| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676465 | A. Building<br>B. Wing | 02/11/2026 |

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

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences, for 1 of 5 residents (Resident #4) reviewed for pain management. The facility failed to identify and provide pain management for Resident #4 for at least 1 month throughout January and February of 2026.These failures could place residents at risk of increased pain and poor quality of life. The findings included:Record review of Resident #4's face sheet dated 02/11/2026 revealed Resident #4 was a [AGE] year-old female with an original admission date of 11/08/2022, and a current admission date of 12/21/2023. Pertinent diagnoses included: Cerebral Infarction (a type of stroke which occurs when a blood clot blocks a brain artery, leading to a loss of blood flow to a specific area of the brain), Dysphagia (difficulty in swallowing, which could occur at any stage of the swallowing process), and Cognitive Communication Deficit (difficulties in communication which arise from impaired cognitive processes, such as attention, memory, organization, and executive functioning), Gout (a common and complex form of arthritis which could affect anyone), Osteoarthritis (the most common form of arthritis which occurs when the protective cartilage which cushions the ends of the bones wears down over time, leading to pain, stiffness, and reduced mobility), Pain to Right Knee, Pain to Ankle and Joint of Right Foot, Effusion of Right Knee (commonly known as water on the knee, occurs when excess fluid accumulates in or around the knee joint, and could be caused by various factors, including arthritis, ligament injuries, or other conditions)Record review of Resident #4's BIMS assessment, dated 02/10/2026, revealed a BIMS score of 15, which revealed intact cognition.Record review of Resident #4's Annual MDS dated [DATE] revealed a diagnosis of pain in the right knee. Record review of Resident #4's care plan dated 01/11/2024 revealed Resident #4 was at risk for experiencing pain related to gout and/or osteoarthritis. Interventions included administering pain medication as recommended and attempt non-pharmacological interventions to promote comfort and relaxation.Record review of Resident #4's physician orders, started 04/02/2024, and revised 02/10/2026, revealed an order for Tylenol 325 MG, give 2 tablets by mouth every 4 hours as needed for elevated temperature or pain. There was also a new order, started 02/10/2026, for Tramadol, give one tablet by mouth every 6 hours as needed for pain. In an observation on 02/10/2026 at 9:40 AM, Resident #4 was observed to be able to slowly answer every question the SW asked her, whether verbally, in writing, hand gestures, or shaking her head yes or no. She was able tell the SW she had pain in her low back for a month, and she had been trying to tell staff, but no one had given her pain medication.In an interview on 02/09/2026 at 1:15 PM Resident #4 was able to answer all basic questions and show surveyor where she was having pain. She nodded that she had pain in her low back (as she pointed to low back) but nodded and mouthed no that the nurses never gave her anything for the pain. In an interview on 02/10/2026 at 8:41 AM, LVN-J stated Resident #4 was able to use the call light and answer simple questions. LVN-J initially stated Resident #4 had pain at times, and she told the CNAs when she had pain, and then the CNAs would let LVN-J know, and she would give her pain medication for it. LVN-J then stated she had asked Resident #4 about pain, but she did not recall<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #4 complaining of pain over the past 1.5 months, so she had not given her anything for pain. In an interview on 02/10/2026 at 10:30 AM, CNA-K stated she worked the hall which Resident #4 was on. She stated Resident #4 had difficulty with communication but could say some things, as well as text and write. She stated Resident #4 never told her she had pain, but CNA-K stated she also never asked Resident #4 if she had pain. She stated if she had known Resident #4 had pain, she would have reported it to the charge nurse. CNA-K stated she should have asked Resident #4 about pain because being in pain could affect how people feel and act. In an interview on 02/11/2026 at 8:26 AM, the DON stated pain was subjective, so if Resident #4 was stating she had pain, then she believed her. The DON stated if Resident #4 had been having pain over the past month, she felt like it would have been identified by either the charge nurse who assessed her each shift for pain, or when the managers did the Ambassador Rounds in the mornings. She stated she did not recall Resident #4 or anyone else reported the pain but also stated the managers did not specifically ask Resident #4 about pain when they rounded on her. The DON stated she did not want any of the residents to be left in pain, so she had addressed the pain issue with Resident #4, as well as started an in-service about pain and pain management with the staff. Record review of the facility's Pain Management policy, implemented 03/14/2019 and revised January 2025, revealed The goal of the community pain management program is that pain is identified and treated timely, effectively and consistently. The community recognized the inter-relationship between uncontrolled pain and the decline in functional abilities, leading to an impaired quality of life. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review the facility failed to ensure kitchen staff served food in a sanitary manner. The facility failed to ensure food was dated and sealed for 9 items in the refrigerator. These failures could place residents at risk of foodborne illnesses. Finding Included: In observation and initial tour of the facility kitchen on 02/08/26 at 10:45 AM the kitchen refrigerator revealed a package of yellow cheese was open and undated. A plastic bag of grey meat substance found undated and open in refrigerator. A clear plastic bag of cooked biscuits was found undated and unsealed in the refrigerator. A bag of salad was found unsealed and undated in the refrigerator. A container of green peppers was found uncovered unprotected from being exposed to air and prevent contamination. A bag of white cheese was found undated and unsealed exposed to air and becoming contaminated. A bag of yellow cheese was undated and unsealed exposed to air and becoming contaminated. A bag of Cilantro was found open and undated exposed to air and becoming contaminated. A package of luncheon meat was found undated in the kitchen refrigerator. In an interview on 02/08/26 at 11:01 AM with [NAME] O she stated all staff were responsible for making sure all items were dated, covered and closed. [NAME] O stated the residents could get sick if the food was contaminated. All spoiled food must be thrown away, and all staff responsible to make sure no spoiled food is in the refrigerator. [NAME] O stated she did not know who put the meat in the refrigerator to thaw out or how long it had been there. [NAME] O stated she will start to be more aware of what food is left in the refrigerator so she can throw away old food and keep it from being used. In an interview on 02/08/26 at 11:11 AM with DA N, she stated all items received must be dated when put in the pantry, refrigerator, and freezer. DA N stated she did not see or know who put the meat to thaw out in the refrigerator. DA N stated the DM usually handles the shipments of food they receive and sometimes gets a helper from the staff working to help her. DA N stated she knew it was important to date food items, so the residents didn't get served expired food. In an interview with DA P he stated he knew it was important to make sure all stored food must have a date so that expired food was not served. DA O stated he did not see the items that were open and not dated. DA P stated he did not know about the meat thawing in the refrigerator. DA P stated he would be more observant of the refrigerator items being left open and not dated. In an interview on 02/08/26 at 11:29 AM the DM stated all items stored in the panty, refrigerator, and freezer must be dated, sealed, or covered, so the food is not exposed to air and becomes contaminated. The DM stated the food items left undated open and unsealed were thrown away and replaced with new dated food items. The grey meat substance was ground beef left to be thawed out and must have been forgotten in the refrigerator, but this meat would never be cooked and served to residents, it must be thrown away. The DM stated the cheese, luncheon meat, salad, cilantro, and biscuits were thrown away. The DM stated the green peppers that were covered would be washed before use. The DM stated the items left open or uncovered by the staff must have been done because they were in a hurry and forgot to be reseal the food item. The DM stated she will reeducate the staff on the importance of dating any food items received and stored in the panty, refrigerator, and freezer. The DM stated she will make sure each staff member understands the importance of closing any food items after use so that the item is not exposed to air and become contaminated. The DM stated it was all staff's responsibility to ensure the safety of the food the kitchen serves. In a second observation and interview of the kitchen on 02/09/2026 at 11:32 AM DA M was seen cutting and plating cake with a bare hand. DA M stated the cake was to be served to the residents and forgot to glove her hands as she was in a hurry to finish. She stated she knew it was important to wear gloves after washing them but was in a hurry and forgot to put them on. DA M stated it was important to always wear gloves, so the food was not contaminated and possibly make the residents sick. DA M stated it was important to make sure all food was safe for the residents by storing and handling the food properly by dating and sealing it after<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | use. In an interview on 02/09/26 at 4:01 PM with the Dietitian she stated it was the responsibility of the DM and cook to make sure the food is not expired. The Dietitian stated all staff were responsible for making sure food was covered and sealed after use. The Dietitian stated the cook and dietary aide are responsible for dating left over food. The Dietitian stated if the DM cannot date the food shipment, the dishwasher usually will help her if not another staff member. In a third observation and interview of the facility kitchen on 02-09-26 at 4:16 PM [NAME] P was seen plating food on trays without gloves. [NAME] P stated she was not aware that gloves must be worn when severing food with utensils as she was not touching the food with her bare hands. [NAME] P stated she was not aware of needing to wear gloves while serving. In a second interview on 02/09/26 at 4:30 PM with the DM, she stated she would educate all staff members on the proper serving procedures when handling and serving any food that is not served prepackaged. The DM stated all staff handling food to be prepared and served must put on gloves while handling ready to serve food and must never be touched food of any kind bare handed that is served to the residents. In record review of the policy and procedures for Food Storage dated 01/25/25 stated, To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines. In record review of the policy and procedures for General Kitchen Sanitation dated 01/25/25 stated The facility recognizes that foodborne illnesses have the potential to harm elderly and frail residents. All Nutrition & Food service employees will maintain clean, sanitary kitchen facilities in accordance with the state and US Food Codes in order to minimize the risk of infection and foodborne illness. In record review of Food Preparation and Handling it stated, To ensure that all food served by the facility is of good quality and safe for consumption, all food will be prepared and handled according to the state and US Food Codes and HACCP guidelines. In record review of policy and procedure for Employee Sanitation dated 06/19/19 stated The Nutrition and Food service employees of the facility will practice good sanitation practices in accordance with the state and US Food Codes in order to minimize the risk of infection and food borne illnesses.6. Glove use with direct food contact. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 2 (Resident #139 and Resident #7) of 5 residents reviewed for infection control and transmission-based precautions, policies, and practices. The facility failed to ensure CNA A performed hand hygiene between glove changes after providing personal care to Resident #139. The facility failed to ensure CNA A performed hand hygiene for at least 20 seconds or greater after transferring Resident 139 from the bed to the shower chair. The facility failed to ensure Resident #7 was placed on the proper infection control precautions for the diagnosis of ESBL Resistant. These failures could place residents at risk of infection through cross contamination of pathogens and infectious diseases. The findings included: Resident #139:Record review of Resident #139's face sheet dated 02/11/26 reflected a [AGE] year-old-female with an original admission date of 03/11/22. Diagnoses include dementia (loss of memory, language, problem solving and other thinking abilities which significantly impairs a person's ability to perform daily activities), Alzheimer's disease (progressive brain disorder that slowly destroys memory and thinking skills), Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), and type 2 diabetes (insufficient production of insulin in the body). During an observation on 02/10/26 at 4:08 PM, CNA A was observed removing her gloves after transferring Resident #139 from the bed to the shower chair, and putting on a new pair of gloves without performing hand hygiene. During an observation on 02/10/26 at 4:44 PM, CNA A was observed removing her gloves, washing her hands for approximately 6 seconds. In an interview on 02/10/26 at 4:54 PM, CNA A stated she was nervous and forgot to sanitize hands after removing her gloves. CNA A stated hands should be washed for approximately 30 seconds to remove germs and bacteria. CNA A stated proper hand hygiene prevented cross-contamination and disease. CNA A stated that if the resident was in contact with the germs, they could get sick. In an interview on 02/11/26 at 9:03 AM, the ICP stated staff were supposed to perform hand hygiene between all glove changes. The ICP stated hand hygiene should be done to prevent cross contamination and potentially exposing wounds or residents to bacteria. The ICP stated staff should be washing their hands for at least 20 seconds or more to remove as many microorganisms as possible. In an interview on 02/11/26 at 10:41 AM, the DON stated all staff should be washing hands or hand sanitizing between every glove change. The DON stated proper hand hygiene helps to prevent cross-contamination. The DON stated that stopping the spread of infection is part of infection prevention. The DON stated staff should be washing their hands for 60 seconds per facility protocol. Record review of the facility's Handwashing/Hand Hygiene policy dated January 2023 reflected: 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): Between gloves changes/After removing gloves 8. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Record review of the WCN's Dressing Change/Wound Care skills check off dated 01/31/26 reflected: 9. Clean wound as indicated, may pat or blot surrounding skin with a clean sterile dry gauze to dry the area as needed.Resident #7's findings included:Record review of Resident #7's face sheet dated 02/11/2026 revealed Resident #7 was a [AGE] year-old male with an original admission date of 05/08/2025, and a current admission date of 12/04/2025. Pertinent diagnoses included: Necrotizing Fasciitis (also known as flesh-eating disease, a serious bacterial infection which affects the tissue under the skin), Extended Spectrum Beta Lactamase Resistance (ESBLs were enzymes [substances which regulate the rate at which chemical reactions proceed] produced by certain bacteria which were resistant to a wide range<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | of antibiotics, which complicates treatment options for the infection), and Diabetes Mellitus (a chronic disorder characterized by high blood sugar levels due to insufficient insulin [a crucial hormone which regulates blood sugar levels and plays a vital role in energy metabolism] production or ineffective use of insulin by the body).Record review of Resident #7's Quarterly MDS dated [DATE] revealed a BIMS score of 15, which revealed intact cognition. The MDS also revealed Resident #7 had an indwelling catheter, as well as an ostomy (a surgically created opening or stoma), and open lesions. The MDS revealed Resident #7 had IV access and was receiving IV antibiotics.Record review of Resident #7's care plan initiated 07/28/2025 and revised 01/16/2026 revealed Resident #7 was at risk for recurrent or chronic infection related to compromised medical condition (suprapubic urinary catheter and open wounds). Interventions included EBP when in contact with suprapubic urinary catheter.Record review of Resident #7's physician orders, started 12/07/2025 and revised 01/16/2026, revealed an order for EBP every shift when in contact with suprapubic urinary catheter and/or open wounds. Record review of Resident #7's Discharge Summary, Final Report, dated 11/23/2025, revealed Resident #7 was started on wound care, consulted by the infectious disease physician and the general surgeon. Wound cultures were obtained showing Klebsiella ESBL positive. In an observation on 02/08/2026 at 12:11 PM, Resident #7 was observed to have had an EBP sign posted on his door, with EBP PPE located outside of his room. In an interview on 02/11/2026 at 8:41 AM, the ICP stated Resident #7 had Necrotizing Fasciitis and ESBL. She stated he had sacral (lower area of spine near tailbone), bilateral (Pertaining to both sides) buttocks, and bilateral heel wounds, and the Necrotizing Fasciitis was in colostomy stoma (a surgically created opening in the abdominal wall that allows stool to exit the body into a pouch when the colon or rectum cannot function normally), but she was not sure where the ESBL was located. The ICP stated the ESBL diagnosis was added to Resident #7's list on 12/04/2025. She stated Resident #7 had completed his IV antibiotics, but he could still