STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676465	A. Building B. Wing	03/01/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide reasonable accommodation of resident needs and preferences for one (Resident #1) of four residents reviewed for call light placement. The facility failed to ensure Resident #1's call light was within reach. This failure could place residents at risk of needs and accommodation being unmet.Record review of a face sheet dated 3/1/2026 indicated Resident #1 was a [AGE] year-old who male, admitted [DATE], with diagnoses including Schizophrenia Disease (a chronic, severe mental disorder characterized by disruptions in thought, perception, emotions, and behavior), Hypertension (high blood pressure), Dementia (significant decline in mental ability-such as memory, thinking and reasoning-that is severe enough to interfere with a person's daily life and activities), and Cirrhosis of the liver (irreversible, late-stage scarring (fibrosis of the liver caused by chronic diseases like hepatitis, alcohol abuse, or fatty liver disease). Review of a quarterly MDS assessment, dated 1/15/2026, indicated Resident #1 had a BIMS score of 3 which indicated severe cognitive impairment. The MDS indicated Resident #1 was able to understand others and to make his needs known verbally. The MDS also indicated Resident #1 needed maximum assistance with toileting hygiene, showering, upper and lower body dressing and moderate assistance with personal hygiene. Record review of Resident #1's care plan, undated, revealed, Resident #1 had a focus goal of call light use and cognition and safety awareness with an intervention to keep resident's call light within reach of the resident and remind the resident of the call light location. During an observation and interview on 2/28/2026 at 2:40 p.m., Resident #1 was in his room, Resident #1 was in his bed with lots of movement, upon entering the room it was observed that Resident #1 did not have his call light as it was on the bedside table outside of the reach of Resident #1. Resident # 1 stated he wanted some cookies and juice. During an interview on 2/28/2026 at 2:45 pm, RN A stated she was unaware Resident #1 could not reach the call light, and the call light should have been left where Resident #1 could reach it. RN A stated the NA may have repositioned the resident and left the call light on the bedside table. RN A stated it was expected that Resident #1 should always have his call light in reach as it was the expectation that all residents have their call light in reach at all times. During an interview on 2/28/2026 at 3:03 pm, NA B stated she did care for Resident #1 today and did reposition Resident #1 in bed. NA B stated she thought she placed the call light within reach of Resident #1 before leaving the room to get supplies. CNA B stated it was expected for the call lights to always be within reach of all residents, including Resident #1. NA B stated since Resident #1 was without his call light he could have fallen or not have had his needs met. During an interview on 3/1/2026 at 12:30 p.m., the DON stated it was not acceptable for residents to not be able to reach the call light. The DON stated she provided re-education to staff about call lights being in reach of all residents to include Resident #1. The DON stated Resident #1's result of not having the call light within reach could mean his needs may not have been met. During an interview on 3/1/2026 at 1:20 p.m., the Administrator stated it was his expectation and the facility's policy for all residents to be within reach of the call light. The Administrator stated he was aware Resident #1 was repositioned by NA B on 2/28/2026 and Resident #1's call light was not within reach of Resident #1. The Administrator stated he was informed NA B went to gather supplies and was gone (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no more than 10 minutes; however, it was still against policy to leave any resident without the call light. Record review of facility policy titled, Routine Resident Care dated 3/14/2019 and revised 01/2024, reflected, Resident call lights should be answered timely and resident requests are addressed, if permitted. Call lights should be placed within easy reach of the resident.