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 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Alturas Nursing & Transitional Care	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on record reviews and interviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 2 (Resident #2 and Resident #3) of 12 residents reviewed for quality of care. 1a. The facility failed to ensure that Resident #2's Admission Assessment was accurately and timely documented in PCC on 9/16/23 when she returned to the facility from the hospital after having surgery. 1b. The facility failed to ensure that an incident in which Resident #2 cut her surgical incision drain tubing on 9/16/23 was timely documented. 2a. The facility failed to ensure that Resident #3's Post Fall Review was documented accurately and timely in PCC after she fell on [DATE]. 2b. The facility failed to ensure that Resident #3's Neuro Checks were accurately and timely documented in PCC after she fell on [DATE]. 2c. The facility failed to ensure that Resident #3's progress notes were timely documented in PCC on 6/15/24 and 6/16/24. 2d. The facility failed to ensure that Resident #3's Change in Condition Evaluation was documented accurately and timely in PCC when she began to experience pain on her right leg on 6/16/24. 2e. The facility failed to ensure that Resident #3's Change in Condition Evaluation was documented accurately and timely in PCC when she had bleeding from her surgical site incision on her right leg on 6/21/24. These failures could affect residents whose records are maintained by the facility and could place them at risk for errors in care and treatment. The findings included: (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Record review of Resident #2's admission record reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2's diagnoses included Alzheimer's disease, unspecified dementia, anxiety disorder, depressive episodes, hypertension (high blood pressure), hypertensive chronic kidney disease (kidney disease due to kidney damage done by high blood pressure), malignant neoplasm of left female breast (breast cancer), acquired absence of left breast and nipple (surgical removal of the breast), and cognitive communication deficit (difficulty with communication). Record review of Resident #2's quarterly MDS dated [DATE] reflected that Resident #2 had a BIMS score of 3 out of 15 which indicated that she had severe cognitive impairment. Resident #2 required total assistance with bathing/ showering. Resident #2 required supervision or touch assistance with eating, oral hygiene, toileting hygiene, upper and lower body dressing, putting on/ taking off shoes, personal hygiene, rolling left and right in bed, sitting to lying flat on the bed, lying on the bed to sitting on the edge of the bed (without back support), transferring from bed to chair or chair to bed, getting on or off a toilet, getting into or out of a tub or shower, walking 10 feet, walking 50 feet with 2 turns, and walking at least 150 feet. Record review of Resident #2's care plan reflected that Resident #2 had focuses of: A. Impaired cognitive function or though processes r/t Alzheimer's and dementia with interventions that included cue, reorient, and supervise as needed which was initiated and created on 5/10/21, B. ADL self-care performance deficit r/t Alzheimer's with interventions that included Resident #2 requiring set up assistance for toileting, transfers, repositioning in bed, dressing and eating which was initiated and created on 5/10/21, C. Bladder incontinence r/t Alzheimer's and dementia with interventions that included check me as needed and as required for incontinence which was initiated and created on 5/10/21, and D. Requirement of anti-depressant medication r/t anxiety which was created and initiated on 4/3/21. E. Risk for falls r/t wandering which was created and initiated on 4/3/21. Record review of Resident #2's Provider Order Summary Report reflected that Resident #2 had the following side effect monitoring and medication orders: a. Side effects- anti-convulsant order date 4/2/21. b. Side effects- anti-depressant order date 4/2/21. c. Side effects- sedative/ hypnotic order date 6/27/22. d. Depakote Delayed Release 125mg. Give 1 tablet PO BID for agitation. e. Lamotrigine 25mg. Give 2 tablets PO every morning and at bedtime for convulsions. f. Losartan Potassium 50mg. Give 1 tablet PO one time a day for HTN. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Trazadone HCl 50mg. Give 1 tablet PO BID for anxiety and agitation. Record review of Resident #2's Admission assessment dated [DATE] at 4:41pm and signed by RN B on 9/21/23 reflected the following: a. The resident required catheter care/ catheter change. b. No EBP (enhanced barrier precautions) were clinically indicated. (Resident #2 had a surgical incision and a surgical drain from a left breast mastectomy that was done on 9/15/23) c. Actual or risk for infection- Focus: at risk for infection or recurrent/ chronic infection r/t compromised medical condition with interventions of report changes in condition to provider as clinically indicated and enhanced barrier precautions practices as clinically indicated. d. A catheter was required post-surgery J [NAME] (a surgical suction drain that gently draws fluid from a surgical site) with intervention of monitor for s/s (signs or symptoms) of infection. e. Vitals, Height, Weight: 1. Most recent weight: 167.5 pounds dated 9/1/23 at 3:58pm 2. Most recent height: 56 inches dated 4/5/21 at 8:24am 3. Most recent blood pressure: 109/83 dated 9/17/23 at 8:01am (1 day AFTER the effective date of this assessment which was 9/16/23 at 4:41pm) 4. Most recent temperature: 97.0 F dated 7/31/23 at 11:35pm (2 months PRIOR to the effective date of this assessment which was 9/16/23 at 4:41pm) 5. Most recent pulse: 72 dated 9/4/23 at 9:37am (12 days PRIOR to the effective date of this assessment which was 9/16/23 at 4:41pm) 6. Most recent respiration: 18 dated 7/31/23 at 11:24pm (2 months PRIOR to the effective date of this assessment which was 9/16/23 at 4:41pm) 7. Most recent O2 sats (oxygen saturation): 98% dated 7/31/23 at 11:25pm (2 months PRIOR to the effective date of this assessment which was 9/16/23 at 4:41pm) 8. Most recent pain level: 0 dated 9/16/23 at 7:15pm (2 hours AFTER the effective date/time of this assessment which was 9/16/23 at 4:41pm) f. Resident's communication is impaired related to: Not Applicable. (Resident #2 had a BIMS score of 3 which indicated severe cognitive impairment) g. Head to toe skin assessment: 1. General skin condition: normal (Resident #2 had a left breast mastectomy on 9/15/23) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	m. Exit seeking Tool: Is the resident physically able to leave the building on their own? no n. Hot liquid evaluation: None of the boxes are checked. o. If any boxes are checked yes, indicate which interim measures were put into place to enhance safety while therapy screen is pending: Focus- Resident has the potential for skin impairment/ burn r/t hot liquid encounters; needs disposable plastic lid on coffee cup for safety. (None of the boxes were checked for hot liquid evaluation). p. 48 hour care planning: 1. Care plan for self-care deficit- Focus: I have a self-care deficit. Intervention: Mobility- I use a wheelchair. (Resident #2 was ambulatory with a walker and required only supervision or touch assistance with walking 10 feet, walking 50 feet with 2 turns, and walking at least 150 feet which was reflected in her MDS.) 2. Care Plan- Cognitive function/ dementia or impaired thought Process is not included. 