

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  12/04/2024
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728</b></p> <p>Resident #10</p> <p>Ftag Initiation</p> <p>12/03/24 03:53 PM</p> <p>During observation on 12/03/2023 at 9:09 AM #10 Lucina [NAME] peri care observed with [NAME] CNA, one person assist stated resident should be a 2 person assist, but it was only her. She did not ask for help. She turned resident on side with wedges in place toward wall. Bed was locked.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728</b></p> <p>Based on observations, interviews and record review, the facility failed to ensure 1 of 1 resident (Resident #10) received adequate supervision to prevent accidents</p> <p>CNA-A failed to perform a 2 person assist for Resident #10 during incontinent care after precautions were put in place after a fall while performing resident care.</p> <p>This failure could place residents at risk for being provided care or treatment different from the plan of care.</p> <p>Findings included:</p> <p>Resident #10</p> <p>Record review of Resident #10's face sheet dated 12/04/2024 revealed the resident was a [AGE] year-old female initially admitted to the facility on [DATE] and was recently readmitted on [DATE] with medical diagnoses of dementia, syncope (fainting), convulsions, hemiplegia (paralysis of one side of the body), aphasia (inability to speak), cerebral infarction (stroke), history of falls, weakness, and tremors.</p> <p>Record review of Resident #10's 5-day scheduled assessment MDS, dated [DATE] revealed the residents Brief Interview for Mental Status Section C - Cognitive Patterns, subsection BIMS Summary Score was 99 indicating the resident was unable to complete the interview. Section GG - Functional Status, subsection Self Care, item C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. 01 was entered indicating Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. Section H - Bladder and Bowel, subsection Urinary Continence was marked 3 indicating Always incontinent (no episodes of continent voiding).</p> <p>Record review of Resident #10's care plan reviewed/revised 10/21/2024 revealed Problem Category: ADLs Functional status/Rehabilitation potential Resident requires assistance with ADLs and transfers with a 2 person assist and bed mobility is with a 2 person assist. Approach TOILETING TOTAL DEPENDENCE WITH Assist of X1 staff.</p> <p>Record review of Resident #10's provider's orders dated 09/24/2020 revealed TRANSFER with assist of x2, orders dated 10/23/2024 revealed BED MOBILITY with assist of x2.</p> <p>During an observation and interview on 12/03/2024 at 9:09 AM, CNA-A performed Resident #10's peri care with one person (herself). She stated this resident should be a 2 person assist but she had not taken the time to ask for help .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/04/2024 at 8:35 AM, the DON stated it was CNA-A who had performed peri-care when the fall of Resident #10 happened. She stated the facility implemented a two person assist during peri care. The DON stated Resident #10 was a one person assist prior to her falling in October. She stated if the resident had acted like she was trying to get out of bed while performing peri care, CNA-A should have at that point addressed the situation and called for further assistance. She stated in not having done so, the resident could have had a recurrence of falling while performing peri care. The DON stated the failure occurred with staff not calling for someone else to help her. She stated her expectation was for all residents to be taken care of to the staffs' full ability with upper management putting plan of care in place and staff to implement those plans.</p> <p>During an interview on 12/04/2024 at 10:49 AM, LVN-B stated Resident #10 was a two person assist for peri care because she was placed at a high risk for falls. She stated since this resident had a prior fall during peri care, so there should have always been two staff at bedside since then. LVN-B stated it was the hall staff supervisor, the ADON, and the DON who monitored.</p> <p>During a follow-up interview on 12/04/2024 at 1:45 PM, CNA-A stated she should have taken the time to ask for assistance because Resident #10 moved a lot. She stated she thought this state surveyor would be her second pair of eyes and that was another reason she did not asking for assistance.</p> <p>Record review of the facility in-service Follow policy on fall management and proper documentation dated 10/21/2024 revealed; CNA-A's signed and printed signature.</p> <p>Record review of the facility in-service policy Nursing Policies and Procedures dated 05/05/2023, revealed:</p> <p>Subject: Fall Management Policy:</p> <ol style="list-style-type: none"> <li>1. The facility will identify each patient/resident who is at risk for falls and will plan care and implement interventions to manage falls.