

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Las Alturas Nursing & Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 4301 North Bartlett Avenue Laredo, TX 78041	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038</p> <p>Based on interview, and record review, the facility failed to promptly notify the residents' representatives immediately of a fall that occurred for one (Resident #1) of two residents reviewed for resident rights.</p> <p>The facility failed to immediately notify Resident #1's responsible party (RP) of a fall that occurred on 9/27/24.</p> <p>This failure could place residents who had falls with injury at risk for not receiving appropriate care and interventions.</p> <p>The findings included:</p> <p>Record review of Resident #1 face sheet dated 10/11/24 reflected an [AGE] year-old-female with an original admitted [DATE]. Diagnoses included urinary tract infection, heart failure, diabetes type 2 (insufficient production of insulin in the body), and chronic kidney disease.</p> <p>Record review of Resident #1's care plan dated 5/24/24 reflected Resident #1 was prescribed medication/medications that lends to a risk for abnormal bleeding, easily bruised and/or skin issues/injury. Resident # 1 had chronic health conditions & co-morbid conditions that have affected her physical function and may further affect her quality of life.</p> <p>Record review of Resident #1's MDS dated [DATE] reflected a BIM score of 5 (severe cognitive impairment) and was dependant for toileting, transfers, dressing, and bathing.</p> <p>In an interview with the ADM on 7/23/24 at 10:50 am. She stated there was no specific timeframe of when the family needed to be notified as long as they were notified of the fall that day. The ADM stated the doctor was aware Resident #1 rolled out of bed and did not order any x-rays and Resident #1 did not require to be sent out to the hospital as Resident #1 was not complaining of pain and had full range of motion to the extremities that were affected. The ADM stated LVN A did address Resident #1's small cut to the eyebrow and put a bandage on it.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a phone interview on 7/23/24 at 11:45 am LVN A stated Resident #1 had fallen on Sunday morning, 7/21/24. LVN A stated the day was really busy. LVN A stated during breakfast Resident #1 ate normal and after the plates were picked up, CNA B went and told him that she found Resident #1 on the floor while doing her rounds. LVN A stated he started to assess Resident #1 and noticed some swelling to her left eyebrow and slight swelling to left knee. LVN A stated after the assessment, he notified the doctor and the doctor stated to just treat the area and continue monitoring Resident #1 for any changes in condition. LVN A stated the doctor stated Resident #1 did not need to be sent out to the hospital and did not feel any other interventions were needed at that time. LVN A stated during that time, he was taking care of another resident who was very ill and was nearing the end of life. LVN A stated he continued to monitor Resident #1 and was not able to notify Resident #1's RP immediately but was going to. LVN A stated Resident #1's family member came to visit Resident #1 approximately 4 hours after the fall and that was when he informed Resident #1's family about what happened and how the doctor did not feel Resident #1 needed to be sent out at that time. LVN A stated he offered to contact the doctor again to see if he wanted to have Resident #1 sent out and the family refused. LVN A stated the family member called 911 themselves and Resident #1 was picked up by an ambulance and transferred to the hospital.</p> <p>In a phone interview on 7/23/24 at 12:37 pm Resident #1's RP stated on Sunday 7/21/23, a family member went to visit Resident #1 and saw Resident #1's face and called the RP and asked what was going on. Resident #1's RP stated she spoke to LVN A on the phone and stated LVN A apologized to her and stated that during the morning he went to check Resident #1's blood sugar and everything was fine and after that CNA B stated she found Resident #1 on the floor after she had a fall trying to get out of bed. Resident #1's RP stated it had been about 4 hours since Resident #1 fell to when they were informed and LVN A apologized again and stated he had not had a chance to call to inform Resident #1's RP. Resident #1's RP stated she understood LVN A was busy, but he could have taken one minute to call them. Resident #1's RP stated the facility called for everything that was going on with Resident #1 and was upset they did not call her right away about the fall.</p> <p>In an interview on 10/11/24 at 11:07 am the ADM stated LVN A was working with the family of a resident who was passing away and stated that everything happened so quick, but LVN A was going to communicate with the family since Resident #1 was stable. The ADM stated in-service on notifications was conducted with all staff.</p> <p>In an interview on 10/11/24 at 12:37pm the DON stated what he remembered from that day was one of the CNA's was doing their rounds and found Resident #1 on the floor and went and called LVN A. The DON stated LVN A did an assessment and Resident #1 had a laceration on her forehead and swelling to her knees. The DON stated LVN A notified the doctor and treated Resident #1 as ordered. The DON stated approximately 10 to 15 minutes after Resident #1's fall, LVN A had to tend to another resident who was nearing the end of life and since Resident #1 was stable, the family was not notified immediately. The DON stated it was not done with malicious intent as there was just circumstances that day and resident needs were being prioritized. The DON stated everything was conducted in the best manner of the residents at that time.</p> <p>Record review of in-services dated 7/30/24 on falls, accident prevention, transfer safety, effective communication, answering of call lights, reporting any change in condition, anticipate resident needs, customer service, and abuse/neglect/exploitation.</p> <p>Record review of facility's Fall Prevention policy dated 3/28/22 stated:</p> <p>(continued on next page)</p>		

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