STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745000	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Alturas DE Penitas	414 Liberty Blvd. Penitas, TX 78576

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on interview and record review, the facility failed to ensure residents had the right to formulate an advance directive for 1 (Resident #5) of 3 residents reviewed for Advance Directives.The facility failed to ensure Resident #5's OOH-DNR was completed. The OOH-DNR form did not have the physician's signature dated, printed name or License number.This failure could affect all residents who have implemented Advance Directives and established their choice not to be resuscitated at risk of receiving CPR against their wishes.The findings were:Record review of Resident #5's electronic face sheet dated 05/28/2026 reflected the resident was a [AGE] year-old female admitted on [DATE], diagnoses included Unspecified Dementia Unspecified Severity with other Behavioral Disturbance (decline in memory and cognitive skills), Hypertension (high blood pressure), Atherosclerotic Heart Disease of Native Coronary Artery with Unspecified Angina Pectoris (heart receives insufficient blood and oxygen) and Dysphagia Oral Phase (difficulty moving food or liquid from mouth to throat).Resident #5's electronic face sheet reflected Advance Directives: DNR.Record review of Resident #5's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 0 which indicated severe cognitive impairment.Record review of Resident #5's Quarterly care plan reflected, Resident #5's Family/RP completed documentation for DNR status. Date Initiated: 12/06/22. Community will follow DNR status request through review date. Code status will be reviewed quarterly and as neededRecord review of Resident #5's OOH-DNR form dated 12/08/22 reflected the form was signed in section C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above person's: adult child. The OOH-DNR revealed the form was not dated or provided with a license number or printed name by the attending physician below section E, Physician's Statement: I am the attending physician of the above noted person and have noted the existence of this order in the person's medical records. I direct health care professionals acting in our-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation. It also revealed the physician did not sign section F, All persons who have signed above must sign below, acknowledging that this document has been properly completed.During an interview on 05/27/28 at 2:58 p.m., Social Services stated he is responsible for assisting in making sure resident DNR forms were completed and signed correctly. He said he had just started working at the facility about 2 months ago and had not known why Resident #5's DNR form was not filled out completely. He said the forms must be filled out completely. Social Services said DNR forms may not be valid if it is missing the date that the physician signed it and if it did not have the physician's license number.During an interview on 05/28/28 at 4:09 p.m., the DON said DNR forms were supposed to be (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	filled out completely. She said in Resident #5's DNR form that did not have the physician's dated signature, they went with the date of the witness signature. The DON said it was valid.Record review of the facility's Advance Directives policy date reviewed/revised 2023, revealed theCompliance Guidelines:Every resident has the right to formulate an advance directive and to refuse treatment. The community will determine the existence of an advance directive at the time of admission.A copy of the advance directive and subsequent revisions will be included in the resident's medical record.The IDT should honor the care decision expressed and initiate the advance directive by initiating the Out of Hospital Do Not Resuscitate (OOH DNR) form and should obtain the medical provider/physician's signature as per the OOH DRN instructions. The medical record and resident plan of care should reflect the residents wishes as well as the physician orders in order to meet the directives described.Record review of the OOH DNR Order instructions for issuing and OOH-DNR Order revised 10/12/23 revealed thePurpose: The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order on reverse side complies with Health and Safety Code (HSC), Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity.Applicability: This OOH-DNR Order applies to health care professions in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments.Implementation: A competent adult person at least [AGE] years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person attending physician will document the existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows: .In addition: the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making and OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on interview and record review, the facility failed to ensure all pre-admission screening and resident review (PASRR) Level 1 residents with mental illness were provided with an accurate PASRR Level 1 for 1 (Resident #93) of 3 residents reviewed for PASRR screening. Resident #93 did not have an accurate and updated PASRR Level 1 assessment reflecting a diagnosis of mental illness.This failure could place residents at risk of not receiving specialized services