

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/01/2025
NAME OF PROVIDER OR SUPPLIER Las Alturas DE Penitas		STREET ADDRESS, CITY, STATE, ZIP CODE 414 Liberty Blvd. Penitas, TX 78576	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40872</p> <p>Based on interview and record reviews the facility failed to ensure the residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 3 of 3 residents (Resident #24, Resident #25 and Resident #26) reviewed for abuse.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure Resident #26 did not inappropriately touch Resident #25 in the groin area, over his clothing, on 02/10/24 . 2. The facility failed to ensure Resident #26 did not inappropriately touch Resident #24 in the breast area on 04/16/24. <p>An Immediate Jeopardy (IJ) situation was identified on 01/30/25. While the IJ was removed on 01/31/25 at 2:09 p.m., the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems .</p> <p>These failures could place residents at risk of emotional distress, fear, decreased quality of life and further abuse.</p> <p>The findings were:</p> <p>Record review of Resident #26's Admission Record, dated 04/18/24, revealed a [AGE] year-old male with admitted d of 03/04/23. Resident #26 had diagnoses which included Cerebral Infraction (stroke), Cognitive Communication Deficit (difficulty with listening, speaking, reading, social communication) Unspecified Dementia (decline in person's ability to do every day activities), Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance (severe mental health disorder), Mood Disturbance and Anxiety.</p> <p>Record review of Resident #26's quarterly MDS, dated [DATE], revealed Resident #26's had a BIMS of 13, which indicated his cognition was intact. Resident #26 had impairment on one side and mobility devices used was a wheelchair.</p> <p>Record review of Resident #26's Quarterly care plan, dated 05/22/24, reflected no interventions after an inappropriate touching incident with Resident #25 that occurred on 02/10/24. Interventions for an incident with Resident #24 reflected room change and closely monitoring during acute phase.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #25's Admission Record, dated 01/08/25, revealed a [AGE] year-old male who had an original admitted [DATE]. Resident #25 had diagnoses which included Bipolar Disorder (mental health condition of extreme changes in mood and behavior), Other Obsessive-Compulsive Disorder (repetitive behavior), Moderate Intellectual Disability (difficulty with learning & problem solving), and Unsteadiness on Feet.</p> <p>Record review of Resident#25's quarterly MDS, dated [DATE], revealed Resident#25 had a BIMS of 0, which indicated severely impaired cognition. Resident #25 was able to ambulate without any assistive devices.</p> <p>Record review of the facility's Provider Investigation Report, dated 02/10/24, revealed an incident between Resident #25 and Resident #26. Resident #26 was observed inappropriately touching Resident #25 by the Dietary Aide on 02/10/24. Further review revealed Dietary Aide wrote in a witness statement, not dated, that when she was clocking in from her break she had seen Resident #26 sitting down next to resident #25 and he had put his hand on Resident #25's penis area. The date of the incident involving Resident #25 and Resident #26 was on 02/10/24. The report stated Resident #26 was placed on 1:1 observation for 72 hours, lab orders for UA, and facility staff were in serviced on abuse, neglect and safe surveys were conducted for residents.</p> <p>Record review of Resident #24's Admission Record, dated 04/16/24, revealed an [AGE] year-old female with an admitted [DATE]. Resident #24 had diagnoses which included Unspecified Dementia (decline in person's ability to do every day activities), Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance (severe mental health disorder), Mood Disturbance and Anxiety, Hemiplegia (severe weakness on one side of the body) and Hemiparesis (mild weakness on one side of the body) following Cerebral Infraction (stroke) affecting left non-dominant side, and Other lack of coordination.</p> <p>Record review of Resident #24's Quarterly MDS record, dated 10/28/24, revealed Resident#24 had a BIMS of 0, which indicated severely impaired cognition. Resident #24's mobility devices used was a wheelchair.</p> <p>Record review of the facility's Provider Investigation Report, dated 04/16/24, revealed an incident which included Resident #24 and Resident #26. Resident #26 was observed by CNA V inappropriately touching Resident #24's breast area in the dining room. The report also revealed Resident #26 was discharged to a behavioral hospital due to this incident and returned to the facility 4 days later.</p> <p>In an interview on 01/07/25 at 2:07 p.m. LVN P said CNA V told her that she had seen Resident #26 sitting next to Resident #24 in the dining area during lunch and she saw him touch Resident #24's breast area.</p> <p>In an interview on 01/08/25 at 2:14 p.m. CNA J said Resident #26 usually would eat his meals in the dining room. She said he also liked to participate in activities.