</li> <li>2. Qualified staff will complete the Fall Risk Evaluation to determine if patient/resident is a fall risk.</li> <li>3. The fall management program includes education for staff in creative, functional strategies while recognizing patients/resident's rights, and highest practicable level of function.</li> </ol>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure residents who are incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 2 of 2 residents (Resident #4 and Resident #5),</p> <p>The facility failed to ensure CNA-A performed proper peri-care (incontinent care) Resident #4, and Resident #52.</p> <p>These failures placed residents of the facility at risk of infections from improper incontinent care and hand hygiene while performing incontinent care.</p> <p>Resident #4</p> <p>Record review of Resident #4's face sheet dated 12/04/2024 revealed, the resident was a [AGE] year-old male admitted to the facility on [DATE]. Resident #4's medical diagnoses included Type 2 diabetes, atrial fibrillation (irregular heartbeat), myocardial infarction (heart attack), embolism and thrombosis deep veins of unspecified lower extremity (blood clots in his legs), and weakness.</p> <p>Record review of Resident #4's Optional State Assessment MDS, dated [DATE] revealed; Section C, Cognitive Behaviors, Resident #4's Brief Interview for Mental Status was not assessed. Section GG-Functional Status, Activities of Daily Living (ADL) Assistance, subsection I Toilet use - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Residents Score for Self-Performance was entered as 3 indicating Extensive assistance - resident involved in activity, staff provided weight-bearing support. Score for Support was entered as 2 indicating One-person physical assist.</p> <p>Record review of resident #4's care plan reviewed and revised 10/29/2024 revealed Problem Category: Baseline Care Plan; Approach Toileting, Assist was marked.</p> <p>During an observation on 12/03/2024 at 07:20 AM, CNA-A, while performing peri-care for Resident #4, had wiped several times with one wipe as well as cleaning foreskin afterward and lastly with the same wipe.</p> <p>Resident #52</p> <p>Record review of Resident #52's face sheet dated 12/04/2024 revealed the resident was a [AGE] year-old male initially admitted to the facility on [DATE] and was recently readmitted on [DATE] with medical diagnoses of Type 2 diabetes, dementia, retention of urine, hemiplegia (paralysis on one side of the body), cerebral infarction (stroke), and history of falls.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #52's 5-day scheduled assessment MDS, dated [DATE] revealed the residents Brief Interview for Mental Status Section C - Cognitive Patterns, subsection BIMS Summary Score was 13 indicating the resident was cognitively intact. Section GG - Functional Status, subsection Self Care, item C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. 03 was entered indicating Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. Section H - Bladder and Bowel, subsection. Appliances A. Indwelling catheter (including suprapubic catheter and nephrostomy tube) was marked.</p> <p>Record review of Resident #52's care plan reviewed/revised 11/20/2024 revealed Problem Category: ADLs Functional status/Rehabilitation potential [Resident] requires assistance with ADLs Approach TOILETING TOTAL DEPENDENT X1 staff.</p> <p>During an observation on 12/02/2024 at 2:49 PM of Resident #52, CNA-A had begun peri-care beginning from the back to the front. CNA-A had used the same wipe 3-4 times before using a new or clean one. She was observed using the same contaminated gloves from cleaning after resident's bowel movement and proceeded with catheter care. CNA-A was observed performing catheter care without pulling the foreskin back.</p> <p>During an interview on 12/03/2024 at 9:24 AM, CNA-A stated she had not felt she needed to do anything different. CNA-A stated peri care was supposed to have been performed from front to back. She stated the negative impact for residents was that it could have led to residents could have had an increase of severe infections and having spread it to other residents and staff.</p> <p>During an interview on 12/04/2024 at 9:49 AM, the DON stated when wipes were used, staff should always have wiped from front to back and if the resident had a catheter, they should have started with the catheter first, not last. The DON stated it was herself as well as the ADON and nurse managers who monitored. She stated the negative impact for the residents was possibly getting a rash or cross contamination between resident care. The DON stated this staff member had received in person training, as well as yearly checkoffs. She stated the failure had occurred with the CNA wiping the resident from back to front.