that would enhance their highest level of functioning. Findings were:Record review of Resident #93's admission Record dated 05/28/26 reflected a [AGE] year-old male with an admission date of 04/10/26 and diagnoses of Essential (Primary) Hypertension (high blood pressure), Mild neurocognitive Disorder Due to Known Physiological Condition Without Behavioral Disturbance (decline in memory or thinking skills), Chronic Kidney Disease Stage 4 (severe kidney damage) and Other Seizures (uncontrolled surge of electrical activity in the brain).Record review of Resident #93's admission MDS dated [DATE] reflected a BIMS score of 05 which indicated severe cognitive impairment. Additionally, under Section I Resident #93 had an active diagnosis of Schizophrenia.Record review of Resident #93's PASRR dated 04/14/26 reflected under section C0100 Evidence of Mental Illness was answered as 0 indicting the resident did not have a mental illness.During an interview on 05/27/26 at 9:32 a.m. Resident #93 said he was doing ok. Resident #93 was not responsive to any other questions at the time of the interview.During an interview on 05/27/26 at 3:47 p.m. RN F said Resident #93's PASRR indicated he did not have a mental illness. She said he had a diagnosis of Schizophrenia and she was trying to communicate with the Local Mental Health Authority to find out if he was receiving services before being admitted to the facility. She said there was no PASRR Level II done. She said it could be an injustice to him if he's not receiving services through the LMHA if he chose to receive them. During an interview on 05/28/26 at 4:02 p.m., the DON said that MDS is responsible for completing resident PASRR's. She said RN F was new to the position and was overseen by regional management. The DON said that residents needed to be evaluated and have their proper diagnoses addressed so they could receive services that were needed. Record review of the facility's Comprehensive Assessments Revised Date March 2023, revealed; Types of AssessmentsThe community conducts frequent and different types of assessments, depending on the resident's condition and need. The community will conduct the following types of assessments during its relationship with the resident:-Preadmission screening and resident review (PASRR) screen is required of all individuals with mental illness (MI) or mental retardation (MR), regardless of the applicant's source of payment. The screen lists the specialized services that are required and identifies the services the state is responsible to provide. The community is responsible for providing the other needed services. These screenings are providedWithin fourteen days of the resident's admission to the community

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided with such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 1 (Resident #69) residents reviewed for tracheostomy/respiratory care. The facility failed to ensure Resident #69's oxygen tubing was connected properly to the tracheostomy mask (used to deliver humidified air and oxygen) on 05/26/26. The facility failed to ensure Resident #69's oxygen was administered at the correct setting of 5 liters per minute (LPM) on 05/26/26 as ordered by the physician. The facility failed to ensure Resident #69's humidifier bottle (a device that attaches to your concentrator to add moisture to the continuous flow of oxygen) was changed on the day indicated by the physician. These deficient practices could place residents who receive respiratory care via tracheostomy at an increased risk of developing respiratory complications and a decreased quality of care. Findings: Record review of Resident #69's admission record dated 05/27/26 revealed a [AGE] year-old female with an original admission date of 03/10/26 and with an initial admit date of 00/24/21. Pertinent diagnoses included personal history of traumatic brain injury, tracheostomy status (a surgically created opening through the front of the neck and directly into the windpipe. A breathing tube is placed into this hole to bypass the nose and mouth, providing an alternative airway for the patient to breathe), hydrocephalus (the buildup of cerebrospinal fluid deep within the brain), muscle wasting and atrophy (the partial or complete wasting away of a part of the body), cognitive communication deficit (an impairment in communication that stems from underlying disruptions in brain function and cognitive processes, and bed confinement status. Record review of Resident #69's quarterly MDS dated [DATE] revealed a score of 00 which indicated severely cognitive impaired. MDS also indicated Resident #69 was on continuous oxygen therapy. Record review of Resident #69's person-centered care plan, initiated date 09/24/21 revealed a Focus of Tracheostomy r/t Impaired breathing mechanics secondary to Traumatic brain injury Interventions included, Give humidified oxygen as prescribed, change my oxygen & trach tubing, humidification & filter as ordered/as indicated, and Provide oxygen as ordered/recommended by my physician. The care plan revealed a Focus of [Resident #69] has oxygen therapy r/t impaired breathing mechanics (a disrupted process where the muscles or bones needed for respiration cannot effectively expand or contract) due to traumatic brain injury. The care plan revealed a Focus of I am at risk for experiencing shortness of breath. Chronic