

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/19/2025
NAME OF PROVIDER OR SUPPLIER  Las Ventanas DE Socorro		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</b></p> <p>Based on observation, interview, and record review the facility failed to ensure residents the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 2 (Residents #1 and Resident #4) of 4 residents reviewed for accommodation of needs.</p> <p>The facility failed to ensure that Residents #1's call light was within reach.</p> <p>The facility failed to ensure that Resident #4's call light was within reach.</p> <p>This failure placed residents at risk of not being able to call have their needs met.</p> <p>Findings included:</p> <p>Resident #1</p> <p>Record review of Resident #1's face sheet dated 05/16/25, revealed, admission on 11/13/24 and re-admission on 05/03/25 to the facility.</p> <p>Record review of Resident #1's hospital history and physical dated 05/03/25, revealed, an [AGE] year-old male diagnosed with hypertension, congestive heart failure, Parkinson's Disease (progressive neurodegenerative disorder that affects movement, primarily due to a loss of brain cells that produce dopamine, a neurotransmitter crucial for coordinating movement), Dementia, and Diabetes.</p> <p>Record review of Resident #1's significant change in status MDS dated [DATE], revealed, there was no BIMS score taken or inputted to measure the resident's cognition for whatever reason. Activities of daily indicated the Resident #1 was dependent (Staff does all the work) for toileting and showers. Resident #1 was partial/moderate assistance (staff do less than half of the work) with rolling left or right in bed, sit to lying on bed, lying to sitting on side of the bed, and transfers was dependent. Resident #1 was always incontinent with urine and bowels. Has a history of falls. Was on a oxygen therapy.</p> <p>Record review of Resident #1's care plan dated 03/28/25, revealed, Problem: Resident was at risk for falling related to immobility, muscle weakness, chronic pain, decreased cognition. Resisting to use call light and self-transferring related to the diagnosis of Parkinson's Disease. Approach: Keep call light in reach at all times.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview with Resident #1 on 05/15/25 at 10:57 AM, revealed, the call light was placed at the HOB area underneath Resident #1's pillow. Resident #1 was lying on his bed awake with the oxygen mask on and fall mat placed on floor. Resident #1 stated he uses the call light to call for nursing staff assistance but did not know where his call light was at.</p> <p>Observation and interview on 05/15/25 at 11:00 AM, with LPN A. LPN A was observed looking for Resident #1's call light and pulled it out from the HOB area underneath the pillow. LPN A stated the call light had to be within reach of the residents. LPN A stated this was because in case the resident needed to use it for assistance. LPN A stated the risk of not having the call light within reach was risk of injury to the resident(s). LPN A stated it was everyone's responsibility to ensure that the call light was within reach of a resident.</p> <p>Resident #4</p> <p>Record review of Resident #4's face sheet dated 05/13/25, revealed, admission on 04/04/25 and re-admission on 05/06/25 to the facility.</p> <p>Record review of Resident #4's hospital history and physical dated 04/08/25, revealed, an [AGE] year-old-female diagnosed with Diabetes Type 2, hypertension, congestive heart failure, and chronic kidney disease.</p> <p>Record review of Resident #4's admission MDS dated [DATE], revealed, a little to no impairment of cognition BIMS score of 13 to be able to recall or make daily decisions. Activities of daily living functionality indicated partial/moderate assistance (staff does less than half the work) for toileting and lower dressing. Functional ability revealed supervision or touching assistance for rolling left or right on bed, sit to lying on bed, and sit to stand, and transfers. Device used was a wheelchair. Resident #4 was diagnosed with lack of coordination, abnormalities of gait and mobility, muscle wasting (loss of muscle mass and strength), muscle weakness (a decrease in the strength and ability of muscles to perform their normal functions, often resulting in a reduced ability to move the body or perform tasks), acute respiratory failure with hypoxia (low levels of oxygen in your body tissues).</p> <p>Observation on 05/13/25 at 2:54 PM, revealed, Resident #4 was in bed asleep covered up. The call light was observed hanging off to the left side off the night stand close to the ground.</p> <p>During an interview on 05/15/25 at 4:20 PM, with the DON, she stated the call light(s) are to be given to the resident(s) to have accessibility to the staff. The DON stated the call light(s) had to be within reach of a resident. The DON stated it was everyone's responsibility for ensuring the call lights where in reach of the resident(s). The DON stated the negative outcome of not having the call light within reach would be the resident would not be able to voice for help if needed.</p> <p>During an interview on 05/16/25 at 12:23 PM, with the NP, she stated the call lights are to be within reach of a resident for the safety of the resident. The NP stated it was the staff responsibility to ensure the call light was within reach. The NP stated no having the call light within could pose a safety risk for the resident depend on the situation.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/16/25 at 3:27 PM, with the Administrator, he stated the department heads conduct Angel Rounds (Rounds of the halls that department heads are assigned to do to ensure residents are being taken care of and/or seeing if there are any issues with the residents) where they check for the placement of the call light(s). The Administrator stated the call lights are to be within reach of a resident so that they had access to be assisted or in case of an emergency. The Administrator stated the call light not being within reach could impact the resident in an emergency when they need assistance and could cause a delay in care. The Administrator stated everyone was responsible for ensuring the call light was a within reach of a resident.</p> <p>Record review of the facility Call Lights, Responding To Policy dated 05/05/23, revealed, Policy: The staff will respond to call lights or other requests for assistance to meet the patient's/resident's needs. Procedures: When leaving the patient or resident room, ensure the call light was placed within the patient's/resident's reach.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>46998</p> <p>Based on interview and record review, the facility failed to implement written policies that prohibit and prevent abuse for 2 of 4 employees (Van Driver &amp; ADON) reviewed for development of abuse policy.</p> <p>The facility failed to conduct the annual EMR check for the Van Driver.</p> <p>The facility failed to conduct the annual EMR check for the ADON.</p> <p>This failure could place residents at risk of potential abuse or ongoing abuse.</p> <p>Findings included:</p> <p>Record review on 05/13/25 at 2:10 PM, revealed, the Van Driver's annual EMR dated 03/22/24, was not conducted.</p> <p>Record review on 05/13/25 at 2:12 PM, revealed, the ADON's annual EMR dated 03/22/24, was not conducted.</p> <p>During an interview on 05/13/25 at 3:09 PM, the Administrator stated corporate had informed him that they did not have an EMR Policy, and they followed state guidelines.</p> <p>During an interview on 05/16/25 at 9:06 AM, with HR, he stated that EMRs are to be conducted annually. HR stated the purpose of conducting the EMR checks was to check that staff were still eligible to work at the facility. HR stated the negative outcome of not conducting the annual EMR checks could result in the staff not being eligible to work and still working at the facility. HR stated there would be a risk to the residents of abuse. HR stated he was responsible for ensuring the EMR checks were done upon hire and annually.</p> <p>During an interview on 05/16/25 at 3:45 PM, with the Administrator, he stated the EMRs are to be done upon hire and annually. The Administrator stated the purpose of conducting EMR checks upon hire and annually was to see if the employee was placed on the EMR registry and could work at the facility. The Administrator stated the risk would depend on the situation the resident was in.</p> <p>Record review of the facility Abuse, Neglect, Exploitation, or Mistreatment Policy not dated revealed, The facility's leadership will implement appropriate and necessary guidelines, which prohibit them mistreatment, neglect, and abuse of the patient/resident including misappropriation of property and/or funds. Component I: Screening - Facility state-specific Background Investigation Policy was available through the facility's regional HR consultant.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility Background Checks - HR Policy 3.2 not dated, revealed, Policy: We will verify and certify the accuracy of information provided by applicants, employees, and independent contractors in a resume or application. We respect applicants' and employees' privacy and will only perform investigations that are job related and conducted in accordance with federal and state law. Procedure: We have established a uniform standard criteria for completing background investigations on employees and actions to take if a problem was detected.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46998</p> <p>Based on observation, interview, and record review the facility failed to ensure medical records, in accordance with accepted professional standards and practices, were maintained on each resident that were accurately documented for 1 of 4 residents (Resident #9) reviewed for medical records.</p> <p>The facility failed to ensure documentation was being done for showers being given to Resident #9 or being refused by Resident #9.</p> <p>This deficient practice could place residents at risk of records being inaccurate due to documentation errors.</p> <p>Finding included:</p> <p>Record review of Resident #9's face sheet dated 05/16/25, revealed, admission on 05/02/25 to the facility.</p> <p>Record review of Resident #9's hospital history and physical dated 05/02/25, revealed, a [AGE] year-old female diagnosed with osteopenia (a condition characterized by reduced bone density, meaning your bones are weaker than normal, but not as severely weakened as in osteoporosis), right hip arthroplasty (a surgical procedure where the hip joint on the right side is replaced with artificial components), shoulder pain, left femoral neck fracture (the ball is essentially disconnected from the rest of the femur).