3. Fall risk plan of care- Focus: at risk for falls r/t wandering. Actual fall 9/20/22. Record review of Resident #2's progress notes in PCC reflected an entry as follows: Late Entry Effective date: 9/16/23 at 12:47pm Created by: DON Created date: 10/9/23 at 12:52pm Note text: During rounds, was advised by SN (skilled nurse) and supervisor noted Jackson Pratt to have an incision made by the resident on the Jackson Pratt's tubing. This information was communicated to the PA (physician's assistant) and orders were given to seal the drainage tube and follow up with the surgeon. Nursing was able to seal the Jackson Pratt tube and drainage was noted at the end of the shift. No s/s of infection were noted in the area or to the resident's mastectomy area. 2. Record review of Resident #3's admission record reflected an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included Alzheimer's disease, dementia, fall from bed (1/18/24), displaced intertrochanteric fracture of right femur (non-aligned fracture of the right thigh bone at the hip) (1/18/24), age-related osteoporosis (bone disease that causes bones to become weak and more likely to break) without current pathological fracture (broken bone not caused by force or impact) (1/16/24), polyosteoarthritis (pain in five or more joints at the same time), and generalized muscle weakness. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Created: 6/18/24 at 10:50am Created by: DON Note: CNA provided incontinent care at this time; no signs and symptoms of pain were noted, and the resident continued to sleep in bed comfortably. 8. Type: eINTERACT SBAR Summary for Providers Effective 6/18/24 at 7:00am Created: 6/18/24 at 11:01am Created by: RN B Situation: Pain to right leg with movement This started on: 6/16/24 (no time or time of day documented) Summarize your observations, evaluation, and recommendations: This morning, nurse was informed by the CNA that while changing resident and preparing for breakfast, noticed swelling above her right knee. Upon assessment, resident complained of tender pain and could move her feet from side to side without pain but experienced pain when moving her leg. Describe functional status changes: (Choices were needs more assistance with ADLs, general weakness, decreased mobility, fall, swallowing difficulty, no changes observed, and other). No changes were observed was checked. (Contradictory to the summarized statement that Resident #3 experienced pain when moving her leg. Vital signs evaluation: Are these the most recent vital signs taken after the change in condition occurred: Yes Most recent blood pressure: 128/79 dated 6/17/24 at 7:48am (1 day AFTER the eINTERACT SBAR Summary for Providers effective date/time of 6/16/24 at 7:00am). Most recent pulse: 66 dated 6/17/24 at 7:48am (1 day AFTER the eINTERACT SBAR Summary for Providers effective date/time of 6/16/24 at 7:00am). Most recent respiration: 18 dated 4/18/24 at 4:11am (2 months BEFORE the eINTERACT SBAR Summary for Providers effective date/time of 6/16/24 at 7:00am). Most recent temperature: 98.0 dated 4/18/24 at 4:11am (2 months BEFORE the eINTERACT SBAR Summary for Providers effective date/time of 6/16/24 at 7:00am). Most recent O2 sats: 98% dated 4/18/24 at 4:11am (2 months BEFORE the eINTERACT SBAR Summary for Providers effective date/time of 6/16/24 at 7:00am). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Las Alturas Nursing & Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 4301 North Bartlett Avenue Laredo, TX 78041	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provider notification and feedback: Date and time of clinician notification: 6/16/24 at 12:00am (7 hours BEFORE the eINTERACT SBAR Summary for Providers effective date/time of 6/16/24 at 7:00am). Recommendations of primary clinician: No bruising or signs of trauma noted at this time. Nurse immediately administered pain medication, advised CNA to leave the resident in bed, and notified the doctor of the situation. New orders were received for an x-ray of the right hip and knee. Pain status evaluation: Is a pain assessment relevant to the change in condition being reported? Answer: Not clinically applicable to the change in condition being reported. (Contradictory to the summarized statement of, Upon assessment, resident complained of tender pain and could move her feet from side to side without pain but experienced pain when moving her leg.) Does the resident have pain: Not answered. (Contradictory to the summarized statement of, Upon assessment, resident complained of tender pain and could move her feet from side to side without pain but experienced pain when moving her leg.) Pain location: Not answered. (See above) General background information: Primary diagnosis: not answered. List any medication changes made in the past week: Not answered. (Contradictory to the Order Summary Report as of 6/15/24 which reflected Resident #3 had an order for Hydroxyzine HCl. Give 12.5 mg by mouth every 8 hours as needed for anxiety that was ordered on 6/11/24) Resident representative notification: Date and time of family/ RP notification: 6/16/24 at 12:00am (7 hours before the effective date/time of 6/16/24 at 7:00am) 9. Type: Nursing progress note Effective: 6/16/24 at 3:00pm Created: 6/18/24 at 10:57am Note: The resident applied a right knee orthopedic brace. At this time, resident was noted trying to get out of bed. SN was at bedside. CNA stayed at the bedside to provide immediate supervision to prevent further injury. The resident was reoriented to time and place and rested comfortably in bed. RP was notified of nursing intervention at this time. 10. Type: eINTERACT SBAR Summary for Providers (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Effective: 