</p> <p>In an interview on 01/28/25 at 4:40 p.m., the ADON said after the incident between Resident #24 and Resident #26, Resident #26 was placed on 1:1 monitoring for 72 hours and was evaluated by the psychiatric nurse practitioner. The ADON also said he was not given any follow up orders to monitor inappropriate behaviors for Resident #26 after either incidents occurred with both Resident #24 and Resident #25. The ADON also said staff were in serviced on ANE after the incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 01/28/25 at 5:32 p.m., CNA L said he worked with Resident #26 after both incidents but was not told to keep an eye on him for behaviors with other residents.</p> <p>In an interview on 01/28/25 at 6:15 p.m., LVN P said after the incident with Resident #24 and Resident #26 the only interventions she knew of was the room change for Resident #26 and the close monitoring for 72 hours after the incident.</p> <p>In an interview on 01/29/25 at 6:50 p.m., LVN M said she did not recall being told about an incident which involved Resident #26 and Resident #24 and Resident #25. She said she did not recall being told about his behaviors or to monitor Resident #26 or behaviors with other residents.</p> <p>In an interview on 01/28/25 at 6:33 p.m., the DON said she started working at the facility in April of 2024 and was not aware of the first incident in February which involved Resident #25 and Resident #26. She said she wasn't sure what interventions were in place . She said when the incident happened with Resident #24 and Resident #26, Resident #26 was placed on critical monitoring every 15 minutes. He was being checked on by staff and documented and was then sent to a behavioral hospital for evaluation . Also done was a room change. He was moved to a different hall. The DON said once Resident #26 returned from the behavioral hospital there was no other interventions .</p> <p>In an interview on 01/30/25 at 2:50 p.m., the Administrator A said she was not yet employed at the facility at the time of either incidents. She said she was made aware once she became the Administrator in May 2024 and no concerns on Resident #26's behavior with other residents was brought to her attention since those incidents.</p> <p>Record review of the facility's policy titled Abuse Guidance: Preventing, Identifying and Reporting, revised date January 2024, reflected:</p> <p>Compliance Guidelines:</p> <p>Every resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Residents should not be subjected to abuse by anyone, including, but not limited to, community team members, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 01/30/2025 at 5:30 p.m. The Administrator was notified. The Administrator was provided with the IJ template on 01/30/2025 at 5:30 p.m.</p> <p>The following Plan of Removal submitted by the facility was accepted on 01/31/25 at 2:09 p.m.</p> <p>It was determined these failures placed Resident #24 and Resident #25 in an IJ situation on 04/16/24.</p> <p>Corrective Action:</p> <p>Residents #24 and #25 were reassessed and monitored following the alleged inappropriate touch incidents. There were no negative outcomes identified.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Following both alleged incidents Resident #26 was reassessed and continued to be monitored by nursing as per usual practice and placed on close monitoring efforts of 1:1 and Q 15 minutes monitoring. There were no negative outcomes identified.</p> <p>IDT and community's leadership will coordinate and collaborate with the PCP/Medical Provider and Mental Health Provider to discuss Resident #26 current status, risks and potential need for relocation to a facility or setting more appropriate to meet his needs and maintain the safety of others who reside within our community. Plan of care and Kardex will be updated. Facility will re-educate team members related to on-going process for monitoring resident and the expectation to report to the nurse/DNS /Administrator any behaviors that pose risk to others.</p> <p>Identification:</p> <p>All residents with cognitive impairment have the potential to be affected by the alleged deficient practice.</p> <p>DNS/ADNS /IDT conducted a review of all current residents identified with behaviors that may affect others, such as inappropriate touch or sexual related behaviors in order to validate that appropriate interventions are in place and noted on the Kardex .</p> <p>Date Completed:</p> <p>Administrator/Social Worker conducted rounds interviewing staff and other interviewable residents in order to identify any concerns with Abuse, Neglect and Exploitation .