</p> <p>Record review of Resident #9's admission MDS dated [DATE], revealed, little to no impairment in cognition BIMS score of 13 to be able to recall or make daily decisions. Resident #9 needs substantial/maximal assistance (nursing staff does more than half the work) for showers, lower dressing, putting on/off footwear, sit to stand. Was dependent (nursing staff do all the work) for transfers and partial/moderate assistance (the nursing staff dose less than had the work) for lying to sitting on bed, sit to lying on bed, and rolling left or right. Resident #9 was occasionally incontinent with bladder and bowels. Resident #9 had orthopedic surgery to repair a fracture (on either the pelvis, hip, leg, knee, or ankle). At risk of developing pressure ulcers.</p> <p>Record review of Resident #9's care plan dated 05/06/25, revealed, Resistant to care, taking medications/injections, and ADLs, and eating. Resident #9 requires assistance with bed mobility for turning and repositioning related to pressure ulcers. Will maintain a sense of dignity by being clean, dry, odor free and well-groomed over next 90 days.</p> <p>Record review of Resident #9's Shower Sheets - Skin Assessment Done Upon Shower dated 05/03/25, 05/10/25, 05/15/25, revealed, Resident #9 had showers done on those days but was missing two shower sheets in which Resident #9 took a shower or refused the shower.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/15/25 at 4:33 PM, with the DON, she stated the facility was submitting another self-report to state regarding an allegation of Resident #9 not being showered. The DON stated the facility had already started in-servicing on bathing and ADL care. The DON stated Resident #9 showered on Tuesdays, Thursdays, and Saturdays. The DON stated the facility used shower sheets to document showers. The DON stated during her interviews with the CNAs, Resident #9 would refuse showers and other times showers were given. The DON stated any refused showers were to be documented on the shower sheet. The DON stated there were three shower sheets indicating Resident #9 was showered but was not able to locate where the other two missing shower sheets were at. The DON stated it was expected for the CNAs to document the showers or refusal of showers. The DON stated the risk was if it was not documented it did not happen as well as knowing if the showers were given or not for the resident. The DON stated the DON, ADONs, and CNAs were responsible for ensuring that the documentation was being for the showers.</p> <p>During an interview on 05/16/25 at 9:30 AM, with the Administrator, he stated a grievance, and a self-report were generated on 05/16/25 for a complaint about showers not being given to Resident #9. The Administrator stated Resident #9 was to be showered on Tuesdays, Thursdays, and Saturdays. The Administrator stated staff showered her while Resident #9 said she was not. The Administrator stated he checked the shower sheets and did not see any refusals for her. The Administrator stated there were two missing shower sheets that were uncounted for. The Administrator stated there had to be a total of 5 shower sheets. The Administrator stated the nursing staff could not give a reason why Resident #9 did not have all her showers/refusals documented. The Administrator stated the CNAs were trained on documenting. The Administrator stated it was expected for the nursing staff to be documenting showers or refusals in the resident's chart. The Administrator stated it was the responsibility of the nurses and administration to ensure that showers were being documented. The Administrator stated the reason for documenting was to keep track if the resident had showered or not. The Administrator stated the negative outcome would be the resident being affect if they have a preference of showering at a certain time or day.</p> <p>During an interview on 05/16/25 at 11:24 AM, with the SW, she stated Resident #9 said she was being showered and had no complaints when she interviewed her on 05/15/25. SW stated it should have been documented if Resident #9 was being showered or</p> <p>had refused.</p> <p>During an interview on 05/16/25 at 12:25 PM, with the NP, she stated the nursing staff are to be documenting the showers and/or any refusals. The NP stated this was so they would know if the resident had any rashes, fungus, or other skin issues that could led to UTIs.</p> <p>During an interview on 05/16/25 at 2:17 PM, with CNA C, she stated when she assisted Resident #9, she had not received any complaints from her about not being showered. CNA C stated anytime a resident shower a shower sheet had to be filled indicating that they showered or refused. CNA C stated they were trained to documents and it was the CNAs responsibility to fill them out.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/16/25 at 2L21 PM, with CNA D, she stated Resident #9 would shower in the afternoons and she had showered her yesterday (05/15/25). CNA D stated Resident #9 had not complained to her about not receiving showers. CNA D stated it was expected for the CNAs to be documenting the showers/refusals which are placed in a binder at the nurse's station. CNA D stated the negative outcome of not documenting was something being wrong with the resident and not knowing about it. CNA D stated the CNAs are trained on how to document.</p> <p>Record review of the facility Documentation Policy dated 05/05/23, revealed, Policy: Documentation pertaining to the patient/resident will be recorded in accordance with regulatory requirements. The nursing staff will be responsible for recording care and treatment, observations, and assessments and other appropriate entries in the patient/resident clinical record.</p>