

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 03/12/2025
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 1 of 6 residents (Resident #22) reviewed for respiratory care.</p> <p>The facility failed to ensure Resident #22's oxygen was administered at 2 lmp instead of 2.5 lpm via nasal cannula as ordered by physician.</p> <p>This failure could place resident(s) at risk of developing respiratory complications and having a decreased quality of care.</p> <p>The findings included:</p> <p>Record review of Resident #22's admission record, dated 03/10/25, reflected an [AGE] year-old male admitted to facility on 11/04/22 and had a readmitted on 09/09/23. His relevant diagnoses included dementia (a decline in mental ability that interferes with daily life, memory loss, thinking abilities, and behavioral changes), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and hypoxemia (a condition where the blood oxygen levels are lower than normal).</p> <p>Record review of Resident #22's quarterly MDS dated [DATE] reflected he had a BIMS score of 0, which indicated his cognition was severely impaired.</p> <p>Record review of Resident #22's quarterly care plan dated 03/05/25 reflected he was on oxygen therapy related to ineffective gas exchange (date initiated: 12/05/23). Part of his interventions were to administer oxygen at 2 lpm prn for signs and symptoms of shortness of breath and comfort (date initiated: 12/05/23).</p> <p>Record review of Resident #22's order summary report reflected an oxygen order at 2 lpm prn via nasal canula to maintain O2 saturation (the percentage of oxygen carried by red blood cells in the blood), effective 01/02/25 with no end date.</p> <p>An observation on 03/10/25 at 10:45 a.m., Resident #22 was observed lying asleep in bed. He was being administered oxygen via nasal canula and his concentrator was set at 2.5 lpm. Resident #22 was not in distress.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation and interview on 03/10/25 at 10:47 a.m., LVN F was witnessed as she checked Resident #22's oxygen setting and said his concentrator was set at 2.5 lpm. She was observed as she checked Resident #22's electronic medical record and said he had an oxygen order for 2 lpm prn. LVN F said her shift on 03/10/25 had started at 6 am and she had checked on Resident #22 at least twice since her shift started. She said it was her responsibility to ensure the oxygen setting was set at the correct setting. LVN F said a possible negative outcome for Resident #22 being administered 2.5 lpm instead of 2 lpm could be oxygen toxicity (too much oxygen).</p> <p>An interview on 03/11/25 at 9:45 a.m., the DON said Resident #22 had an oxygen order for 2 lpm prn. She said nursing staff were responsible to ensure residents oxygen setting was set according to their order. The DON said a possible negative outcome for Resident #22 not administered the ordered lpm of oxygen would be that the facility would not offer the appropriate oxygen the resident needed.</p> <p>Record review of facility's Oxygen Administration policy dated 03/14/19 and revised in January 2023 reflected:</p> <p>Compliance Guidelines:</p> <p>A resident receives oxygen therapy when there is an order by a physician. The resident's disease, physical condition, and age will help determine the most appropriate method of administration and should be reflected in the physician order.</p> <p>3. Obtain physician order for oxygen administration. Order should include the following:</p> <p>a) Oxygen source to be used (concentrator, mask, etc.)</p> <p>b) Method of delivery (cannula, mask etc.)</p> <p>c) Flow rate of delivery</p> <p>d) Oxygen saturation monitoring parameters, if indicated.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487</p> <p>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 #36 and Resident # 78) out of 4.</p> <ol style="list-style-type: none"> 1. LVN A did not perform hand hygiene for 20 seconds or longer after medication administration to Resident #36. 2. The facility failed to prevent Resident#78's urinary catheter bag/tubing from touching the floor. <p>These failures could place residents at risk for infection through cross contamination of pathogens.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Record review of Resident # 36's face sheet dated 3/11/2025 reflected a [AGE] year-old male with an admitted [DATE]. Diagnoses included Pressure ulcer of unspecified buttock stage 2, Chronic Obstructive Pulmonary Disease (a group of lung conditions that cause long-term damage to the airways and lungs, leading to breathing difficulties), Gastrostomy Status (whether a person has an artificial opening in their stomach (a gastrostomy) for feeding, medication, or drainage). <p>Record review of Resident #36's care plan dated 10/24/2024 reflected Resident #36 had a feeding tube related to Dysphagia (Difficulty swallowing foods or liquid).</p> <p>Record review of Resident #36's MDS dated [DATE] reflected a BIMS of 3 (Severe cognitive impairment) and feeding tube while a resident.</p> <p>During an observation of medication administration for Resident #36 on 03/11/2025 at 9:30 AM LVN A after medication administration was performed, LVN A performed hand hygiene for approximately 13 seconds.</p> <p>In an interview on 3/11/2025 at 9:50 AM, LVN A stated hand washing should be at least 20 seconds to prevent the spread of germs to residents and others. LVN A said that the 20 seconds started when she opened the faucet until she closed the faucet.</p> <ol style="list-style-type: none"> 2. Record review of Resident #78's face sheet dated 3/10/2025 reflected a [AGE] year-old-female with an original admitted [DATE]. Diagnoses included neuromuscular dysfunction of bladder (occurs when the nerves that control bladder function are damaged or disrupted, leading to problems with bladder storage and emptying). <p>Record review of Resident #78's care plan dated 10/31/2024 reflected resident had indwelling foley catheter related to neurogenic bladder.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #78's MDS dated [DATE] reflected a BIM score of 99 (severe cognitive impairment) and had an indwelling catheter.</p> <p>During a rounding observation for Resident #78 on 03/10/25 at 10:08 AM, the foley bag was lying on the floor.</p> <p>During an Interview on 03/10/25 at 10:36 AM, CNA D stated that was important to foley bag from touching the floor because the resident could get an infection. CNA D stated that Resident #78's the foley bag was supposed to be attached to the bed frame, and she stated that was not attached properly and fell to the floor.</p> <p>During an interview on 3/10/25 at 10:45 AM, LVN B stated that the foley bag should have been hanging. LVN B stated that the foley bag being on the floor would put the resident at risk of infection and staff or visitors could trip with the tubing.</p> <p>In an interview on 03/5/25 at 05:20 PM, the ADON stated effective hand washing was at least 20 seconds or greater was important to prevent the spread of infection to residents, staff, and visitors. ADON stated that the foley bag should not touch the floor to prevent any infections. ADON stated that the foley bag could get contaminated and could introduce an infection or it could get a leak.</p> <p>In an interview on 03/5/25 at 05:35 PM, the DON stated hand washing should be 20 seconds or greater to prevent the spread of bacteria to residents and other surfaces. DON stated that the foley bag should not been on the floor because this puts the resident on high risk for infection.</p> <p>Record review of Hand Hygiene policy dated 2019 stated:</p> <p>Policy Statement</p> <p>This facility considers hand hygiene the primary means to prevent the spread of infection</p> <p>Record review of Infection Prevention and Control Program implemented on 3/13/2019 stated:</p> <p>The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. The elements of infection prevention and control program consist of coordination/oversight, guidance/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety.</p> <p>Record Review of the Centers for Disease Control and Prevention (CDC) Handwashing Guidelines: How to Wash Your Hands:</p> <p>Wet your hands with clean, running water (warm or cold).</p> <p>Apply soap and lather your hands by rubbing them together.</p> <p>Scrub all surfaces of your hands, including between your fingers, under your nails, and the backs of your hands.</p> <p>(continued on next page)</p>		

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