</p> <p>Date Completed:</p> <p>Systematic Changes:</p> <p>Administrator/DNS were in-serviced by the [NAME] President of Operations/Director of Clinical Operations regarding the facility's expected process for:</p> <ul style="list-style-type: none"> o 1. Identifying residents at risk for behavioral concerns that may cause physical and/or emotional harm. o 2. Identifying, Preventing, Protecting against and Reporting ANE. o 3. Tx HHSC Provider Letter regarding reportable incidents. o 4. Updating the plan of care, ensuring that appropriate interventions are in place. o 5. Ensure that appropriate interventions are noted on the plan of care as well as the Kardex. o 6. Educating staff on the intervention such as specific monitoring efforts such as Q15 minutes and 1:1 monitoring. <p>Administrator/DNS / Designee to conduct retraining for all team members prior to assuming their next shift regarding:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> o 1. Identifying residents at risk for behavioral concerns that may cause physical and/or emotional harm. o 2. Identifying, Preventing, Protecting against and Reporting ANE. o 3. Tx HHSC Provider Letter regarding reportable incidents. o 4. Updating the plan of care, ensuring that appropriate interventions are in place. o 5. Ensure that appropriate interventions are noted on the plan of care as well as the Kardex. o 6. Educating staff on the intervention such as specific monitoring efforts such as Q15mins and 1:1 monitoring. o 7. Educated the nursing team (RN/LVN/CMA /CNA) regarding the importance of reviewing the Kardex so that they are aware of the level of care needed and the interventions to be implemented during their assigned shift. o 8. RAI process to include but not limited to completion of a resident centered comprehensive care plan on each resident regarding services to attain or maintain the resident's highest practical level of physical, mental, and psychosocial well-being. <p>Date Completed:</p> <p>Additionally, all newly hired staff will receive the above education as outlined during their orientation, prior to assuming their work assignment.</p> <p>Monitoring of the POR included the following:</p> <p>Observation on 01/31/25 at 3:45 p.m. revealed Resident #26 in his room with CNA O outside his room.</p> <p>Observation on 02/01/25 at 11:30 a.m. revealed Resident #26 in his room with CNA O outside his room.</p> <p>Interviews with facility staff were conducted from 01/30/25 at 1:30 p.m. through 02/01/25 at 11:25 a.m. A Total number of staff included: 14 CNA's, 9 LVN's, 1 Housekeeping, 1 CMA, 1 RN. Interviews revealed that staff were able to voice how to identify abuse neglect and exploitation as well as residents with inappropriate behaviors. Staff were also able to voice knowledge of 1:1 monitoring of residents with behaviors. Staff also were able to identify the process of documenting and reviewing the electronic system in place to check for residents new or existing behaviors.</p> <p>Based on observations, interviews and record review there were no other residents identified with behaviors similar to Resident #26.</p> <p>Scheduled shifts: 6:00 a.m. to 2:00 p.m., 2:00 p.m. to 10:00 p.m., 10:00 p.m. to 6 a.m., 10:00 a.m. to 5:00 p.m.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Content:</p> <ul style="list-style-type: none"> -Identifying, Preventing, Protecting against and reporting abuse and neglect of all residents -Monitoring and observing residents for inappropriate or any other behaviors -Knowledge of 1:1 observation of residents for behaviors -Reviewing the facility's electronic system set in place to document residents level of care needed and the interventions to be implemented . <p>The Administrator was informed the Immediate Jeopardy was removed on 01/31/25 at 2:09 p.m. the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40872</p> <p>Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency, in accordance with State law through established procedures for three of three residents (Resident#24, Resident#25, and Resident#26) reviewed for reporting abuse.</p> <p>The facility failed to report two separate incidents of resident-to-resident abuse to the state agency within the given time frame.</p> <p>This failure could place residents at increased risk for potential abuse.</p> <p>The findings were:</p> <ol style="list-style-type: none"> 1. Record review of Resident #26's Admission Record, dated 04/18/24, revealed a [AGE] year-old male with admitted [DATE]. Resident #26 had diagnoses which included Cerebral Infraction (stroke), Cognitive Communication Deficit (difficulty with listening, speaking, reading, social communication) Unspecified Dementia (decline in person's ability to do every day activities), Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance (severe mental health disorder), Mood Disturbance and Anxiety. <p>Record review of Resident #26's quarterly MDS, dated [DATE], revealed Resident #26's had a BIMS of 14, which indicated his cognition was intact, also noted under functional limitation range of motion, impairment on one side and mobility devices used was a wheelchair.</p> <p>Record review of Resident #25's Admission Record, dated 01/08/25, revealed a [AGE] year-old male with an original admitted [DATE]. Resident #25 had diagnoses which included Bipolar Disorder (mental health condition of extreme changes in mood and behavior), Mild, Other Obsessive-Compulsive Disorder (repetitive behavior), Moderate Intellectual Disability (difficulty with learning & problem solving), and Unsteadiness on Feet.</p> <p>Record review of Resident#25's quarterly MDS, dated [DATE], revealed Resident#25 had a BIMS of 0, which indicated severely impaired cognition. Resident #25 was able to ambulate without any assistive devices.