6/21/24 at 9:15am Created: 6/23/24 at 11:17pm Created by: RN B Vital signs evaluation: Are these the most recent vital signs taken after the change in condition occurred: Yes Most recent blood pressure: 133/70 dated 6/23/24 at 7:21pm (2 days AFTER the eINTERACT SBAR Summary for Providers effective date/ time of 6/21/24 at 9:15am). Most recent pulse: 74 dated 6/23/24 at 7:21pm (2 days AFTER the eINTERACT SBAR Summary for Providers effective date/ time of 6/21/24 at 9:15am). Most recent respiration: 18 dated 6/23/24 at 2:38pm (2 days AFTER the eINTERACT SBAR Summary for Providers effective date/ time of 6/21/24 at 9:15am). Most recent temperature: 97.8 dated 6/23/24 at 2:38pm (2 days AFTER the eINTERACT SBAR Summary for Providers effective date/ time of 6/21/24 at 9:15am). Most recent weight: 127.0 dated 6/1/24 at 7:29pm. Most recent O2 sats: 97% dated 6/23/24 at 2:38pm (2 days AFTER the eINTERACT SBAR Summary for Providers effective date/ time of 6/21/24 at 9:15am). Provider notification and feedback: Were the change in condition and notifications reported to primary care clinician: Yes Date and time of clinician notification: 6/21/24 at 12:00am (9 hours BEFORE the eINTERACT SBAR Summary for Providers effective date/ time of 6/21/24 at 9:15am). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/30/24 at 1:57pm RN C stated she had been working at the facility for 5 years. When asked about the readmission process, RN C stated when a resident was admitted after a hospital stay as a readmission, a progress note was put in the computer, and admission assessment was done, the primary provider would be notified, and any new orders would be entered. RN C stated the readmission assessment was done immediately upon the resident's arrival in the facility. RN C stated in reference to the resident's most recent vital signs, that they were on the top of the page in PCC. RN C stated there was a button to click that had recent vital signs that showed the previous vital signs, but you had to click on each one individually. In reference to what would be documented in the progress notes, RN C stated that any orders that were given, any risk management documentation, appointments, and any information that would need to be passed on to the next shift should be documented in the progress notes. RN C stated the SBAR was its own assessment but showed up in progress notes. RN C stated an SBAR and change in condition would be done for fever, abnormal vital signs, lethargy, and anything that has to do with a change in the resident's condition. RN C stated that progress notes were to be documented immediately. RN C stated notifications to the RP, provider, and ADON/ DON were done and documented immediately in PCC in the change in condition documentation. RN C stated she was familiar with Resident #2 and had her as a patient after her mastectomy. RN C stated she was not working the day of the incident with Resident #2's JP drain, but she was told that Resident #2 pulled out her JP drain. RN C stated Resident #2 had dementia, forgot things right away, and had to be redirected frequently. RN C stated the nurse who was in charge when the JP drain incident happened fixed the drain and it was still draining. LVN C stated if something like that happened on her shift, she would notify the surgeon, the RP and the DON immediately to see what the plan of action was. RN C stated the documentation would include the change in condition form or a risk management form in PCC and a progress note would be written, also in PCC. RN C stated the progress note would have a summary of what happened, who was contacted, and what the plan of care was. RN C stated the risk management documentation would have more detailed information and it would automatically generate the date, time, and resident information at the top of the form. In an interview on 10/30/24 at 2:37pm, the ADON stated she had been working at the facility as a floor nurse for 2 years, became the DCE (Director of Clinical Education) for 2 1/2 years and then became the ADON. The ADON stated when a resident was gone for a little while (to the hospital) a readmission assessment, medication reconciliation, and the whole screening and care planning were done again when the resident returned. The ADON stated anything that was new or changed was revised in orders and/ or care plans. The ADON stated when someone returned to the facility, the head to toe assessment and vital signs were done as soon as they got to the facility. The ADON stated the vital signs were pulled automatically to the admission form and the nurse had to change them to the correct vital signs. The ADON stated progress notes were used for documenting any changes, new orders, appointments, and anything related to the resident's clinical status. The ADON stated that change in condition documentation was used for any changes, critical laboratory result and any change in a resident's condition. The ADON stated it was done at the time of the change in condition. The ADON stated the provider, RP and DON were notified for any change in condition immediately. The ADON stated th [TRUNCATED]

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49157 Based on record reviews and interviews, the facility failed to maintain clinical records on each resident, in accordance with accepted professional health information management standards and practices, that were accurately documented for 2 (Resident #2 and Resident #3) of 12 residents reviewed for clinical records. 1a. The facility failed to ensure that Resident #2's Admission Assessment was accurately and timely documented in PCC on 9/16/23 when she returned to the facility from the hospital after having surgery. 1b. The facility failed to ensure that an incident in which Resident #2 cut her surgical incision drain tubing on 9/16/23 was timely documented. 2a. The facility failed to ensure that Resident #3's Post Fall Review was documented accurately and timely in PCC after she fell on [DATE]. 2b. The facility failed to ensure that Resident #3's Neuro Checks were accurately and timely documented in PCC after she fell on [DATE]. 2c. The facility failed to ensure that Resident #3's progress notes were timely documented in PCC on 6/15/24 and 6/16/24. 2d. The facility failed to ensure that Resident #3's Change in Condition Evaluation was documented accurately and timely in PCC when she began to experience pain on her right leg on 6/16/24. 