</p> <p>Record review of facility policy titled Nursing Policies and Procedures dated 05/05/2023 revealed:</p> <p>Subject: Perineal and incontinence Care</p> <p>Policy:</p> <p>Staff will perform perineal/incontinent care with each bath and after each incontinent episode.</p> <p>Procedures:</p> <p>Reference: Lippincott Nursing Procedures, 9th Edition., Perineal Care, pages 654-653.</p> <p>.The procedure promotes cleanliness and prevents infection. It also removes irritation and odorous secretions .Standard precautions must be followed when providing perineal care</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854</b></p> <p>Resident #79</p> <p>Respiratory Care</p> <p>12/02/24 01:49 PM Ms. [NAME] was in bed at this time. Her brother was visiting they both stated that the staff from the facility are very professional and they are very respectful. Ms. [NAME] had no complaints from the facility or staff and said she had no concerns. Scrapes on wall. She was wearing her nasal cannula and there was no oxygen sign posted outside the room.</p> <p>Posting of cautionary and safety signs indicating the use of oxygen policy was provided and it stated in part. Respiratory Policies and Procedures: Oxygen Therapy. Procedures- C. Check the patient's/resident's room to make sure it's safe for oxygen administration, place oxygen precautions sign on the door of the patient's/resident's room.</p> <p>12/03/24 12:51 PM Observation 210 Virginia [NAME]. Call light was pressed at this time to interview on Oxygen. [NAME] MDS stated that she believed there is supposed to be an oxygen sign. She stated that the risk of a resident who needs oxygen not having a sign outside their room was that staff might not know to go in and check for oxygen levels or if a family member came to visit and they had a lighter there was a potential fire hazard.</p> <p>12/03/24 12:55 PM Elvia [NAME] CNA. working at the facility for 9 years. She stated that the residents who have oxygen in their room need to have an oxygen sign posted outside of the door indicating that there is oxygen in their room. If there is no oxygen sign posted, she has been trained to let the DON or LVN know the sign is missing. [NAME] CNA is assigned to [NAME] today and she was assigned to [NAME]. She stated that if there is no oxygen sign posted by the residents door, the potential outcome could be that staff doesn't remember to check for the residents oxygen level and also if a family member has a lighter and they don't know they can't smoke in the facility there was a potential fire accident.</p> <p>12/03/24 01:03 PM [NAME] Woodart LVN. She stated that both residents from 213 and 210 receive oxygen and their are supposed to have oxygen signs posted outside their room. She said that if she knows a resident receives oxygen and notices they don't have a sign posted outside the room, they need to report it to the DON or ADON. She said that the DON and ADON are responsible to post the signs in the residents' rooms when they are admitted . She stated that the potential outcome of a resident not having an oxygen sign posted outside their room is that staff would not know they need to check for their oxygen levels or there was a potential fire hazard.</p> <p>12/03/24 01:21 PM DON. They have a concentrator in their room and they have oxygen as needed. They need to have a sign at the door regardless if the oxygen is as needed or not. They have a no smoking policy but there is a fire hazard. It has to be a close contact with a fire source in order to be a fire hazard and the concentrators would prevent that. The nurses need to check for the residents to have oxygen, there is no potential for nurses to forget not to check the residents who require oxygen.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>12/03/24 01:34 PM Administrator. Stated that the administration, nursing administration and admission team was responsible of ensuring that the residents who need oxygen have a sign posted outside their door. He stated that there was no potential negative outcome for a resident not having a sign outside their door because the nurses have to check the residents orders that clarifies the oxygen administration. He stated that there was no fire hazard because it was a non smoking facility and in order to have a fire hazard it would be necessary to be in close proximity to the oxygen concentrator or on top of it.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728</b></p> <p>Based on observations, interviews, 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 1 CNA (CNA-A) staff observed during incontinent care.</p> <p>The facility failed to ensure CNA-A performed proper hand hygiene for Resident #4, Resident #10, and Resident #52.</p> <p>These failures placed residents of the facility at risk of infections from improper incontinent care and hand hygiene while performing incontinent care.</p> <p>Findings included:</p> <p>Resident #4</p> <p>Record review of Resident #4's face sheet dated 12/04/2024 revealed, the resident was a [AGE] year-old male admitted to the facility on [DATE]. Resident #4's medical diagnoses included Type 2 diabetes, atrial fibrillation (irregular heartbeat), myocardial infarction (heart attack), embolism and thrombosis deep veins of unspecified lower extremity (blood clots in his legs), and weakness.</p> <p>Record review of Resident #4's Optional State Assessment MDS, dated [DATE] revealed; Section C, Cognitive Behaviors, Resident #4's Brief Interview for Mental Status was not assessed. Section GG-Functional Status, Activities of Daily Living (ADL) Assistance, subsection I Toilet use - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Residents Score for Self-Performance was entered as 3 indicating Extensive assistance - resident involved in activity, staff provided weight-bearing support. Score for Support was entered as 2 indicating One-person physical assist.</p> <p>Record review of resident #4's care plan reviewed and revised 10/29/2024 revealed Problem Category: Baseline Care Plan; Approach Toileting, Assist was marked.</p> <p>During an observation on 12/03/2024 at 07:20 AM, CNA-A did not remove her gloves or use hand hygiene throughout resident care. CNA-A then dressed the resident, touched his call light, then cleaned Resident #4's face with the same gloves on as when she performed his peri care.</p> <p>Resident #52</p> <p>Record review of Resident #52's face sheet dated 12/04/2024 revealed the resident was a [AGE] year-old male initially admitted to the facility on [DATE] and was recently readmitted on [DATE] with medical diagnoses of Type 2 diabetes, dementia, retention of urine, hemiplegia (paralysis on one side of the body), cerebral infarction (stroke), and history of falls.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 12/03/2023 at 9:09 AM, CNA-A was observed performing peri care for Resident #10 with no changing of gloves or hand hygiene throughout resident care. CNA-A had not changed her gloves, nor did she perform hand hygiene prior to redressing the resident after performing peri care.</p> <p>During an interview on 12/03/2024 at 9:24 AM, CNA-A stated she had not felt she needed to do anything different. When asked if she felt if she should have changed gloves between clean and dirty while performing resident care, she stated yes. She stated the negative impact for residents was that it could have led to residents could have had an increase of severe infections and having spread it to other residents and staff.</p> <p>During an interview on 12/04/2024 at 9:49 AM, the DON stated the staff member should have changed her gloves directly after performing peri care. The DON stated it was herself as well as the ADON and nurse managers who monitored. She stated the negative impact for the residents was possibly getting a rash or cross contamination between resident care. The DON stated this staff member had received in person training, as well as yearly checkoffs. She stated the failure had occurred with the CNA wiping the resident from back to front.</p> <p>Record review of facility policy titled Infection Prevention and Control Policies and Procedures complete revision: dated 9/2011, CMS FR:11/27/2017 revealed:</p> <p>Subject: Hand Hygiene/Handwashing</p> <p>Plain soap refers to products that do not contain antimicrobial agents, or contain very low concentrations or antimicrobial agents</p> <p>Surgical hand antiseptic. Antiseptic hand wash or antiseptic hand rub</p> <p>Visibly soiled hands. Hands showing visible dirt or visibly contaminated with proteinaceous body substances (e.g., blood, fecal material, urine)</p> <p>Waterless antiseptic agent. An antiseptic agent that does not require use of exogenous water</p> <p>Procedures:</p> <p>1. Hand hygiene/hand washing is done:</p> <p>Before:</p> <p>A. Before patient/resident contact</p> <p>After:</p> <p>A. After contact with soiled or contaminated articles, such as articles that are contaminated with body fluids.</p> <p>B. After patient/resident's contact.</p> <p>(continued on next page)</p>		

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  12/04/2024
NAME OF PROVIDER OR SUPPLIER  Las Ventanas DE Socorro		STREET ADDRESS, CITY, STATE, ZIP CODE  10064 Alameda Avenue Socorro, TX 79927	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>C. After contact with a contaminated object or source where there is a concentration of microorganisms, such as, mucous membranes, non-intact skin, body fluids or wounds.</p> <p>D. After toileting or assisting others with toileting, or after personal grooming.</p>