STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676393	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Ventanas DE Socorro	10064 Alameda Avenue Socorro, TX 79927

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 51012 Based on observation, interview and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one resident (Residents #1) who was provided incontinence care by two (CNA A and CNA B) of two CNAs observed. 1. CNA A and CNA B failed to perform hand hygiene during incontinent care for Resident #1. 2. CNA A failed to clean Resident #1 from vagina to buttocks. These failures can place residents at risk for urinary tract infections. Findings include : In an observation on 02/20/25 at 4:43PM revealed CNA A and CNA B prepared Resident #1 CNA B disposed of the dirty brief and the dirty gloves in the trashcan. CNA B was observed putting on new gloves without performing hand hygiene. CNA A cleaned Resident #1's genitalia area with a clean wipe from rectum to perineum (the area between the anus and the vulva) and perineum to rectum . CNA A cleaned the resident's buttocks from front to back and disposed of the wipe. CNA A and CNA B disposed of the dirty wipes and dirty gloves into the trashcan. They both were observed putting on new gloves without performing hand hygiene and put a clean brief on the resident. During an interview with CNA A on 2/20/24 at 4:48 PM, revealed she did not wash her hands before the perineal care for Resident #1. CNA A stated the risks of not performing hand hygiene included bacteria and other viruses that could possibly be transmitted to the resident. She stated lack of hand hygiene can also place other residents at risk for infections by transmitting it from one resident to the next when providing care. She stated it is important for a female to be cleaned with a clean wipe from the genitalia to the buttocks to avoid fecal matter contaminating a female's vagina as this can also put the resident at risk for infections or illness. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CNA B on 2/20/24 at 4:51 PM, she stated it is important for females to be cleaned from front to back. CNA B stated to clean genitalia to buttocks is to prevent infections of the resident who received perineal care. She stated she changed gloves constantly when she provided perineal care, so her hands were clean because the new gloves she had put on were clean. She stated the clean gloves help to avoid infections or bacteria being spread to residents when providing perineal care. During an interview with the ADON on 2/21/25 at 2:39PM, she stated perineal care starts with hand hygiene and cleaning the genitalia area with clean wipes, from front to back. The ADON stated after cleaning the genitalia area, staff are to change their gloves from dirty to clean and apply a new brief to the resident. The ADON stated hand hygiene is done before and after perineal care, but not in between as leaving the patient alone and exposed to perform hand hygiene is an issue with the resident's dignity. The ADON stated training for perineal care is provided to nursing staff during orientation, and in-services. She is unable to recall the last in-service. During an interview with the Wound Care LVN on 02/24/25 at 10:09 AM, revealed staff are to perform hand hygiene before providing perineal care. He stated staff are to clean the groin area well, from the vagina to buttocks, and avoiding from buttocks to vagina. He stated the risk of not cleaning the area properly during perineal care included skin breakdown or infections. The Wound Care LVN stated hand hygiene such as hand sanitizer is to be done in between cleaning the resident and applying new briefs. He stated the risk of lack of hand hygiene for the resident included possible infection. Record Review of the facility's policy and procedures titled Staff Education/Orientation: Competency dated 1/12/24, revealed in part that staff is to: Perform hand hygiene, applies disposable gloves and other PPE (Protective Personal Equipment) as indicated; cleanse labia majora; Wipes in the direction from perineum to rectum (clean to dirty); cleans in one direction, clean to dirty; uses separate section of cloth for each stroke; Discard soiled gloves, perform hand hygiene and don gloves; Cleanses by wiping from vagina toward anus with one stroke, uses clean area of cloth for each stroke, continues until skin is clean; discard soiled gloves, perform hand hygiene and don clean gloves.

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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 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** 51012 Based on interviews, and record reviews, the facility failed to maintain clinical records that were complete and accurate, in accordance with accepted professional standards and practices, for 1 of 2 residents (Resident #2) whose closed medical records were reviewed in that: -The Facility failed to have Resident #2's hospital documentation from her injury to her left eyebrow and under her left eye on 2/03/25 in her facility medical records. This deficient practice could affect residents and result in errors in care and treatment. The findings include: Record review of Resident #2's Face Sheet, dated 2/24/25, revealed the resident was admitted on [DATE] with diagnoses: Age-related physical debility, Ataxic gait (staggering movements), Dementia (term used to describe a group of symptoms affecting memory, thinking and social abilities). Record review of Resident #2's Quarterly MDS dated [DATE] revealed a BIMS revealed Resident #2 was not able to answer questions. BIMS is a structured evaluation aimed at evaluating aspects of cognition in elderly patients. Record review of Resident #2's Health and Physical dated 01/07/25 revealed Resident #2 was [AGE] year-old female with diagnoses Muscle Atrophy. Resident #2's ordered assessment revealed the resident is a fall risk and has no safety awareness. Plan ordered as follows: Call light within reach, bedside table close, frequent rounding and toileting. Record review of Resident #2's care plan dated 02/04/25 revealed the resident does not have a plan addressing resident's injury to her left eyebrow and under her left eye. Record review of Resident #2's Progress note dated 02/04/25 signed by the Former DON, revealed she spoke with Resident #2's Responsible Party regarding the resident's left lower eyelid and above the eyebrow. The progress note reflected the former DON informed the responsible party that the resident accidentally hit the side of her face with her own hand while upper dressing was being performed in the morning. The former DON informed the responsible party the MD (Medical Doctor) was notified, and close monitoring was being performed, and ensured them that the resident did not sustain a fall. Record review of Resident #2's medical records progress notes dated 2/04/25 at 10:53 AM revealed LVN C noted the resident returned from the hospital, and had a CT of her Head without contrast, and an x-ray of her pelvis (the area below the abdomen) was completed and there were no new orders. Record Review of Resident #2's progress notes in her medical record revealed no follow-up documentation regarding the condition of Resident #2's bruise on the left side of her face including the size of the bruise or the healing stage. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADON on 2/24/25 at 4:39 PM, she stated there was no hospitalization documentation and is pending for a response. Hospital documentation was not provided prior to investigation exit. During an interview with LVN D on 2/20/25 at 2:50 PM, he stated protocol for incidents of residents with an injury of unknown origin is to notify the Nurse Practitioner and the resident's family. He stated staff is to find out more information regarding the injury from the progress notes or the nurse from the previous shift. LVN D stated protocol for head injuries included neurological checks and monitoring the resident's vital signs. Record review of facility's policy and procedures titled Accident/Incident reporting- Patient/Resident, dated 11/01/17, revealed, -For 3 days following an incident/accident the nurse documents the condition of the patient/resident in the medical record every shift.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 51012 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 one of one resident (Resident #1) reviewed for infection control. -CNA A failed to perform hand hygiene before providing perineal care to Resident #1. -CNA A and CNA B failed to perform hand hygiene after disposing of dirty wipes and briefs, and before applying new briefs on Resident #1. These failures can place residents at risk for urinary tract infections. Findings include : In an observation on 02/20/25 at 4:43PM revealed CNA A and CNA B prepared Resident #1 CNA B disposed of the dirty brief and the dirty gloves in the trashcan. CNA B was observed putting on new gloves without performing hand hygiene. CNA A cleaned Resident #1's genitalia area with a clean wipe from rectum to perineum (the area between the anus and the vulva) and perineum to rectum . CNA A cleaned the resident's buttocks from front to back and disposed of the wipe. CNA A and CNA B disposed of the dirty wipes and dirty gloves into the trashcan. They both were observed putting on new gloves without performing hand hygiene and put a clean brief on the resident. During an interview with CNA A on 2/20/24 at 4:48 PM, revealed she did not wash her hands before the perineal care for Resident #1. CNA A stated the risks of not performing hand hygiene included bacteria and other viruses that could possibly be transmitted to the resident. She stated lack of hand hygiene can also place other residents at risk for infections by transmitting it from one resident to the next when providing care. She stated it is important for a female to be cleaned with a clean wipe from the genitalia to the buttocks to avoid fecal matter contaminating a female's vagina as this can also put the resident at risk for infections or illness. During an interview with CNA B on 2/20/24 at 4:51 PM, she stated it is important for females to be cleaned from front to back. CNA B stated to clean genitalia to buttocks is to prevent infections of the resident who received perineal care. She stated she changed gloves constantly when she provided perineal care, so her hands were clean because the new gloves she had put on were clean. She stated the clean gloves help to avoid infections or bacteria being spread to residents when providing perineal care. During an interview with the ADON on 2/21/25 at 2:39PM, she stated perineal care starts with hand hygiene and cleaning the genitalia area with clean wipes, from front to back. The ADON stated after cleaning the genitalia area, staff are to change their gloves from dirty to clean and apply a new brief to the resident. The ADON stated hand hygiene is done before and after perineal care, but not in between as leaving the patient alone and exposed to perform hand hygiene is an issue with the resident's dignity. The ADON stated training for perineal care is provided to nursing staff during orientation, and in-services. She is unable to recall the last in-service. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Wound Care LVN on 02/24/25 at 10:09 AM, revealed staff are to perform hand hygiene before providing perineal care. He stated staff are to clean the groin area well, from the vagina to buttocks, and avoiding from buttocks to vagina. He stated the risk of not cleaning the area properly during perineal care included skin breakdown or infections. The Wound Care LVN stated hand hygiene such as hand sanitizer is to be done in between cleaning the resident and applying new briefs. He stated the risk of lack of hand hygiene for the resident included possible infection. Record Review of the facility's policy and procedures titled Staff Education/Orientation: Competency dated 1/12/24, revealed in part that staff is to: Perform hand hygiene, applies disposable gloves and other PPE (Protective Personal Equipment) as indicated; cleanse labia majora; Wipes in the direction from perineum to rectum (clean to dirty); cleans in one direction, clean to dirty; uses separate section of cloth for each stroke; Discard soiled gloves, perform hand hygiene and don gloves; Cleanses by wiping from vagina toward anus with one stroke, uses clean area of cloth for each stroke, continues until skin is clean; discard soiled gloves, perform hand hygiene and don clean gloves.