be colonized or a carrier of ESBL. The ICP stated no follow up labs were performed on Resident #7 when he came back from the hospital in December 2025, but follow-up labs should have been done to assess for ESBL status. She stated the facility placed him on EBP for the wounds, but he should have been placed on contact precautions for the ESBL. The ICP stated since Resident #7 was not placed on contact precautions this could have caused cross-contamination if the appropriate PPE was not being utilized by everyone who entered the room. She also stated there had not been any other concerns or evidence of any other residents in the facility having ESBL. The ICP stated she was the person who wrote the orders for the type of precautions needed, as well as placed the signs and PPE by the residents' room. She stated she thought she may have overlooked Resident #7's need for contact precautions since he had previously been on EBP. In an interview on 02/11/2026 at 10:25 AM, the DON stated Resident #7 was placed on EBP due to the Foley, colostomy, and the wounds. She stated since he was diagnosed with ESBL, he should have been placed on contact precautions to prevent spread of infection and cross contamination. The DON stated typically the ICP wrote the orders for precautions, but any nurse, including herself, should have caught this and clarified it. The DON stated no other residents have been affected by this incident she knew of.Record review of the facility's Infection Prevention and Control policy, dated 03/13/2019 and revised April 2024, revealed The elements of the infection prevention and control program consist of coordination/oversight, guidance/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection. When infection or colonization with epidemiologically important organisms is suspected, cultures may be sent, if appropriate, to a contracted laboratory for identification or confirmation. 10. Isolation Precautions: implementation of and discontinuation of isolation precautions should be in collaboration with the licensed nurse, physician, nurse practitioner, medical director, and if indicated through collaboration with the state or local health department. In addition to Standard Precautions, Contact Precautions may be implemented for a resident known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or patient-care items in the resident's environment.Review of<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the CDC hand washing procedures on CDC.gov, it reflected:With soap and water:Wet your hands with warm water. Use liquid soap if possible. Apply a nickel- or quarter-sized amount of soap to your hands.Rub your hands together until the soap forms a lather and then rub all over the top of your hands, in between your fingers and the area around and under the fingernails.Continue rubbing your hands for at least 15 seconds. Need a timer? Imagine singing the Happy Birthday song twice.Rinse your hands well under running water.Dry your hands using a paper towel if possible. Then use your paper towel to turn off the faucet and to open the door if needed. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in comprehensive assessment for 1 (Resident #139) of 8 residents reviewed for care plans. The facility failed to ensure Resident #139's care plan was developed by not including any plan of care for her contractures (permanent, rigid tightening of muscles, tendons, skin, or tissues around a joint, restricting movement and causing deformity) in her hands. This failure could place residents at an increased risk of needs going unmet or harm. The findings included:Record review of Resident #139's face sheet dated 02/10/26 revealed a [AGE] year-old female with an admission date of 03/11/22. Resident #139's pertinent diagnoses included unspecified dementia (symptoms of cognitive decline are present but not clearly linked to a specific cause) and stiffness of unspecified joint (a general restriction, tightness, or difficulty moving a joint that cannot be classified elsewhere). Record review of Resident #139's quarterly MDS assessment dated [DATE] revealed a BIMS score could not be obtained because the resident was rarely or never understood. Further review revealed Resident #139 was dependent on staff to perform all effort for all functional abilities. During an observation of Resident #139 lying in bed in her room at 4:30 PM on 02/08/26, Resident #139's hands were severely contracted with Resident #139 unable to move them. No item was placed in Resident #139's hands. Record review of Resident #139's comprehensive care plan dated 02/10/26 revealed the contractures in her hands were not addressed. In an interview with LVN I at 8:46 AM on 02/11/26, LVN I stated she was the MDS Coordinator at the facility. LVN I stated it was her responsibility to ensure nursing-related items were added to residents' care plans. LVN I stated Resident #139's care plan did not currently have any plan of care for her contractures, but it should have. LVN I stated if the contractures were left off the plan of care then the floor nursing staff may not know to look for the issue, or they may not properly care for it. LVN I stated she was going to address the plan of care immediately. In an interview with the DON at 10:50 AM on 02/11/26, the DON stated Resident #139's contractures should have been care planned. The DON stated the IDT discussed what belonged in the care plan and the MDS coordinator would put it in the care plan. The DON stated it was important to ensure the care plan was accurate, so nursing staff could implement the appropriate interventions. Record review of the facility policy Care Plans implemented February 2017 and revised January 2024 revealed the following: The community develops a comprehensive care plan for each resident that includes measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan should be reflective of the identified problem or risk, a measurable outcome objective and appropriate intervention/interventions in relation to the identified problem or risk, outcome objective, and the resident's ability, needs, medical condition, preventative measures. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to update the comprehensive care plan and provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 5 Residents (Resident #4) reviewed for care plans.The facility failed to update Resident #4's care plan when her BIMS score changed from 08 to a 03 on her annual MDS dated [DATE]. This failure could place residents at risk of not receiving adequate or required care.The findings included:Record review of Resident #4's face sheet dated 02/11/2026 revealed Resident #4 was a [AGE] year-old female with an original admission date of 11/08/2022, and a current admission date of 12/21/2023. Pertinent diagnoses included: Cerebral Infarction (a type of stroke which occurs when a blood clot blocks a brain artery, leading to a loss of blood flow to a specific area of the brain), Dysphagia (difficulty in swallowing, which could occur at any stage of the swallowing process), and Cognitive Communication Deficit (difficulties in communication which arise from impaired cognitive processes, such as attention, memory, organization, and executive functioning).Record review of Resident #4's Annual MDS dated [DATE] revealed a BIMS score of 03, which indicated severely impaired cognition. The MDS also revealed no evidence of an acute change in mental status and no pain or hurting at any time in the last 5 days.Record review of Resident #4's care plan dated 01/11/2024 revealed Resident #4 had impaired cognitive function or thought processes as evidenced by a BIMS score of 08 (moderately impaired cognition). Interventions included: ask yes or no questions to determine needs, communicate regarding capabilities and needs, discuss concerns about confusion, disease process, and nursing home placement; notify doctor of any changes in cognitive function, specifically changes in decision-making ability, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. Record review of Resident #4's BIMS assessment dated [DATE] revealed a BIMS score of 15, which revealed intact cognition. In an interview on 02/10/2026 at 9:10 AM, the SW stated he did the BIMS assessment portion on the MDS. The SW stated if the resident was non-verbal or mostly non-verbal, he would have them write down answers to the question if they were capable, as well as he gave them options to shake their heads yes or no to applicable questions. He stated Resident #4 had not wanted to talk or participate on the date he did her last BIMS assessment, and because she was non-verbal and had a cognitive communication deficit, she ended up scoring a BIMS of 03, which dropped her down from her previous BIMS of 08. The SW stated sometimes he went back and reassessed the resident if he did not feel like the score was appropriate, but he had not reassessed Resident #4, even though he did not feel like 03 was an accurate BIMS score for her. The SW stated Resident #4 was able to tell staff if she had pain, and sometimes she would have behaviors or outbursts when she had pain. The SW stated he went to the care plan meetings, but the MDS nurse filled out the majority of the care plans. In an interview on 02/10/2026 at 9:54 AM, the MDS nurse stated the SW did the BIMS assessment and then MDS updated the care plan. She stated she could see Resident #4's care plan for the BIMS score of 08 was completed in January of 2024 and revised with no changes in October of 2024. The MDS nurse stated Resident #4's care plan relating to her BIMS score should have been revised when her BIMS score changed. She stated she was not sure why it had not been revised, but she may have overlooked it. In an interview on 02/11/2026 at 10:25 AM, the DON stated the social worker did the BIMS assessments and updated the BIMS on the care plan. The DON stated since Resident #4 was rated at a lower BIMS score than what she actually was, this could have caused staff to avoid asking Resident #4 important questions regarding her care or pain. The DON also stated the MDS nurse should have checked to make sure the care plans were accurate and up to date. Record review of the facility's Care Plan policy, implemented February 2017 and revised January 2024, revealed The care plan should be reflective of the identified problem or<br>(continued on next page) |

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|---|---|---|---|
| | 676465 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Las Alturas Nursing & Transitional Care | 4301 North Bartlett Avenue<br>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.

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | risk, a measurable outcome objective and appropriate intervention/interventions in relation to the identified problem or risk, outcome objective, and the resident's ability, needs, medical condition, preventative measures. The care plan should be updated quarterly thereafter, then annually and with significant changes in conditions. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 5 residents (Resident #139) reviewed for ADL care. The facility failed to ensure Resident #139's hand contractures were cleaned and maintained appropriately This failure could place the residents at risk for decreased feelings of self-worth, skin breakdown, and infection.The findings include: Record review of Resident #139's face sheet dated 02/10/26 revealed a [AGE] year-old female with an admission date of 03/11/22. Resident #139's pertinent diagnoses included unspecified dementia (symptoms of cognitive decline are present but not clearly linked to a specific cause) and stiffness of unspecified joint (a general restriction, tightness, or difficulty moving a joint that cannot be classified elsewhere). Record review of Resident #139's quarterly MDS assessment dated [DATE] revealed a BIMS score could not be obtained because the resident was rarely or never understood. Record review of Resident #139's comprehensive care plan revealed the contractures in her hands were not addressed. During an observation of Resident #139 lying in bed in her room at 10:33 AM on 02/10/26, Resident #139's hands were severely contracted with Resident #139 unable to move them. No item was placed in Resident #139's hands. Upon opening Resident #139's hands briefly, a strong foul odor was detected coming from Resident #139's hands. CNA D and RN E were both individually brought into Resident #139's room and detected the odor as well coming from Resident #139's hands. In an interview with CNA D at 10:39 AM on 02/10/26, CNA D stated sometimes the CNAs did put a little cloth in Resident #139's hands. CNA D stated Resident #139 did not like to have her hands opened because it hurt her. CNA D stated she opened up Resident #139's hands yesterday, but it did not have an odor then. CNA D stated the CNAs who bathed her in the shower room were supposed to clean her hands. CNA D stated she had not cleaned Resident #139's hands. CNA D stated the odor coming from Resident #139's hands today was a foul odor. CNA D stated it was important to take care of Resident #139's hands so her condition did not deteriorate. In an interview with RN E at 11:04 AM on 02/10/26, RN E stated she had not seen Resident #139 with a hand roll. RN E stated she had not seen a physician's order to place a hand roll in Resident #139's hands. RN E stated she did smell a foul, pungent odor coming from Resident #139's hands this morning. RN E stated the foul odor indicated to her that Resident #139's hands were not being cleaned properly. RN E stated this morning was the first time she had smelled the odor coming from Resident #139's hands. RN E stated it was important to properly care for Resident #139's contractures so her condition did not deteriorate at all. In an interview with the DON at 10:50 AM on 02/11/26, the DON stated there should not be a strong, foul odor coming from Resident #139's hands. The DON stated the odor indicated to her that Resident #139's hands were not being cleaned properly. The DON stated the CNAs had a daily task to perform hygiene care on Resident #139. The DON stated not caring for Resident #139's contractures appropriately could lead to a worsening of her condition and possibly lead to an infection. Record review of the facility policy Statement of Resident Rights implemented on February 2017 and revised on January 2023 revealed the following: .Resident/Patient Rights include:1. To all care necessary for them to have the highest possible level of health;2. To safe, decent and clean conditions. |

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| Las Alturas Nursing & Transitional Care | 4301 North Bartlett Avenue<br>Laredo, TX 78041 |

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|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choices for one (Resident #67) of four residents reviewed for quality of care. 1. The facility failed to ensure the WCN followed doctor's orders (pat dry wound) during wound care for Resident #67. This failure could place residents at risk for not receiving appropriate care and treatment. The findings included:1. Record review of Resident #67's face sheet dated 02/0/26 reflected a [AGE] year-old-female with an original admission date of 09/24/21. Diagnoses include acute (sudden) respiratory failure with hypoxia (low level of oxygen in your body tissues), heart failure, type two diabetes (insufficient insulin production in the body), and chronic (recurring frequently) kidney disease. Record review of Resident #67's physician orders dated 02/06/26 reflected:Cleanse sacrum (a triangular bone in the lower back formed from fused vertebrae and situated between the two hip bones of the pelvis) with wound cleanser, pat dry, apply collagen sheet (promotes healing by stimulating new tissue growth), and secure with super absorbent dressing every day and every shift for wound healing for Stage 3 (full-thickness skin loss potentially extending into the subcutaneous tissue layer) pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) and as needed for wound healing. Record review of Resident #67's quarterly MDS dated [DATE] reflected a BIMS of 3 (severe cognitive impairment). Record review of Resident #67's care plan initiated on 02/03/26 reflected:Resident #67 had a Stage 3 Pressure Ulcer to the sacrum r/t immobility.Interventions included:Administer treatments as ordered and monitor for effectiveness.During an observation of Resident #67's wound care on 02/09/26 at 9:42 AM, the WCN cleansed Resident #67's wound with wound cleanser and did not pat dry the wound as per doctor's orders. In an interview on 02/09/26 at 10:02 AM, the WCN stated she was nervous and forgot to pat dry after cleaning Resident #67's wound with wound cleanser. The WCN stated Resident #67's wound should be completely dry to prevent the wound from getting macerated (softened or separated by soaking in a liquid) and to maintain skin integrity. The WCN stated it was important to follow doctor's orders because they were person centered and individualized.In an interview on 02/09/26 at 3:46 PM, the DON, stated the WCN should have pat dried Resident #67's wound as per doctor's orders. The DON stated it was important to follow the doctor's orders so the wound could heal. The DON stated Resident #67's wound could get macerated and could delay healing. The DON stated there was no policy on wound care, but she did provide a policy on Professional Standard of Care. In an interview on 02/10/26 at 2:25 PM, the ICP stated the wound should have been pat dried to get the moisture out, and if not, it could cause maceration or slow healing. The ICP stated she did a skills check off with the WCN last month with no concerns noted. The ICP stated that the WCN was probably just nervous. |

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| | 676465 | A. Building<br>B. Wing | 02/11/2026 |

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| Las Alturas Nursing & Transitional Care | 4301 North Bartlett Avenue<br>Laredo, TX 78041 |

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|---|---|
| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident who was incontinent of bowel/bladder and each resident with an indwelling catheter received appropriate treatment and services to prevent urinary tract infections, for 1 (Resident #139) of 3 residents reviewed for incontinent care and indwelling urinary catheters. The facility failed to ensure Resident #139's indwelling urinary catheter tubing was secured during personal care to prevent dislodgement and injury. This deficient practice has the potential to result in urinary tract infections and at risk of accidental pulling of the catheter tubing and/or injury. The findings included: Record review of Resident #139's face sheet dated 02/11/26 reflected a [AGE] year-old-female with an original admission date of 03/11/22. Diagnoses include dementia (loss of memory, language, problem solving and other thinking abilities which significantly impairs a person's ability to perform daily activities), Alzheimer's disease (progressive brain disorder that slowly destroys memory and thinking skills), Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), and type 2 diabetes (insufficient production of insulin in the body). Record review of Resident #39's care plan initiated on 03/12/22 and revised on 05/30/24 reflected: Resident #139 required a catheter r/t neurogenic bladder (condition in which nerve damage or neurological disorders disrupt the normal communication between the brain, spinal cord, and bladder, leading to loss of bladder control). Interventions included: Catheter Care every shift and as indicated. Provide a catheter secure band/tape as indicated. Offer/provide a privacy bag or cover drainage bag as indicated.On 02/10/26 at 4:28 PM, CNA A and CNA B were both observed transferring Resident #139 from the bed to the shower chair. Both CNA A and CNA B did not have Resident #139's Foley catheter anchored during the time of the transfer from the bed to the shower chair, during the shower and during dressing the resident. In an interview on 02/10/26 at 5:31 PM, CNA A stated Resident #139 should not have been moved without the Foley tubing being secured. CNA A stated Resident #139 did not have a catheter strap on her, but the strap was used to prevent any yanking and pulling during care or transfers. CNA A stated Resident #139's Foley could have possibly come out causing pain and discomfort. In an interview on 02/10/26 at 5:38 PM, CNA B stated Resident #139's Foley tubing was not secured while care was being provided and should have to prevent possible injury or pain to the resident. In an interview on 02/11/26 at 9:09 AM, the ICP stated Resident #139's Foley should have been secured with a strap to prevent any tugging or dislodging of the Foley and possibly hurting the resident causing trauma. The ICP stated she was responsible for teaching and the CNA Program at the facility, and she taught both CNA A and CNA B. The ICP stated the CNA staff were taught proper Foley care and both CNA A and CNA B knew Resident #139's Foley tubing should have been secured to the resident prior to care. In an interview on 02/11/26 at 10:50 AM, the DON stated Resident #139's Foley tubing should have been secured to prevent dislodgment and could cause injury or trauma to the resident. Record review of the facility's Routine Resident Care policy dated January 2024 reflected: 8. Residents who utilize with/without tubing should have the device and/or tubing properly secured. Staff should ensure that the device/tubing is properly attached to the bed/chair/wheelchair/assistive device in order to prevent/minimize risk of injury. Staff should handle the device/tubing with caution, adhering to all safety measures during patient care encounters, when the resident is mobile such as when out of bed, ambulating or when utilizing an assistive device such as a wheelchair in order to prevent accidental tugging or dislodging. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 2 of 7 residents (Resident #6 and Resident #2) reviewed for pharmacy services in that: The facility failed to ensure Resident #6 was administered insulin before breakfast as ordered by the physician. The facility failed to ensure the nurse cart for 400-hall was free from expired insulin pens.The facility failed to ensure expired insulin was not administered to Resident #2 on [DATE]. These failures could place residents at risk for non-therapeutic responses to medications.Findings included:1. Record review of Resident #6's face sheet dated [DATE] revealed a [AGE] year-old male with an admission date of [DATE]. The pertinent diagnosis included Type 2 Diabetes Mellitus (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar). Record review of Resident #6's MDS assessment dated [DATE] revealed a BIMS score of 3 indicating severe impairment. Record review of Resident #6's comprehensive care plan dated [DATE] revealed the focus I have chronic health conditions & co-morbid conditions that have affected my physical function and may further affect my quality of life.[Diabetes Mellitus]. initiated on [DATE]. An intervention listed for the focus included Administer my medications, treatments, respiratory treatments/therapy and/or devices as order by my doctor initiated on [DATE]. Record review of Resident #6's order summary revealed an active order for Insulin Lispro Injection Solution Inject 5 units subcutaneously (situated or applied under the skin) before meals for [Diabetes Mellitus] initiated on [DATE]. During an observation of medication administration at 9:40 AM on [DATE], RN E administered 5 units of insulin lispro subcutaneously to Resident #6. In an interview with RN E at 11:04 AM on [DATE], RN E stated she administered Resident #6's morning insulin after he had already eaten breakfast on [DATE]. RN E stated she fell behind earlier that morning because another resident required more care than usual. RN E stated Resident #6's insulin should have been administered before breakfast as ordered by the physician. RN E stated not following physician's orders when administering insulin to residents could lead to unexpected blood glucose levels. In an interview with the DON at 10:50 AM on [DATE], the DON stated insulin should be administered as ordered by the physician. The DON stated Resident #6's insulin should have been administered before breakfast on [DATE] as ordered. The DON stated administering insulin outside of a physician's order could lead to either high or low blood sugar depending on the circumstances of the incident. 2 and 3. Record review of Resident #2's face sheet dated [DATE] revealed a [AGE] year-old female with an original admission date of [DATE] and a current admission date of [DATE]. The pertinent diagnosis included Type 2 Diabetes Mellitus. Record review of Resident #2's MDS assessment dated [DATE] revealed a BIMS score of 3 indicating severe impairment. Record review of Resident #2's comprehensive care plan dated [DATE] revealed the focus I have diabetes and I am at risk for: Complications associated with diabetes: Frequent Infections, Diabetic wounds, Vision Impairment, Hyper/Hypo-Glycemia (high and low blood sugar), Renal (Kidney) Failure, Cognitive/Physical Impairment initiated on [DATE]. An intervention listed for the focus included Administer my medications as recommended by my doctor, monitor labs as indicated. initiated on [DATE]. Record review of Resident #2's order summary revealed an active order for Lantus insulin Inject 10 unit subcutaneously one time a day related to TYPE 2 DIABETES MELLITUS. initiated on [DATE].Record review of Resident #2's February 2026 medication administration record revealed LVN F administered 10 units of Lantus insulin at 7:00 AM on [DATE] to Resident #2. During an observation of the 400-hall nurse cart at 4:25 PM on [DATE], a Lantus insulin pen with an open date of [DATE] in the top drawer. The label on the pen revealed it was ordered for Resident #2. In an interview with LVN F at 3:52 PM on [DATE], LVN F stated she administered Resident #2's Lantus insulin pen in her cart to<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #2 around 7:00 AM on [DATE]. LVN F stated based on the open date written on the pen, the pen would have expired on [DATE], 28 days after it was opened. LVN F stated she was supposed to check the expiration dates on medications before administering them. LVN F stated administering expired insulin to a resident could lead to elevated glucose and cause excessive thirst or frequent urination. In an interview with the DON at 10:50 AM on [DATE], the DON stated expired insulin should not be stored in the nurse's carts. The DON stated insulin expired 28 days after it was taken out of the refrigerator. The DON stated an insulin pen opened on [DATE] would have expired on [DATE]. The DON stated expired insulin should not be administered to a resident because it may affect glucose in unpredictable ways leading to higher or lower glucose levels than expected. Record review of the facility policy titled Medication Administration implemented in [DATE] stated the following: 2.a. The nurse/medication aide shall be responsible to read and follow precautionary instructions on prescription labels.6. Administer medications as ordered by the physician. Routine medications shall be administered according to the established medication administration schedule for the community. Record review of the facility policy titled Diabetes Management implanted on [DATE] and revised on [DATE] stated the following: Routine Care:. Anti-diabetic agents (insulin or oral anti-diabetic agents) should be administered as per physician order. |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain clinical records that were accurately documented for 1 (Resident #13) of 5 residents reviewed for medical records. 1. The facility failed to ensure Resident #13's blood pressure readings were accurately documented for the month of January 2026. This failure could affect residents whose records were maintained by the facility and could place them at risk for errors in care and treatment. The findings included: Record review of Resident #13's face sheet dated 02/10/26 reflected a [AGE] year-old-female with an original admission date of 05/13/23. Diagnoses include hypertensive heart disease (damage to the heart caused by long-term high blood pressure) and chronic (long-term) kidney disease. Record review of Resident #13's care plan initiated on 10/11/24 reflected Resident #13 had heart disease. Interventions included: Administer medications as ordered by my physician. Monitor vital signs as indicated and report abnormal findings to MD as indicated. Record review of Resident #13's MD orders reflected: Vitals one time a day. Start date, 08/16/23. Give Amlodipine Besylate oral tablet 5 MG. 1 tablet by mouth one time a day for HTN (high blood pressure). Hold if systolic blood pressure (top number) is less than 100. Start date 08/16/23. Record review of Resident #13's January 2026 blood pressure log reflected: 01/12/26 07:55 126/77 mmHg 01/12/26 09:04 126/77 mmHg 01/16/26 07:23 115/61 mmHg 01/16/26 09:13 115/61 mmHg 01/19/26 08:29 126/65 mmHg 01/19/26 09:33 126/65 mmHg 01/26/26 09:49 110/76 mmHg 01/26/26 11:48 110/76 mmHg 01/27/26 08:35 114/60 mmHg 01/27/26 09:01 114/60 mmHg 01/28/26 08:01 119/64 mmHg 01/28/26 09:29 119/64 mmHg 01/29/26 08:24 119/65 mmHg 01/29/26 09:37 119/65 mmHg 01/30/26 09:25 112/70 mmHg 01/30/26 12:07 112/70 mmHg In an interview on 02/10/26 at 8:15 AM, MA C stated there was a recall button on the system used when documenting resident blood pressures, and she would use it sometimes. MA C stated sometimes when Resident #13 refused to let her take their blood pressure, MA C stated she would use the previous blood pressure reading that was taken. MA C stated she should be documenting that Resident #16 was refusing her blood pressure to be taken instead of using the previous blood pressure recorded. MA C stated if Resident #13's blood pressure was documented wrong, the resident's blood pressure could become low if medication was given when it was not supposed to. In an interview on 02/11/26 at 10:32 AM, the DON stated MA C should not have been using the previous blood pressure readings recorded. The DON stated that if a blood altering medication was given to Resident #13 when her blood pressure was not actually taken, it could cause the resident's blood pressure to drop, causing potential complications. The DON stated a resident's blood pressure could change drastically within an hour of the last reading. The DON stated there was no policy on documentation but did provide a Professional Standard of Care Policy. Record review of the facility's Professional Standard of Care policy dated Jan. 2024 reflected: Compliance Guidelines: The community provides services that meet professional standards of quality and are provided by appropriately qualified persons (e.g., licensed, certified). |