2e. The facility failed to ensure that Resident #3's Change in Condition Evaluation was documented accurately and timely in PCC when she had bleeding from her surgical site incision on her right leg on 6/21/24. These failures could affect residents whose records are maintained by the facility and could place them at risk for errors in care and treatment. The findings included: 1. Record review of Resident #2's admission record reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2's diagnoses included Alzheimer's disease, unspecified dementia, anxiety disorder, depressive episodes, hypertension (high blood pressure), hypertensive chronic kidney disease (kidney disease due to kidney damage done by high blood pressure), malignant neoplasm of left female breast (breast cancer), acquired absence of left breast and nipple (surgical removal of the breast), and cognitive communication deficit (difficulty with communication). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's quarterly MDS dated [DATE] reflected that Resident #2 had a BIMS score of 3 out of 15 which indicated that she had severe cognitive impairment. Resident #2 required total assistance with bathing/ showering. Resident #2 required supervision or touch assistance with eating, oral hygiene, toileting hygiene, upper and lower body dressing, putting on/ taking off shoes, personal hygiene, rolling left and right in bed, sitting to lying flat on the bed, lying on the bed to sitting on the edge of the bed (without back support), transferring from bed to chair or chair to bed, getting on or off a toilet, getting into or out of a tub or shower, walking 10 feet, walking 50 feet with 2 turns, and walking at least 150 feet. Record review of Resident #2's care plan reflected that Resident #2 had focuses of: A. Impaired cognitive function or though processes r/t Alzheimer's and dementia with interventions that included cue, reorient, and supervise as needed which was initiated and created on 5/10/21, B. ADL self-care performance deficit r/t Alzheimer's with interventions that included Resident #2 requiring set up assistance for toileting, transfers, repositioning in bed, dressing and eating which was initiated and created on 5/10/21, C. Bladder incontinence r/t Alzheimer's and dementia with interventions that included check me as needed and as required for incontinence which was initiated and created on 5/10/21, and D. Requirement of anti-depressant medication r/t anxiety which was created and initiated on 4/3/21. E. Risk for falls r/t wandering which was created and initiated on 4/3/21. Record review of Resident #2's Provider Order Summary Report reflected that Resident #2 had the following side effect monitoring and medication orders: a. Side effects- anti-convulsant order date 4/2/21. b. Side effects- anti-depressant order date 4/2/21. c. Side effects- sedative/ hypnotic order date 6/27/22. d. Depakote Delayed Release 125mg. Give 1 tablet PO BID for agitation. e. Lamotrigine 25mg. Give 2 tablets PO every morning and at bedtime for convulsions. f. Losartan Potassium 50mg. Give 1 tablet PO one time a day for HTN. g. Trazadone HCl 50mg. Give 1 tablet PO BID for anxiety and agitation. Record review of Resident #2's Admission assessment dated [DATE] at 4:41pm and signed by RN B on 9/21/23 reflected the following: a. The resident required catheter care/ catheter change. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions: apply treatment as ordered, keep clean and dry and apply skin barrier cream as indicated, pressure relieving cushion device in wheelchair as indicated, therapeutic pressure reducing mattress. (Did not address the surgical incision from Resident #2's left breast mastectomy on 9/15/23) h. Degree of physical activity- Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. (Resident #2 was ambulatory with a walker and required only supervision or touch assistance with walking 10 feet, walking 50 feet with 2 turns, and walking at least 150 feet which was reflected in her MDS.) i. Mobility- Ability to change and control body position: No limitations: makes major and frequent changes in position. (Contradictory to the above assessment answer that Resident #2's ability to walk was severely limited or non-existent). j. Friction and shear- No apparent problem: Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times. (Contradictory to assessment answer (h) that Resident #2's ability to walk was severely limited or non-existent). k. Incontinence- Resident is incontinent to: Neither. (Contradictory to Resident #2's care plan which reflected bladder incontinence r/t Alzheimer's and dementia with interventions that included check me as needed and as required for incontinence which was initiated and created on 5/10/21). l. Fall risk assessment: 1. Recent falls: none in the last 12 months. (Resident #2 had an actual fall dated 9/20/22) 2. Medications (hypnotics, sedatives, anxiolytics, anti-depressants, anti-Parkinson's, diuretics, anti-hypertensives): Not taking any of these medications. (Contradictory to Resident #2's order summary report which reflected she was taking an anxiolytic, anti-depressant, and an anti-hypertensive). 3. Psychological (anxiety, depression, decline in cooperativeness, decline in insight/judgement): Does not appear to have any of these. 4. Cognitive status: Intact. (Contradictory to Resident #2's BIMS score of 3 which indicated severe cognitive impairment). 5. Automatic high risk status: Recent change in functional status and/or medications with the potential to affect safe mobility. (This answer contradicted the answer to (2) above which stated Resident #2 was not on medications with the potential to affect safe mobility). m. Exit seeking Tool: Is the resident physically able to leave the building on their own? no n. Hot liquid evaluation: None of the boxes are checked. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o. If any boxes are checked yes, indicate which interim measures were put into place to enhance safety while therapy screen is pending: Focus- Resident has the potential for skin impairment/ burn r/t hot liquid encounters; needs disposable plastic lid on coffee cup for safety. (None of the boxes were checked for hot liquid evaluation). p. 48 hour care planning: 1. Care plan for self-care deficit- Focus: I have a self-care deficit. Intervention: Mobility- I use a wheelchair. (Resident #2 was ambulatory with a walker and required only supervision or touch assistance with walking 10 feet, walking 50 feet with 2 turns, and walking at least 150 feet which was reflected in her MDS.) 2. Care Plan- Cognitive function/ dementia or impaired thought Process is not included. 3. Fall risk plan of care- Focus: at risk for falls r/t wandering. Actual fall 9/20/22. Record review of Resident #2's progress notes in PCC reflected an entry as follows: Late Entry Effective date: 9/16/23 at 12:47pm Created by: DON Created date: 10/9/23 at 12:52pm Note text: During rounds, was advised by SN (skilled nurse) and supervisor noted Jackson Pratt to have an incision made by the resident on the Jackson Pratt's tubing. This information was communicated to the PA (physician's assistant) and orders were given to seal the drainage tube and follow up with the surgeon. Nursing was able to seal the Jackson Pratt tube and drainage was noted at the end of the shift. No s/s of infection were noted in the area or to the resident's mastectomy area. 2. Record review of Resident #3's admission record reflected an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included Alzheimer's disease, dementia, fall from bed (1/18/24), displaced intertrochanteric fracture of right femur (non-aligned fracture of the right thigh bone at the hip) (1/18/24), age-related osteoporosis (bone disease that causes bones to become weak and more likely to break) without current pathological fracture (broken bone not caused by force or impact) (1/16/24), polyosteoarthritis (pain in five or more joints at the same time), and generalized muscle weakness. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's quarterly MDS dated [DATE] reflected that Resident #3 had a BIMS score of 0 of 15 and a cognitive skills for daily decision making score of 3 which indicated severe impairment- resident never/rarely made decisions. Resident #3 required substantial/ maximal assistance for toileting hygiene, shower/ bathing self, lower body dressing, and putting on/ taking off footwear, rolling left and right in bed, sit on side of bed to lying flat on the bed, and transferring to and from a bed to chair (or wheelchair). Resident #3 required partial/ moderate assistance for upper body dressing, standing from a sitting position, and walking 10 feet. Resident #3 required supervision or touch assistance for personal hygiene. Resident #3 required set up or clean up assistance for eating and oral hygiene. Resident #3 did not attempt to walk 50 feet with two turns or to walk 150 feet due to medical condition or safety concerns nor did Resident #3 attempt to get on or off a toilet or get into or out of a tub/shower as she did not perform these activities in the past. Record review of Resident #3's care plan reflected Resident #3 had focuses of: A. Risk for falls r/t impaired cognition/mobility, poor safety awareness with goals of 1-3 fewer falls through next review date, not experiencing any significant injuries associated with a fall through next review date, and safety r/t falls will be managed with interventions for orthostatic hypotension (a condition where blood pressure drops when changing positions from saying to sitting and sitting to standing) through review date. Interventions included anticipate and meet needs, call bell within reach, bed at appropriate height when unattended, room rearrange Resident #7's bed closer to hers, routine rounds to help with safety checks by all team members, and call light sign B. Requirement of psychotropic medications and at potential risk for side effects with an intervention of educate care givers that sometimes a behavior outburst can indicate pain, hunger, thirst, or need of toileting, rest, activity, or comforting. C. Risk for experiencing discomfort or pain r/t history of right hip fractur and left distal femur fracture with interventions including Resident #3 being able to participate in pain assessment using the numerical pain scale. Record review of Resident #3's provider order summary report as of 6/15/24 reflected that Resident #3 had the following side effect monitoring and medication orders: a. Anti-depressant side effect monitoring. b. Anti-anxiety side effect monitoring. c. Hydroxyzine HCl. Give 12.5 mg by mouth every 8 hours as needed for anxiety. Ordered on 6/11/24) d. Amlodipine Besylate 10mg. Give 1 tablet PO once a day for HTN. Record review of Resident #3's Post Fall Review in PCC dated 6/15/24 at 7:08pm and signed by the DON on 6/19/24 reflected the following: 1. Date and time of fall: 6/15/24 at 7:00pm 2. Was the fall observed: No. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Most recent blood pressure: 152/74 on 6/19/24 at 7:41am (4 days AFTER the Post Fall Review effective date of 6/15/24). 4. Most recent pulse: 71 on 6/19/24 at 7:41am (4 days AFTER the Post Fall Review effective date of 6/15/24). 5. Most recent O2 sats: 97% on 6/18/24 at 11:20am (3 days AFTER the Post Fall Review effective date of 6/15/24). 6. Has patient received 1 or more of the following in the past 24 hours (antianxiety, anticoagulant, antipsychotic, cardiovascular, diuretic, hypnotic, or pain medication)? None of the boxes were checked. (Contradictory to Resident #3's order summary report which reflected that she was taking an anti-anxiety and an anti-hypertensive medication). Record review of Resident #3's Neuro Checks in PCC dated 6/15/24 at 7:00pm and signed by the DON on 6/19/24 reflected the following: The neuro checks were to be done every 15 minutes- 4 times (6/15/24 at 7:15pm, 7:30pm, 7:45pm, and 8:00pm), every 30 minutes- 4 times (6/15/24 at 8:30pm, 9:00pm, 9:30pm, and 10:00pm), every 1 hour- 4 times (6/15/24 at 11:00pm, 6/16/24 at 12:00am, 1:00am, and 2:00am), every 2 hours- 4 times (6/16/24 at 4:00am, 6:00am, 8:00am, and 10:00am), every 4 hours- 2 times (6/16/24 at 2:00pm and 6:00pm) and every 8 hours- 6 times (6/17/24 at 2:00am, 10:00am, 6:00pm, 6/18/24 at 2:00am, 10:00am, and 6:00pm). 1. 15 minute check-1st: A. Date/time: 6/15/24 at 7:15pm B.1. Level of consciousness: Alert C.1. Pupil response: Pupils equal and reactive to light: yes 2. Right pupil: Brisk 3. Left pupil: Brisk D.1.Motor functions: Hand grasps: Hand grasps are equal. 2. Moves all extremities: Yes 3. Moves right arm: Yes 4. Moves left arm: Yes 5. Moves right leg: Yes 6. Moves left leg: Yes (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Las Alturas Nursing & Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 4301 North Bartlett Avenue Laredo, TX 78041	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Unable to follow commands: No 8. Absent: No E.1. Resident response to pain: Appropriate pain response 2. Most recent pain level: 0 on 6/17/24 at 6:53am. (2 days AFTER the Neuro checks effective date of 6/15/24) F.1. Vitals: Most recent blood pressure: 128/79 on 6/17/24 at 7:48am (2 days AFTER the Neuro checks effective date of 6/15/24). 2. Most recent temperature: 98.0 on 4/18/24 at 4:11am (2 months BEFORE the Neuro checks effective date of 6/15/24). 3. Most recent pulse: 66 on 6/17/24 at 7:48am (2 days AFTER the Neuro checks effective date of 6/15/24). 