Respiratory Disease (long-term conditions affecting the airways and lungs, making breathing difficult). Interventions included, Continuous Oxygen 5 Liters via Tracheostomy. Record review of Resident #69's Active Order Summary revealed an order dated 03/11/26, O2 5 LPM via Trach to maintain SPO2 (the percentage of red blood cells in the blood carrying oxygen) @ 93-99%. The Active Order Summary also revealed an order dated 03/11/26, Change humidifier bottle Q weekly and PRN one time a day every Sunday. During an observation on 05/26/27 at 3:03pm, Resident #69 was observed lying on her bed. No respiratory distress was observed. Resident #69's O2 tubing was not connected to the trach mask. Resident #69's humidifier bottle was noted to be dated 05/18/26. During an observation and interview on 05/26/27 at 3:03pm LVN A stated she was not aware Resident #69's O2 tubing was off. LVN A was observed quickly attempting to connect O2 tubing back into trach mask. LVN A stated she was having difficulty keeping the O2 tubing connected to the trach mask. LVN A stated, I don't know why these are very hard to keep in place. After several attempts, LVN A was successful in attaching the O2 tubing into the trach mask. Once O2 tubing was back in place, LVN A was observed checking Resident #69's O2 saturation level (the percentage of red blood cells in the blood carrying oxygen). Resident #69 O2 saturation level was at 97%. LVN A stated Resident #69's O2 tubing might have disconnected when Resident #69 was repositioned but was not sure. LVN A was observed checking the O2 level on the oxygen concentrator (a medical device that delivers oxygen). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN A stated O2 level was at 4LPM. LVN A stated that the order for the O2 was supposed to be at 5LPM. LVN A was observed adjusting the level but the flow meter ball (a ball that provides a visual measurement of the oxygen being delivered) on the oxygen concentrator would not stay at 5LPM; it would drop back down to 4LPM. LVN A stated that the oxygen concentrator machine must not have been working properly. LVN A stated Resident #69 was checked every 2 hours or sooner. LVN A stated she last checked on Resident #69 at the start of her shift, which was around 2:00pm. LVN A stated it was important to continuously check on Resident #69 because she was unable to use the call light button. LVN A stated not checking on Resident #69 often could lead to not catching Resident #69 in respiratory distress. LVN A stated that she had checked the oxygen level on the oxygen concentrator machine at the start of her shift. LVN A stated she had raised the level to 5LPM and thought it had stayed there. LVN A stated she had not noticed the flow meter ball was not working properly. LVN A stated it was important for the oxygen concentrator to work properly because ensured Resident #69 was getting the correct level of oxygen to prevent going into respiratory distress or shortness of breath. LVN A stated that the concentrator machine was faulty and would be changed out. LVN A confirmed the date on the humidifier bottle was 05/18/26. LVN A stated that the humidifier bottle along with all the oxygen tubing should be changed every Sunday during the night shift. LVN A was observed looking at the dates on the oxygen tubing and all the dates indicated, 05/24/26. LVN A stated, It looks like all the tubing was changed except the humidifier bottle. LVN A stated it was important for the tubing and humidifier bottle to be changed as ordered because it prevented germs and infection.In an interview on 05/26/26 at 3:28pm CNA C stated she was the CNA for the hall where Resident #69 was in. CNA C stated she was aware Resident #69 was on continuous oxygen. CNA C stated she started her shift at 2:00pm but had not yet checked on Resident #69. CNA C stated it was important to check on residents that could not use their call lights more frequently than 2 hours because they could be in a type of distress, and no one would know. CNA C stated she had received in-services (teachings) on how to care for residents on oxygen.In an interview on 05/26/26 at 5:01pm, the DON stated that the nurses were responsible for checking that the oxygen tubing was connected properly to Resident #69. The DON stated that the nurses were to follow oxygen settings in physician's orders. The DON stated that the nurse should also have checked that the concentrator machine was also working properly. The DON confirmed that the night shift nurse on Sunday was responsible for changing the oxygen tubing along with the humidifier bottle. The DON stated it was important for the humidifier bottle to be changed because it would prevent infections and changes in care. The DON stated the nurses received training on how to care for a trach patient quarterly and annually. The DON stated the nurses were ultimately in charge of assessing residents with trachs.In an interview on 05/28/26 at 11:31am, LVN B stated he worked the night shift of Sunday, 05/24/26 and was the nurse for Resident #69. LVN B stated he was aware the humidifier bottle had to be changed. LVN B stated that when he gathered all the supplies for changing the oxygen tubing, he must have forgotten to get the humidifier bottle. LVN B stated it was important to change the humidifier bottle to prevent bacteria from building up and to prevent infection.Record review of the facility's policy titled Tracheostomy Management with a revised date of January 2023 revealed, Guidelines: 7. Assess the residents need for oxygen per physician's orders and have available bedside, setup with appropriated tubing. Record review of the facility's policy titled Oxygen Administration with a revised date of January 2023 revealed, Procedure 4. Assess the resident's condition. 