</p> <p>Record review of facility's Provider Investigation Report, dated 02/10/24, revealed an incident between Resident #25 and Resident #26. Resident #26 was observed inappropriately touching Resident #25 by the Dietary Aide on 02/10/24. The date of the incident involving Resident #25 and Resident #26 was on 02/10/24 and time of incident was at 4:00 p.m. The date the incident was reported to HHSC was 02/10/24 at 9:45 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #24's Admission Record, dated 04/16/24, revealed an [AGE] year-old female with an admitted [DATE]. Resident #24 had diagnoses which included Unspecified Dementia (decline in person's ability to do every day activities), Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance (severe mental health disorder), Mood Disturbance and Anxiety, Hemiplegia (severe weakness on one side of the body) and Hemiparesis (mild weakness on one side of the body) following Cerebral Infraction (stroke) affecting left non-dominant side, and Other lack of coordination.</p> <p>Record review of Resident #24's Quarterly MDS record, dated 10/28/24, revealed Resident#24 had a BIMS of 0, which indicated severely impaired cognition. Resident #24 used a wheelchair as a mobility device.</p> <p>Record review of facility's Provider Investigation Report, dated 04/16/24, revealed an incident involving Resident #24 and Resident #26. Resident #26 was observed by CNA V inappropriately touching Resident #24 in the dining room. The report also revealed the date of the incident was on 04/16/24 and time of incident was at 2:00 p.m. The date the incident was reported to HHSC was 04/16/24 at 6:30 p.m.</p> <p>In an interview on 01/08/25 at 2:10 p.m., LVN P said when CNA V told her she saw Resident #26 inappropriately touching Resident #24, she immediately assessed Resident #24 and reported it to the DON and the Administrator. LVN P said she received in services on abuse, neglect and exploitation and was told abuse and neglect allegations must be reported immediately within two hours to the DON and the Administrator.</p> <p>In an interview on 01/08/25 at 4:47 p.m., the DON said the abuse incident which involved Resident #26 inappropriately touching Resident #24 was immediately reported to the Administrator. She said she could not recall the time. She said it was within 2 hours that it happened because she knew that was the time frame, they had to report it to the State. The DON said they were in serviced frequently on Abuse and Neglect and was told it needed to be reported immediately to her and the Administrator. She said the facility could get cited if they did not report these types of allegations immediately. The DON said the Administrator at the time of this incident was no longer employed at the facility.</p> <p>In an interview on 01/08/25 at 4:49 p.m., the DON said she was not employed at the facility at the time of the incident between Resident #25 and Resident #26.</p> <p>Record review of the facility's policy titled Abuse Guidance: Preventing, Identifying and Reporting revision date January 2024 reflected:</p> <p>Seven Elements of ANE:</p> <p>- Reporting/Response- All alleged/suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities are individuals as may be required by law and per the current state/federal reporting requirements.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40872</p> <p>Based on 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 set forth, that included measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for one of three residents (Resident#26) reviewed for comprehensive person centered care plan .</p> <p>The facility failed to ensure Resident #26's care plan reflected the need for interventions for monitoring inappropriate behaviors with residents after 2 separate incidents of inappropriate behavior with 2 Residents (Resident #24 and Resident #25) had occurred .</p> <p>This failure could place residents in the facility at risk of not being provided with the necessary care or services and implementing personalized plans developed to address their specific needs.</p> <p>The findings were :</p> <p>1. Record review of Resident #26's Admission Record, dated 04/18/24, revealed a [AGE] year-old male had an admitted [DATE]. Resident #26 had diagnoses which included Cerebral Infraction (stroke), Cognitive Communication Deficit (difficulty with listening, speaking, reading, social communication) Unspecified Dementia (decline in person's ability to do every day activities), Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance (severe mental health disorder), Mood Disturbance and Anxiety.</p> <p>Record review of Resident #26's quarterly MDS, dated [DATE], revealed Resident #26's had a BIMS of 13, which indicated his cognition was intact, no behaviors were documented, and also noted under functional limitation range of motion, impairment on one side and mobility devices used was a wheelchair.