4. Most recent respiration: 18 on 4/18/24 at 4:11am (2 months BEFORE the Neuro checks effective date of 6/15/24). G. Observations: no neuro deficits The next 11 of the Neuro Checks were dated and timed correctly for when Resident #3 was supposed to be neurologically assed, however ALL of the vital signs (Sections E2 and F1-4) were documented with the same date/time and values that were documented for the neurological assessment that was completed for 6/15/24 at 7:15pm. Those vital signs were dated either 2 days AFTER (pain level, blood pressure, and pulse) or 2 months BEFORE (temperature and respirations) these neurological assessments were documented as being completed. The 1st 2 hour check was incorrectly timed for 3:00am on 6/16/24. The correct date/time was 6/16/24 at 4:00am. Sections E.2 and F.1-4 were documented with the same date/time and values that were documented for the neurological assessment that was completed for 6/15/24 at 7:15pm. Those vital signs were dated either 1 day AFTER (pain level, blood pressure, and pulse) or 2 months BEFORE (temperature and respirations) this neurological assessment was documented as being completed. The 2nd 2 hour check was incorrectly timed for 5:00am on 6/16/24. The correct date/time was 6/16/24 at 6:00am. The only documentation done was: B.1. Level of consciousness: Alert C.1. Pupil response: Pupils are equal and reactive to light: Yes 2. Right pupil: Brisk 3. Left pupil: Brisk (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sections D.1-8 (motor function) and E.1 (Resident response to pain) were blank. Sections E.2 and F.1-4 were documented with the same date/time and values that were documented for the neurological assessment that was completed for 6/15/24 at 7:15pm. Those vital signs were dated either 1 day AFTER (pain level, blood pressure, and pulse) or 2 months BEFORE (temperature and respirations) this neurological assessment was documented as being completed. The 3rd and 4th 2 hour check were dated correctly but timed incorrectly. All the questions in sections A through E.1 were blank. Sections E.2 and F.1-4 were documented with the same date/time and values that were documented for the neurological assessment that was completed for 6/15/24 at 7:15pm. Those vital signs were dated either 1 day AFTER (pain level, blood pressure, and pulse) or 2 months BEFORE (temperature and respirations) the neurological assessments were documented as being completed. The 1st and 2nd 4 hour checks, and all 6 of the 8 hour checks were blank where the assessment date and time were to be documented. All the questions in sections A through E.1 were blank. Sections E.2 and F.1-4 were documented with the same date/time and values that were documented for the neurological assessment that was completed for 6/15/24 at 7:15pm. Those vital signs were dated either 6/17/24 (pain level, blood pressure, and pulse) or 4/18/24 (temperature and respirations). Record review of Resident #3's progress notes dated 6/11/24 to 6/28/24 in PCC reflected that Hydroxyzine (an anti-anxiety medication) was ordered on 6/11/24. Resident #3 received Hydroxyzine on 6/14/24 at 12:23pm. The following progress notes were late entries: 1. Type: Nursing progress note Effective: 6/15/24 at 9:28am Created: 6/18/24 at 10:30am Created by: DON Note: Resident performing restorative therapy with Restorative aide at this time, patient tolerated well restorative therapy. RP was notified. 2. Type: Nursing progress note Effective: 6/15/24 at 3:30pm Created: 6/18/24 at 10:31am Created by: DON Note: Family member was present at this time with resident. RP was helping resident to ambulate around the facility, resident was ambulating with the help of a walker. No pain noted at this time. 3. Type: Nursing progress note (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Effective: 6/15/24 at 7:00pm Created: 6/18/24 at 10:38am Created by: DON Notes: Informed by medication aide that resident was found on her knees next to her family member's bed. Upon entering the room, nurse noted resident was on her knees beside the bed. Resident stated she was trying to go and check on her family member, who is her roommate. With the assistance of CNA, SN carefully transferred the resident back to her own bed. A thorough head-to-toe assessment was conducted immediately, and no skin injuries, edema, or bruising were noted. ROM as previously noted with no s/s of pain to all four extremities. Notified MD and RP of incident. 4. Type: Nursing progress note Effective: 6/15/24 at 9:00pm Created: 6/18/24 at 10:40am Created by: DON Note: Resident was rounded at this time, no c/o pain or discomfort noted, and no s/s of distress. RP was notified. 5. Type: Nursing progress note Effective: 6/15/24 at 11:15pm Created: 6/18/24 at 10:46am Created by: DON Note: Resident was rounded at this time, no c/o pain or discomfort noted, and no s/s of distress. 6. Type: Nursing progress note Effective: 6/16/24 at 12:30am Created: 6/18/24 at 10:49am Created by: DON Note: CNA provided incontinent care at this time; no signs and symptoms of pain were noted, and the resident continued to sleep in bed comfortably. 7. Type: Nursing progress note Effective: 6/16/24 at 4:00am (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Created: 6/18/24 at 10:50am Created by: DON Note: CNA provided incontinent care at this time; no signs and symptoms of pain were noted, and the resident continued to sleep in bed comfortably. 8. Type: eINTERACT SBAR Summary for Providers Effective 6/18/24 at 7:00am Created: 6/18/24 at 11:01am Created by: RN B Situation: Pain to right leg with movement This started on: 6/16/24 (no time or time of day documented) Summarize your observations, evaluation, and recommendations: This morning, nurse was informed by the CNA that while changing resident and preparing for breakfast, noticed swelling above her right knee. Upon assessment, resident complained of tender pain and could move her feet from side to side without pain but experienced pain when moving her leg. Describe functional status changes: (Choices were needs more assistance with ADLs, general weakness, decreased mobility, fall, swallowing difficulty, no changes observed, and other). No changes were observed was checked. (Contradictory to the summarized statement that Resident #3 experienced pain when moving her leg. Vital signs evaluation: Are these the most recent vital signs taken after the change in condition occurred: Yes Most recent blood pressure: 128/79 dated 6/17/24 at 7:48am (1 day AFTER the eINTERACT SBAR Summary for Providers effective date/time of 6/16/24 at 7:00am). Most recent pulse: 66 dated 6/17/24 at 7:48am (1 day AFTER the eINTERACT SBAR Summary for Providers effective date/time of 6/16/24 at 7:00am). Most recent respiration: 18 dated 4/18/24 at 4:11am (2 months BEFORE the eINTERACT SBAR Summary for Providers effective date/time of 6/16/24 at 7:00am). Most recent temperature: 98.0 dated 4/18/24 at 4:11am (2 months BEFORE the eINTERACT SBAR Summary for Providers effective date/time of 6/16/24 at 7:00am). Most recent O2 sats: 98% dated 4/18/24 at 4:11am (2 months BEFORE the eINTERACT SBAR Summary for Providers effective date/time of 6/16/24 at 7:00am). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provider notification and feedback: Date and time of clinician notification: 6/16/24 at 12:00am (7 hours BEFORE the eINTERACT SBAR Summary for Providers effective date/time of 6/16/24 at 7:00am). Recommendations of primary clinician: No bruising or signs of trauma noted at this time. Nurse immediately administered pain medication, advised CNA to leave the resident in bed, and notified the doctor of the situation. New orders were received for an x-ray of the right hip and knee. Pain status evaluation: Is a pain assessment relevant to the change in condition being reported? Answer: Not clinically applicable to the change in condition being reported. (Contradictory to the summarized statement of, Upon assessment, resident complained of tender pain and could move her feet from side to side without pain but experienced pain when moving her leg.) Does the resident have pain: Not answered. (Contradictory to the summarized statement of, Upon assessment, resident complained of tender pain and could move her feet from side to side without pain but experienced pain when moving her leg.) Pain location: Not answered. (See above) General background information: Primary diagnosis: not answered. List any medication changes made in the past week: Not answered. (Contradictory to the Order Summary Report as of 6/15/24 which reflected Resident #3 had an order for Hydroxyzine HCl. Give 12.5 mg by mouth every 8 hours as needed for anxiety that was ordered on 6/11/24) Resident representative notification: Date and time of family/ RP notification: 6/16/24 at 12:00am (7 hours before the effective date/time of 6/16/24 at 7:00am) 9. Type: Nursing progress note Effective: 6/16/24 at 3:00pm Created: 6/18/24 at 10:57am Note: The resident applied a right knee orthopedic brace. At this time, resident was noted trying to get out of bed. SN was at bedside. CNA stayed at the bedside to provide immediate supervision to prevent further injury. The resident was reoriented to time and place and rested comfortably in bed. RP was notified of nursing intervention at this time. 10. Type: eINTERACT SBAR Summary for Providers (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Effective: 6/21/24 at 9:15am Created: 6/23/24 at 11:17pm Created by: RN B Vital signs evaluation: Are these the most recent vital signs taken after the change in condition occurred: Yes Most recent blood pressure: 133/70 dated 6/23/24 at 7:21pm (2 days AFTER the eINTERACT SBAR Summary for Providers effective date/ time of 6/21/24 at 9:15am). Most recent pulse: 74 dated 6/23/24 at 7:21pm (2 days AFTER the eINTERACT SBAR Summary for Providers effective date/ time of 6/21/24 at 9:15am). Most recent respiration: 18 dated 6/23/24 at 2:38pm (2 days AFTER the eINTERACT SBAR Summary for Providers effective date/ time of 6/21/24 at 9:15am). Most recent temperature: 97.8 dated 6/23/24 at 2:38pm (2 days AFTER the eINTERACT SBAR Summary for Providers effective date/ time of 6/21/24 at 9:15am). Most recent weight: 127.0 dated 6/1/24 at 7:29pm. Most recent O2 sats: 97% dated 6/23/24 at 2:38pm (2 days AFTER the eINTERACT SBAR Summary for Providers effective date/ time of 6/21/24 at 9:15am). Provider notification and feedback: Were the change in condition and notifications reported to primary care clinician: Yes Date and time of clinician notification: 6/21/24 at 12:00am (9 hours BEFORE the eINTERACT SBAR Summary for Providers effective date/ time of 6/21/24 at 9:15am). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/30/24 at 1:57pm RN C stated she had been working at the facility for 5 years. When asked about the readmission process, RN C stated when a resident was admitted after a hospital stay as a readmission, a progress note was put in the computer, and admission assessment was done, the primary provider would be notified, and any new orders would be entered. RN C stated the readmission assessment was done immediately upon the resident's arrival in the facility. RN C stated in reference to the resident's most recent vital signs, that they were on the top of the page in PCC. RN C stated there was a button to click that had recent vital signs that showed the previous vital signs, but you had to click on each one individually. In reference to what would be documented in the progress notes, RN C stated that any orders that were given, any risk management documentation, appointments, and any information that would need to be passed on to the next shift should be documented in the progress notes. RN C stated the SBAR was its own assessment but showed up in progress notes. RN C stated an SBAR and change in condition would be done for fever, abnormal vital signs, lethargy, and anything that has to do with a change in the resident's condition. RN C stated that progress notes were to be documented immediately. RN C stated notifications to the RP, provider, and ADON/ DON were done and documented immediately in PCC in the change in condition documentation. RN C stated she was familiar with Resident #2 and had her as a patient after her mastectomy. RN C stated she was not working the day of the incident with Resident #2's JP drain, but she was told that Resident #2 pulled out her JP drain. RN C stated Resident #2 had dementia, forgot things right away, and had to be redirected frequently. RN C stated the nurse who was in charge when the JP drain incident happened fixed the drain and it was still draining. LVN C stated if something like that happened on her shift, she would notify the surgeon, the RP and the DON immediately to see what the plan of action was. RN C stated the documentation would include the change in condition form or a risk management form in PCC and a progress note would be written, also in PCC. RN C stated the progress note would have a summary of what happened, who was contacted, and what the plan of care was. RN C stated the risk management documentation would have more detailed information and it would automatically generate the date, time, and resident information at the top of the form. In an interview on 10/30/24 at 2:37pm, the ADON stated she had been working at the facility as a floor nurse for 2 years, became the DCE (Director of Clinical Education) for 