 7 of 15 (indicating her cognition was severely impaired). Review of Resident # 4's quarterly Care Plan dated 3/09/2025 revealed she has the potential for mood problem r/t the disease process and diagnosis of PTSD, anxiety disorder and schizophrenia which influence her interpretation of what occurs in reality by dwelling on the episode, verbally repeating the incident to others and or expressing emotional distress even after the episode passes. Interventions included: Administer medications as ordered, assist to identify strengths, positive coping skills, Document or report to MD mood patterns s/sx of depression, anxiety, or sadness, refer to appropriate behavioral health, psychiatrist or counselor consults as needed. Review of Resident # 4's care plan revealed there were no triggers for a diagnosis of PTSD addressed. In an interview on 9/24/2025 at 2:44 PM with the Social Worker said Resident # 4 had a diagnosis of Post Traumatic Stress Disorder. The Social Worker said that Resident # 4 had voiced that Spanish ballads would take her back to a time when an incident occurred involving her relative K and relative L. The Social Worker said she had identified a specific kind of music (Spanish ballads) that made Resident # 4 cry and increased her anxiety. The Social Worker said she had documented Resident # 4's trigger in her report binder. The Social Worker said that upon identifying Resident # 4's trigger, she was referred to a local counseling agency and psychiatric nursing service where she continued to receive services. The Social Worker said the care plan was written broadly because it was a hit or miss because Resident # 4 was a poor historian. In an interview on 9/24/2025 at 4:09 PM with CNA H said she knew to notify the charge nurse immediately if there was a change in behavior with any resident. CNA H said many Residents cannot verbally express themselves but changes in behavior sometimes meant they had an in infection and the nurses would follow up. She said the nursing staff would let the CNAs know the resident's baseline behaviors. CNA H said she did not know Resident # 4 had triggers related to the diagnosis of PTSD. In an interview on 9/24/2025 at 4:14 PM with RN I said she did not know Resident # 4 had a diagnosis of Post Traumatic Stress Disorder and did not know any of her triggers. In an interview and observation on 9/24/2025 at 4:39 PM the MDS Coordinator was observed as she reviewed Resident # 4's care plan and said she did not see any triggers listed. She said triggers should have been added to the care plan to ensure staff were aware of what might cause changes in her behaviors. The MDS Coordinator said they had daily and weekly Interdisciplinary Team meetings where they discussed and addressed resident problems. She said it would have been beneficial to have Resident # 4's triggers included in the care plan because it is a preventable measure. In an interview on 9/24/2025 at 4:49 PM the DON said she did not recall the Social Worker (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	having voiced Resident # 4's PTSD triggers. She said that during the morning meetings held daily with their IDT, the topic of PTSD and its corresponding triggers would be discussed, and that information would then be relayed to the rest of the staff. The DON said the facility had a form titled Stop and Watch that staff could use to identify any change in resident's behavior. The form would be turned into the DON and she would follow up. The DON said it would be beneficial to have PTSD triggers listed in the resident's electronic medical record for staff to be aware. The DON said the negative outcome for Resident # 4 not having her PTSD triggers on her care plan could place her in distress. Record review of facility policy titled Comprehensive Person-Centered Care Planning Revision/Review date:1/2022 Policy It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's 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 admission, 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. Procedure: The facility IDT will develop and implement a comprehensive person-centered care plan for each resident within seven (7) days of completion of the Resident Minimum Data Set (MDS) and will include resident's needs identified in the comprehensive assessment, any specialized services as a result of PASARR recommendation, and resident's goals and desired outcomes, preferences for future discharge and discharge plans.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preference for 1 (Resident #79) of 25 residents reviewed for call lights. The facility failed to ensure Resident #79 had the call light within reach while in bed in their room.This failure could place residents at risk of being unable to obtain assistance or help when needed and in the event of an emergency.Findings include: 1.Record review of Resident #79's admission record dated 09/24/25 reflected an [AGE] year-old female with diagnoses of Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline), Muscle Wasting And Atrophy Multiple Sites, Need for assistance with personal care, Difficulty in Walking. Record Review of Resident #79's Quarterly MDS dated [DATE] reflected a BIMS score of 3 indicating severe cognitive impairment. Resident #79 used a wheelchair. Record review of Resident #79's care plan dated 09/28/21 reflected has ADL self-care performance deficit related to needs extensive assist with all ADLs, interventions: needs assistance with transfers with weight bear, pivot, use arms to support, take two steps. Observation on 9/22/25 at 10:10 a.m. revealed Resident #79's call light device was on the bed frame; Resident #79 was not able to reach it. During an interview on 9/22/25 at 10:10 a.m. ADON B said that Resident #79 usually used the call light when they needed something. She said she always makes sure residents had it within reach and reminds them to use it. ADON B said that if a resident cannot reach the call light, then they cannot get help, they may have a fall and be at risk of getting hurt. During an interview on 9/24/25 at 2:00 p.m. DON said that if call lights are not within reach, residents might need help. DON said that Resident #79 could have fallen. Record review of facility's policy titled Routine Procedures, Call Light/Bell with date revised: 5/2023 stated: Policy: It is the policy of this facility to provide the resident a means of communication with nursing staff Procedures: 1. Answer the light/bell within a reasonable time 2. Turn off the call light/bell. 3. Listen to the resident's request/need. 4. Respond to the request. If the item is not available or you are unable to assist, explain to the resident and notify the charge nurse for further instructions. 5. Leave the resident comfortable. Place the call device within resident's reach before leaving room. If the call light/bell is defective, immediately report this information to the unit supervisor.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 6 residents (Resident #35) reviewed forThe facility failed to ensure Resident #35's order for a nutritional supplement included the route of administration and prescribed dose. The deficient practice could place residents at risk of not receiving the therapeutic effects from their medications as intended by the prescribing physician order.The findings include:Record review of Resident #35's admission sheet dated 09/24/25 reflected an [AGE] year-old female with an admit date of 04/19/23 and an initial admission date of 01/15/21. Her relevant diagnoses included dementia (a group of thinking and social symptoms that interferes with daily functioning), anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen), and moderate protein-calorie malnutrition (a condition where a person does not consume enough protein and calories to meet their body's needs).Record review of Resident #35's quarterly MDS assessment dated [DATE] reflected a BIMS score of 10, which indicated her cognition was moderately impaired.Record review of Resident #35's quarterly care plan dated 09/22/25 reflected:Problem: [Resident #35] is on a mechanically altered diet and is at risk of weight fluctuation, malnutrition, and dehydration.Interventions: in part included continue current diet (date initiated 06/02/2025).Record review of Resident #35's order summary reflected an active order for a nutritional supplement three times a day for wt. loss, start date was 02/06/2025. The order was missing from the route of administration and the amount.In an observation and interview on 09/22/25 at 9:20 am, Resident #35 was observed lying in bed awake. She said she would get a nutritional drink several times a dayRecord review of the Resident #35's eMAR for the months of 02/25 to 09/25 reflected she received a nutritional supplement three times a day.In an interview and observation on 09/23/25 at 5:15 pm, MA E was observed as she reviewed Resident #35's electronic medical record and said Resident #35 had an order for a nutritional supplement three times a day for weight loss. MA E said the order was considered incomplete because it did not include the route of administration and the dosage. MA E said she had not noticed the order was incomplete until this interview. MA E said there were no negative outcomes to Resident #35 not having her nutritional supplement order include the route of administration and dosage. MA said Resident #35 received one can of the nutritional supplement by mouth three times a day (morning, afternoon, and evening).In an interview on 09/23/25 at 5:30 pm, LVN F said Resident #35 had an order for a nutritional supplement three times a day for weight loss she said an order to be considered complete needed to have the resident's name, amount, route, frequency, and time. She was observed as she checked Resident #35's electronic medical record and said Resident #35's nutritional supplement order was not considered complete. LVN F said the order did not include the route of administration and the dosage. She said Resident #35's administration schedule showed on the eMAR three times a day in the morning, midafternoon, and evening. She said the amount she said would administer was 1 can. LVN F said there were no negative outcomes to Resident #35 for not having a complete nutritional supplement order because Resident #35 was being administered the nutritional supplement as ordered.An interview and observation on 09/23/25 at 5:45 pm, the DON said for an order to be considered complete, it needed to include the resident's name, amount, route, frequency, and time. She was observed checking Resident #35's electronic medical record and said she had an order for a nutritional supplement for weight loss. She said the order was missing the amount and route and it was not considered a complete order. The DON said the nursing staff were regularly in-serviced on the topic of medication administration. She said it was her and the ADONs responsibility to ensure all orders were complete.Record review of the (continued on next page)

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	11/19/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's physician orders, telephone orders and recapitulation process policy dated 08/16 and most recently revised on 07/25 reflected: Policy:This policy ensures that the hybrid record state during the transition to the EHR is managed in accordance with the requirements for maintaining the designated record set.Definition of hybrid record: The state of the clinical record during the transition to the EHR, where part of the record is on paper, and part is in electronic form.2).The admission orders must include, but not limited to, orders for the following:b. Medication (name, strength/dose, frequency, route of administration, diagnosis, PRN is to include specific reason)Transcription of Orders1.Licensed nurses are responsible for the correct transcription of all physician orders onto the appropriate form or into the electronic medical record system.3.If orders are illegible, unclear, or appear erroneous, the licensed nurse or pharmacist shall, in an expedient manner and before filling, consult the provider who wrote the order for clarification.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 25 residents (Resident #71) observed for infection control. 1. The facility failed to ensure LVN A used the required Personal Protective Equipment (gown) for Resident #71, who was on enhanced barrier precautions due to her sacral wound during wound care on 9/22/25. 2. The facility failed to ensure LVN A performed hand hygiene while providing wound care to Resident #71 on 09/22/25 and failed to ensure LVN A lather her hands for at least 20 seconds. These failures could place the residents at risk of cross-contamination and development of infection.Findings include: 1. Record review of Resident #71's face sheet dated 09/22/25 reflected a [AGE] year-old female with and admission date of 01/28/25. Diagnoses included dysphagia (difficulty swallowing), pressure ulcer of sacral region, stage 4(is the most severe type of pressure ulcer, characterized by full-thickness tissue loss with exposure of muscle, tendon, bone, or supporting structures), and muscle weakness. Record review of Resident #71's September 2025 Physician order sheet report reflected, . Orders: Tx to Sacrum surgical incision: cleanse wound with NS, pat dry, skin prep peri wound, may use Stoma paste to aid with seal, frame wound with transparent dressing, white foam to tunnel, apply black foam to wound bed, apply Negative Pressure Wound Treatment at 125 millimeters of mercury continuous every Monday Wednesday and Friday and as needed for dislodgement. During an observation on 09/22/25 at 02:10 p.m. LVN A washed hands before treatment and after treatment was completed. LVN A did not don Personal Protective Equipment properly (gown). LVN A sanitized hands in between glove changes. Old dressing was labeled and did not have drainage. No odor or drainage noted coming from wound. LVN A performed wound care following doctors order correctly. Dressing applied was dated and initialed. LVN A during handwashing she lathered hands for 13 seconds. In an interview with LVN A on 09/22/25 at 02:45 p.m. She stated any resident with a wound was required to be in enhanced barrier precautions. She stated she should have worn a gown and just overlooked it when she entered the room. She stated the risk of not following Enhanced Barrier Precautions was the spread of Multiple Drug-Resistant Organisms. LVN A said that she sang the happy birthday song twice and that she knew it was 20 seconds of lathering. In an interview with the DON on 09/24/25 at 02: 00 p.m. she stated any resident who had any type of wound was placed on Enhanced Barrier precautions to help reduce the spread of Multiple Drug-Resistant Organisms. She stated any contact with a resident with a wound required the use of gown and gloves. She stated the staff had received numerous trainings on the use of Enhanced Barrier Precautions. She stated staff were always required to perform hand hygiene before care and after care. She stated they do train on infection control during their skills checks and anytime they had any issues with infections in the building. She stated the risk of not adhering to the protocol was increased risk of infections. Record review of the Facility's policy titled, Infection Prevention and Control Program, dated June 2021, reflected, The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program Record review of the facility's policy titled, Hand Hygiene dated May 2007, reflected, washing hands: vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 second (or longer) under a moderate stream of running water, at a comfortable temperature.