</p> <p>Record review of Resident #26's Quarterly care plan, dated 05/22/25, reflected interventions after an inappropriate touching incident with Resident #25 which occurred on 02/10/24. Interventions for the incident with Resident #24 reflected close monitoring as needed.</p> <p>2. Record review of Resident #25's Admission Record, dated 01/08/25, revealed a [AGE] year-old male with an original admitted [DATE]. Resident #25 had diagnoses which included Bipolar Disorder (mental health condition of extreme changes in mood and behavior), Other Obsessive-Compulsive Disorder (repetitive behavior), Moderate Intellectual Disability (difficulty with learning & problem solving), and Unsteadiness on Feet.</p> <p>Record review of Resident#25's quarterly MDS, dated [DATE], revealed Resident#25 had a BIMS of 0, which indicated severely impaired cognition. Resident #25 was able to ambulate without any assistive devices.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/01/2025
NAME OF PROVIDER OR SUPPLIER Las Alturas DE Penitas		STREET ADDRESS, CITY, STATE, ZIP CODE 414 Liberty Blvd. Penitas, TX 78576	
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's Provider Investigation Report, dated 02/10/24, revealed an incident between Resident #25 and Resident #26. Resident #26 was observed inappropriately touching Resident #25 by the Dietary Aide on 02/10/24. The date of the incident involving Resident #25 and Resident #26 was on 02/10/24. The report stated Resident #26 was placed on 1:1 observation for 72 hours, lab orders for UA, and facility staff were in serviced on abuse, neglect and safe surveys were conducted for residents.</p> <p>3. Record review of Resident #24's Admission Record, dated 04/16/24, revealed an [AGE] year-old female with an admitted [DATE]. Resident #24 had diagnoses which included Unspecified Dementia (decline in person's ability to do every day activities), Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance (severe mental health disorder), Mood Disturbance and Anxiety, Hemiplegia (severe weakness on one side of the body) and Hemiparesis (mild weakness on one side of the body) following Cerebral Infraction (stroke, blood flow to brain is interrupted) affecting left non-dominant side, and Other lack of coordination.</p> <p>Record review of Resident #24's Quarterly MDS record, dated 10/28/24, revealed Resident#24 had a BIMS of 0, which indicated severely impaired cognition Resident #24's used a wheelchair as a mobility device .</p> <p>Record review of the facility's Provider Investigation Report, dated 04/16/24, revealed an incident involving Resident #24 and Resident #26. Resident #26 was observed by CNA V inappropriately touching Resident #24's breast area in the dining room. The report also revealed Resident #26 was discharged to a behavioral hospital due to this incident and returned to the facility 4 days later.</p> <p>In an interview on 01/31/25 at 11:50 a.m., RN X said either he, or any nurse on the floor or the DON could update a care plan. He said he just started working 2 months ago and was not present at the time of the 2 incidents involving Resident #26. RN X said care plans needed to be updated anytime there was a change in a resident's condition, or a change in medication. He said if a care plan was not updated the residents needs could be overlooked and the resident may not receive the care they needed.</p> <p>In an interview on 01/31/25 at 12:15 p.m., the ADON said care plans needed to be updated anytime any changes happened with a resident or new admissions. He said resident changes were discussed in morning meetings to make sure the care plan was appropriate for the resident, if they needed interventions, it should be put on there. He said Resident #26's admission to the behavioral hospital should have been care planned and he did not know why it was not. He said this needed to be done because they could miss out on something that should have been done with the resident risking health and safety. He also said updating the care plan was important because it was connected with the facility's online system which could be viewed by nurses and CNA's so they were aware of any changes to the resident.</p> <p>In an interview on 02/01/25 at 10:40 a.m., the DON said Resident #26's care plan should have been updated after the 2 incidents of inappropriate behaviors. She said nurses, and administration are able to update care plans as needed. She also said there should have been specific interventions documented for his behaviors. She said not updating his care plan failed to prevent or protect other residents .</p> <p>Record review of the facility's Care Plans Guidelines, revised January 2023, reflected:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Guidelines:</p> <p>Care Plans</p> <p>.The care plan should be initiated upon admission .</p> <p>The care plan should be updated and reviewed at least quarterly thereafter, then annually and with significant changes in conditions as defined in the RAI manual. Additional updates to the care plan should be done as indicated.</p> <p>The care plan should be prepared, reviewed, and updated in accordance with the RAI guidance on a routine cadence (admission, quarterly, annually and with significant change.) Additionally, the care plan should be modified as appropriate and on an as needed basis as per RAI instructions.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487</p> <p>Based on interviews and record review, the facility failed to ensure residents remained free from accidents, hazards and each resident received adequate supervision and assistance when being transferred for 1 of residents (Resident #1) reviewed for accidents and hazards,</p> <p>CNA A failed to transfer Resident #1 using two employees as required by his care plan.</p> <p>This deficient practice has the potential to affect all residents in the building who require assistance with transfers by 2 staff members by causing resident injuries, such as falls, fractures, and even death.</p> <p>Findings included:</p> <p>Record review of Resident #1's Face Sheet dated 12/31/24 documented a [AGE] year-old male was admitted to the facility on [DATE] with the following diagnoses: dementia (a general term for a group of brain disorders that cause a gradual decline in cognitive abilities, memory, and behavior), muscle weakness (a condition where a muscle is unable to contract properly, resulting in a loss of strength), unspecified lack of coordination (uncoordinated movement is due to a muscle control problem that causes an inability to coordinate movements).</p> <p>Resident #1's Care Plan, dated 11/27/24, documented Transfers: Resident #1 required assistance for transfers by two staff due to poor physical functioning.</p> <p>-Resident #1's quarterly MDS resident assessment, dated 12/3/24, documented Resident #1 needed substantial/maximal assistance with transfers from chair to bed and from bed to chair.</p> <p>During an observation on 12/31/2024 at 11:05am of bed to wheelchair (w/c) transfer of Resident #1, revealed, CNA A failed to transfer Resident #1 using two employees as required by his care plan. The transfer continued and Resident #1 was lifted off the bed by CNA A. CNA A had to place their arm under Resident #1's underarms to transfer the resident to his wheelchair. During transfer, Resident #1's legs were shaking while pivoting.</p> <p>During an interview on 12/31/24 at 11:30am, CNA A said that she did not know Resident #1 was a two person assist. CNA A said that she thought he was a one person assist. CNA A said that she checked on the Point Click System (electronic medical records) every week to know which residents needed a one person assist, two persons assist, or mechanical lift for transfers. CNA A said that the 300 hall residents were the ones for short term stay and that she checked frequently. CNA said that if she did not follow the plan of care, the resident or herself could be harmed.</p> <p>During an interview on 12/31/24 at 11:45am, CNA B said that the plan of care was accessible to all CNAs in the Point Click Care system. CNA B said that in the plan of care staff could find how many people were needed to assist each resident. CNA B said if they did not follow the plan of care the residents could sustain an injury, fall, or fracture. CNA B said that the last inservice on transfers was two weeks ago.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/31/24 at 1:10pm, LVN C said that CNAs were able to access the plan of care of each resident to check the assistance level each resident required. LVN C said that CNAs and charge nurses were supposed to follow the plan of care of each resident. LVN C said that if they did not follow the plan of care it could cause a fall, fracture, or harm to Resident #1 or to staff. LVN C said that the last inservice on transfers was the last week of December.</p> <p>During an interview on 12/31/24 at 1:20pm, LVN D said that all staff could check the plan of care of each resident in the Point Click Care system. LVN D said that by not following the plan of care residents or staff could get injured. LVN D said that the last inservice on transfers was on 12/27/24.</p> <p>During an interview on 12/31/24 at 2:12pm, the ADON said all CNAs had access to the resident's plan of care and staff should follow it. The ADON said if they did not follow the plan of care it could put residents at high risk for injury and to prevent any injury to residents and staff. The ADON said that staff was in-serviced on transfers every month.</p> <p>During an interview on 12/31/24 at 2:32pm, the DON said staff should follow the plan of care of each resident to do the proper transfer. The DON said that both the resident and the staff could get injured if they failed to follow the plan of care. The DON said that the last inservice on transfers was done last week.</p> <p>Record review of the facility policy titled, Resident Handling/Transfers, implemented date December 1, 2021, revealed the following:</p> <p>It is the policy of this community to ensure that patients/residents are handed and transferred safely to prevent or minimize risk for injury and provide and promote a safe, secure and comfortable experience for the patient/resident while keeping the team members safe in accordance with current standards and guidelines.</p> <p>Lifting and transferring will be performed according to the individualized plan of care.</p>		