2 1/2 years and then became the ADON. The ADON stated when a resident was gone for a little while (to the hospital) a readmission assessment, medication reconciliation, and the whole screening and care planning were done again when the resident returned. The ADON stated anything that was new or changed was revised in orders and/ or care plans. The ADON stated when someone returned to the facility, the head to toe assessment and vital signs were done as soon as they got to the facility. The ADON stated the vital signs were pulled automatically to the admission form and the nurse had to change them to the correct vital signs. The ADON stated progress notes were used for documenting any changes, new orders, appointments, and anything related to the resident's clinical status. The ADON stated that change in condition documentation was used for any changes, critical laboratory result and any change in a resident's condition. The ADON stated it was done at the time of the change in condition. The ADON stated the provider, RP and DON were notified for any change in condition immediately. The ADON stated that

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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** 47371 Based on observation, record review, and interview, the facility failed to establish and 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 (Resident # 1) of five residents that were reviewed for infection control and transmission-based precautions policies and practices, in that: a. On 10/27/2024, CNA A touched multiple surfaces and did not perform hand hygiene prior to commencing Resident #1's perineal care . These failures could place residents at risk for infection through cross contamination of pathogens. The findings included: Record review of Resident #1's Face Sheet dated 10/27/2024, revealed the resident was admitted originally on 05/27/2019, Resident #1 was an [AGE] year-old female with the following diagnoses: Alzheimer's (degenerative cognition), atherosclerotic heart disease of native coronary artery (heart disease), acute kidney failure, type 2 diabetes mellitus (endocrine disease), pleural effusion (abnormal build-up of fluid in the space around lungs) muscle weakness, and hypertension (high blood pressure). Record review of Resident #1's MDS dated [DATE] documented 6 out of 15 BIMS score suggesting severe cognitive impairment. As well as extensive dependency of staff to assist in activities of daily living. Resident #1 was coded for always incontinent. Record review of Resident #1's Comprehensive Care Plan date initiated 06/28/2019 and revised 01/24/2024 revealed, Focus: Resident #1 have bladder incontinence r/t diuretic, dementia and Alzheimer's. Goal: I will remain free from skin breakdown due to incontinence and brief use through the review date. Intervention: clean peri-area with each incontinence episode. During an observation on 10/27/2024 at 1:23PM, CNA A entered Resident #1's room, washed her hands then immediately applied clean gloves. With the clean gloves on, CNA A closed Resident #1's curtain, retrieved the bed remote, lowered the head of bed, followed by raising the bed to hip height, removed the pillows and Resident #1's brief, then proceeded to grab clean cleansing wipes and began cleaning Resident #1's perineal area without performing hand hygiene after touching the multiple surfaces were touched. During an interview on 10/27/2024 at 1:36PM CNA A stated she was nervous and had forgotten to change her gloves and perform hand hygiene prior to her care performance. CNA A stated she should have removed her contaminated gloves after touching the multiple surfaces, followed by performing hand hygiene and application of new clean gloves. CNA A stated by not performing hand hygiene nor glove change, she could have potentially introduced infectious microorganism onto Resident #1. CNA A also stated Resident #1 has multiple skin irregularities and infectious organisms could also be introduced through those skin openings. CNA A stated she could not recall when she last attended an hand hygiene or infection control in-service. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/27/2024 at 2:59PM the DON stated the facility's expectation would be for all clinical staff to follow the facility's policy and procedures regarding hand hygiene. The DON stated the facility does follow the CDC guidelines regarding hand hygiene. The DON stated his expectation would be for the clinical staff to remove contaminated gloves and perform hand hygiene prior to performing perineal care. The DON stated by adhering to the hand hygiene policy and procedures, the facility promotes infection control. The DON stated he could not for certain state that microorganisms were on Resident #1, but proceeded to state that microorganisms could live on various surfaces. The DON stated he could not definitively state that microorganisms were potentially introduced onto Resident #1, as he could not conclude a specific transmissional route. The DON stated infectious microorganism could potentially negatively affect the well-being of all residents, especially those who have chronic co-morbidities, which would include diabetes mellitus. The DON stated he does not believe microorganism would migrate upwards vaginally to cause infection as there are microorganisms present in the vaginal flora to the urinary tract. The DON continued by stating there could be a possible chance that unknown microorganisms, that potentially were on other surfaces around Resident #1, could have been introduced onto Resident #1, which could have potentially caused infection. The DON stated he would address hand hygiene adherence by conducting an impromptu hand hygiene in-service starting 10/27/2024. Record review of the facility's Handwashing/Hand Hygiene policy and procedure date implemented 2019, date revised January 2023 documented, 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for situations such as this (including but not limited to): Before moving from contaminated/soiled to clean care or procedures; after handling used dressings, contaminated equipment etc.; between gloves changes/after removing gloves. Record review of the facility's Infection Control, Hand Hygiene and Perineal Care In-service dated 10/27/2024, documented topic: Remove gloves and wash hands before touching any items such as bed control, blankets, follow proper handing washing techniques was reviewed. Record Review of the CDC Guidelines regarding Clinical Safety: Hand Hygiene for Healthcare Workers, last reviewed February 27, 2024, stated, Healthcare providers should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal.