STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745049	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Alturas Nursing & Transitional Care Brownsvill	180 East Price Road Brownsville, TX 78521

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement baseline care plans that included the instructions needed to provide effective and person-centered care within 48 hours of admission for 2 of 4 residents (Resident #3 and Resident #2) reviewed for baseline care plans: 1. The facility failed to complete Resident #3's baseline care plan within 48 hours. 2. The facility failed to include in her baseline care plan that Resident #2's was admitted with a PICC line to upper right arm. These deficient practices could affect residents who receive care at the facility and could result in missed or inadequate care. The findings included: 1.Record review of Resident #3's face sheet dated 6/12/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (a progressive, irreversible brain disorder that primarily affects memory, thinking and reasoning eventually leading to difficulty with everyday tasks), dementia (a decline in cognitive function that is severe enough to interfere with daily life and activities) without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Record review of Resident #3's admission MDS dated [DATE] revealed the resident had a BIMS score of 00 which indicated severe cognitive impairment. It also revealed Resident #3 was dependent on assistance with toileting hygiene, required substantial/maximal assistance with shower/bathe self, upper and lower body dressing, putting on/taking off footwear and personal hygiene, and partial/moderate assistance with eating and oral hygiene. Record review of Resident #3's Admission/readmission assessment revealed he was admitted on [DATE] and assessed by LVN A. Record review of Resident #3's undated Comprehensive Care Plan revealed the following: (continued on next page)

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

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

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Baseline / Initial Care Plan: I may be at risk for: self-care deficit, falls, skin concerns, pain, infection & nutritional/hydration concerns and emotional distress. Date Initiated: 05/19/2025. During an interview on 6/12/25 at 9:20 a.m., LVN A stated she had performed the admission assessment on Resident #3 on 5/15/25. LVN A said when she completed an admission, she reviewed medications, received/clarified orders, completed head-to-toe assessment, completed inventory, completed Braden scale for the skin, received consents for psychotropic medications, and the look back period for the past 3 days. LVN A said she believed the RNs completed the baseline care plans, but she would have to check with the DON to ensure that it was accurate. LVN A said it is important for the baseline to be completed and accurate because if not, a resident who could be at risk for falls for example could have a fall especially if he attempted to get out of bed and staff were not aware of his fall risks. During an interview on 6/12/25 at 10:36 am, the MDS Coordinator said when the admitting nurse completed the initial admission assessment, that initial assessment triggered and created the baseline care plan. She said the baseline care plan was usually completed withing 24 hours. She said she was the only MDS staff, so she oversaw the care plans. She said at times the regional MDS and the DON helped with the care plans, so an RN usually completed the care plans. She said the LVNs don't really understood that their initial/admission assessment was the baseline care plan. The surveyor asked the MDS if Resident #3 could be at risk for falls since the baseline care plan was not added until 5/19/25, 4 days later. She said any resident was at risk of falls due to age and co-morbidities. The MDS coordinator said when she worked on the assessment, she placed a fall risk on every resident. During an interview on 6/12/25 at 4:10 pm the DON said most of the time the baseline care plan was triggered off the admission and readmission assessment. The Surveyor asked the DON if the baseline care plan was not completed within their policy time frame, could it cause a resident to fall if they were a fall risk. The DON said they tried and treated most residents as they were a fall risk. The DON said for Resident #3, his bed had always been set to the lowest position. The DON said any resident could fall. She said even after the fall risk was added on 5/19/25, the resident sustained a fall after. 2. Record review of Resident #2's admission record dated 06/12/25 reflected she was an [AGE] year-old female admitted on [DATE], an original admit date of 10/03/24 and a discharge date of 11/14/24. Her relevant diagnoses included sepsis (a life-threatening complication of an infection) , cerebral infarction (occurs when blood flow to the brain is blocked, causing brain tissue to die), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and seizures (uncontrolled jerking, loss of consciousness, blank stares, or other symptoms by abnormal activity in the brain). Record review on 060/11/25 of Resident #2's progress notes dated 10/03/24 at 3:00 p.m. authored by RN D reflected in part .Resident arrived at facility via facility .head to toe assessment done midline (PICC) to right upper arm. Record review on 06/11/25 of Resident #2's quarterly MDS assessment dated [DATE] reflected a BIMS score of 99, which indicated her cognition was severely impaired. Further review reflected that she had an IV access: central (picc line) when she had been admitted . (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 06/11/25 of Resident #2's baseline care plan dated 10/03/24, Section D: Special Care/Needs reflected an answer of no to having a PICC/Central Line/Implanted Catheter-Access Port. In an interview on 06/11/25 at 1:54 pm, LVN C said Resident #2 had been admitted with a PICC line to her right upper arm and which was required to be flushed before and after medication and the dressing to be changed/cleaned at least once a week. LVN C said if a resident had a physician's order for monitoring and flushing their PICC line, it would automatically populate on their electronic medical administration record and that was what she followed. An interview on 06/11/25 at 2:00 p.m., The MDS Coordinator said when a resident was admitted with a PICC line it needed to be included in their baseline care plan. She said Resident #2 had been admitted with a PICC line to her upper right arm on 10/03/24. She said RN D had completed the baseline care plan and had failed to answer yes to Section D, which asked if the resident had a PICC/central/implanted catheter access port. She said by answering no to that question, it did not trigger any interventions. She said there were no negative outcome to Resident #2 because Resident #2 had not started her IV therapy until 10/22/24. She said Resident #2 had a physician's order to monitor PICC line and to flush the PICC line before and after medication effective 10/22/24. The MDS Coordinator said nurse's really just look at the orders and not at the care plans. An interview on 06/11/25 at 2:35 p.m., the DON said Resident #2 had been admitted on [DATE] with a PICC line to her upper right arm. She said RN D had completed the baseline assessment which triggered off the admission and readmission assessment. She said RN D had not indicated that Resident #2's had a PICC line on her baseline assessment. The DON said Resident #2 had not sustained any negative outcome due to her baseline care plan not indicating she had a PICC line because it wasn't until 10/22/24, that Resident #2 had started on IV therapy. In a telephone interview on 06/12/25 at 12:45 p.m., RN D (former employee) said she had been the admitting nurse for Resident #2. She said she did not remember if Resident #2 had a PICC line. She said if Resident #2 did have a picc line, she should have answered yes to the question asking if resident had a picc line. She said after she completed the base line assessment the facility's MDS Coordinator should have revised it and make any corrections or additions that she might have missed. RN D said there were no negative outcome to Resident #2 baseline care plan not indicating she had a PICC line when admitted . On 6/12/25 at 4:30 pm, a baseline care plan policy was requested from the Administrator. The Administrator provided a Care Plans policy, dated February 2017 and revised January 2024, and stated they did not have a policy specific to baseline care plans. He said the Care Plans policy was the only policy they had regarding care plans. Record review of the facility's Care Plan's policy dated February 2017 and revised January 2024 reflected, . The care plan should be initiated upon admission, continued to be developed during the initial 48-72 hrs., throughout the completion of the admission comprehensive assessment.The care plan should be considered part of the medical record and should be utilized in conjunction with the complete medical record. The care plan should serve as a guide, which should direct care needs, care choices and care preferences .the care plan should serve as a guide, that identified risks, direct care needs, care choices and care preferences.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure adequate supervision was provided for 1 of 3 residents reviewed for accidents and supervision. (Resident #1) The facility failed to ensure Resident#1 received adequate supervision to prevent elopement. Resident #1 eloped from the facility on 02/12/2025 and was found by the police department approximately 2700 feet (0.5 mile) away from the facility. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 02/12/2025 and ended on 02/13/2025. The facility had corrected the noncompliance before the survey began. This failure could prevent residents from receiving appropriate supervision which could lead to residents sustaining serious injury, harm, or death. Findings included: Record Review of Resident #1's electronic facility face sheet dated 06/11/2025, revealed she was an [AGE] year-old male admitted to the facility on [DATE]. Her diagnoses included Unspecified Dementia, Hypertension (high blood pressure), Insomnia (sleep disorder in which you have trouble falling asleep), Unspecified Mood Disorder, and Hyperlipidemia (high cholesterol). Record Review of Resident #1's quarterly MDS assessment, dated 03/24/2025 revealed a BIMS score of 01 indicating Resident #1 was severely cognitive impaired and ambulated independently with a walker. Record Review of Resident #1's admission assessment dated [DATE] revealed the resident had a wandering history, and she had a wander guard in place. Record review of an incident report dated 02/13/2025, revealed on 02/12/2025 at around 9:00 p.m. the Administrator was notified by the DON, that Resident #1 had left the facility unattended and was returned to the facility without incident by the PD. The PD indicated they had located the resident around 8:19 p.m. after receiving a call from a civilian. Resident #1 was safely dropped off at the facility around 8:50 p.m. Surveillance footage revealed that the resident left from the facility at 7:00 p.m. A head-to-toe assessment was completed with no findings. Record review of LVN A's written statement on 02/12/2025 regarding Resident #1's incident indicated that she last saw Resident #1 in front of the nurse's station around 6:30 p.m.-6:40 p.m. She did not understand what the resident was asking and when asked again the resident was not able to answer. LVN A redirected Resident #1 to sit in the common area. Resident #1 walked away from nurse station as LVN A used desktop. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/11/2025 at 1:58 p.m., the DON stated she received a call from LVN A notifying her Resident #1 had returned to the facility and was brought in by the PD. She notified the Administrator. She stated that CNA B was doing her round in Resident #1's room when she realized Resident #1 was not there. She then walked out to notify the nurse and at that time LVN A had called her and told her the PD had just brought in Resident #1. She stated a head-to-toe assessment was done; no injuries were noted. The facility's secured unit was not open at that time. She stated the interventions prior to the elopement were a wander guard, redirection, and activities. The DON stated interventions after the elopement were Resident #1 was monitored every 30 minutes, the code was changed to the front door, residents were assessed for exit seeking tendencies with the need for additional personalized interventions. The DON stated that staff were trained and had drills on elopement and exit seeking management procedures. The DON stated there have been no elopements since the incident on 02/12/2025. In an interview on 06/11/2025 at 2:19 p.m., the Administrator stated the DON notified him of the incident. He reviewed the facility's surveillance cameras and was able to identify that a visitor had opened the door for Resident #1. The visitor was not aware Resident #1 was a resident, allowing her to leave the facility. The Administrator was able to identify the visitor and was called in for an interview. The visitor did confirm that she had opened the door for Resident #1 when she visited but did not know that that person was a resident. She stated that the individual had told her to hold the door open and not to close it. The Administrator educated the visitor regarding not to hold the door open for anyone and ensuring the door closes behind her anytime she was visiting. She was reminded to be aware of her surroundings and other individuals to help prevent future incidents. The Administrator also sent out a mass message via text and email, depending on families' preferred method of communication on file, to not hold the door open. Record Review of an Elopement Response & Exit Seeking Management Policy with date revised of January 2023, revealed Guideline: A. Elopement Response: Unable to locate resident: 1. If a resident is unable to be located or the alarms have sounded, immediately initiate a search of the entire community both inside and outside premises. B. Response following the location of the resident: 1. Once located and safety confirmed, conduct an assessment. Record Review of Routine Resident Care Policy with date revised of January 2024, revealed Compliance Guidelines: Care is taken to maintain resident safety at all times. Responsible Disciplines License nurses and non-licensed direct care team members. The facility had implemented the following interventions: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident was placed on a 1:1. Vitals monitored every 4 hours for 24 hours The RP and physician notified. Head count. All other residents were assessed for exit seeking tendencies with a need for additional personalized interventions. Educated visitor regarding not opening the door for anyone and being aware of her surroundings and other individuals. Staff were trained in elopement/supervision procedures on 02/12/2025. Interviews with staff revealed that they were aware of the policy and procedures of elopement. The code changed to the front door. Reminder sent out to all families regarding entering/exiting the facility. Posted sign on the front entrance reminding visitors to exercise caution when entering/exiting the community to ensure residents do not follow them out. No additional elopement events had been identified since 02/12/2025. Resident placed in the new secured care unit for increased supervision on 02/26/2025. During an observation on 06/11/2025 at 8:30 a.m. revealed a posted sign on the front entrance which reflected, Please refrain from providing assistance to anyone out of the community without checking with a team member. During an observation on 06/11/2025 at 9:16 a.m. revealed Resident #1 was sitting in a chair in her room that was located in the secured unit. She was well dressed and appeared with good personal hygiene. The resident was observed without injury. Record review of Resident #1 revealed that she was placed on a 1:1, vitals were monitored every 4 hours for 24 hours, the RP and physician were notified. Record review of Resident #1 revealed that all other residents were assessed for exit seeking tendencies with a need for additional personalized interventions. Record review of Resident #1 revealed that visitors were educated regarding not opening the door for anyone and being aware of her surroundings and other individuals. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of an in-service attendance record with topic of Elopement and subject Missing person response & Elopement/exit seeking risk & response/Identifying & responding to triggers to prevent elopement drill and procedure, dated 02/12/2025, indicated that staff signed the in-service record. Record review of Resident #1 revealed the code was changed to the front door and a reminder was sent out to all families regarding entering/exiting the facility. Record review revealed no additional elopement events had been identified since 02/12/2025. In interviews on 06/11/2025 at 10:28 a.m. - 06/12/2025 at 2:20 p.m., 4 CNAs from different shifts were able to identify residents at risk for elopement; all were knowledgeable of the elopement policy and procedure. In interviews on 06/11/2025 from 4:05 p.m. - 06/12/2025 2:40 p.m., 3 LVNs from different shifts were able to identify residents at risk for elopement, all were knowledgeable of the elopement policy and procedure. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 02/12/2025 and ended on 02/13/2025. The facility had corrected the noncompliance before the survey began.