5. Monitor the resident's response to oxygen therapy.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview and record review the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption for 2 (Resident #13 and Resident #43) of 4 resident refrigerators reviewed for refrigerator sanitation. The facility failed to ensure Resident #13 and Resident #43's personal refrigerator did not contain food that was not labeled, dated or expired.Resident #13's personal refrigerator had 3 small individual cups of yogurt that had no expiration date and a plastic ziploc bag with candy pieces that was not labeled or dated.Resident #43's personal refrigerator had 4 small probiotic drink bottles with no expiration date on them and 1 individual cup of yogurt that was expired.This failure could place residents who store food items in resident refrigerators, at risk of cross-contamination and food-borne illnesses if consumed.Findings included:Record review of Resident #13's admission Record dated 05/29/26 reflected a [AGE] year-old female, re-admitted on [DATE], diagnoses included Vascular Dementia Mild Without Behavioral Disturbance (cognitive impairment), Type 2 Diabetes Mellitus with Hyperglycemia (high blood sugar), Other Lack of Coordination, and Hyperkalemia (high potassium levels).Record review of Resident #13's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 indicating intact cognitive function. Section GG, - Functional Abilities and Goals, indicated Resident #13 was able to eat on her own but required assistance with setting up and cleaning up and was able to walk independently.Record review of Resident #43's admission Record dated 05/29/26 reflected a [AGE] year-old female, admitted on [DATE], diagnoses included Unspecified Systolic (Congestive) Heart Failure (heart failure), [NAME] 2 Diabetes Mellitus without Complications (high blood sugar), Muscle Weakness (Generalized), and Essential (Primary) Hypertention (high blood pressure).Record review of Resident #43's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 13 indicating intact cognitive function. Section GG, - Functional Abilities and Goals, indicated Resident #43 used a manual wheelchair and was able to eat on her own but required assistance with setting up and cleaning up.During observation and interview on 05/26/26 at 10:05 a.m. Resident #13 was observed in her room sitting upright on her bed and was alert. Resident #13 consented to have her personal refrigerator observed. Inside the refrigerator were 3 small individual cups of yogurt that had no expiration date and a plastic zip top bag that contained candy pieces that was not labeled or dated. Resident #13 said her family had brought in the items but was not able to remember when. During an interview on 05/26/26 at 4:48 p.m., CMA D said she was responsible for checking Resident #13's refrigerator temperature. She said she checked the temperature when she started her shift and logged the temperature in Resident #13's MAR. She said she was not responsible for checking for expired food. CMA D said managers were in charge of that task.During observation and interview on 05/26/26 at 3:45 p.m. Resident #43 was observed in her room lying on her bed and was alert. Resident #43 consented to have her personal refrigerator observed. Inside the refrigerator were 4 small probiotic drink bottles with no expiration date on them and 1 individual cup of yogurt with an expired date of 03/21/26. Resident #43 said her family had brought the items for her but she was not sure if it was a week ago. She said she was not able to remember exactly when they were brought. Resident #43 said staff checked her refrigerator every day but could not remember who had checked it today.During an interview on 05/26/26 at 5:20 p.m., the DON said the temperatures on residents' personal refrigerators were checked by cma's. She said managers were assigned to specific resident rooms to check refrigerators to make sure there was no expired food, food was labeled and refrigerators were (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clean. She said managers were responsible for checking every morning. She said she did not know which manager was assigned to check Resident #13 or Resident #43. The DON said that a resident could have gotten diarrhea or food poisoning if they had consumed expired food.During an interview on 05/28/26 at 4:24 p.m. the ADM said the resident refrigerators were supposed to be checked daily by the manager assigned to each resident room. He said they were training new management staff and had not assigned specific management to those rooms. He said staff were supposed to be checking them. The ADM said he didn't know if anything could have happened if Resident #13 or Resident #43 had eaten expired food but said nothing had happened. Record review of the facility's policy titled Food Storage dated 01/01/26 revealed; Policy: 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.2. Refrigerators. d. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage.