

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Las Alturas Nursing & Transitional Care Brownsvill		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 1 (Resident # 1) of 2 residents reviewed for parenteral fluids. The facility failed to ensure on 8/15/2025 that Resident # 1's intravenous medication bag was correctly labeled with the resident's name. This failure could place residents at risk for medication error and delay in medication administration. The findings included: Record review of Resident # 1's MDS assessment, dated 8/01/2025, reflected the resident was an [AGE] year-old-resident who was admitted to the facility on [DATE]. The resident had a diagnoses which included: Atrial Fibrillation (an irregular and often rapid heart rhythm in the upper chambers of the heart, called the atria), Coronary Artery Disease (a condition where the heart's blood vessels narrow or become blocked, usually due to a buildup of plaque made of fat, cholesterol, and other substances), Hypertension (high blood pressure), Wound Infection, Diabetes Mellitus (a condition where the body cannot properly use glucose, a type of sugar, for energy), Non-Alzheimer's dementia (brain conditions that cause a decline in thinking, memory, or other cognitive abilities but are not caused by Alzheimer's disease. Resident # 1's BIMS score was 03 which indicated severe cognitive impairment. Record review of Resident # 1's physician's order dated 7/29/2025 reflected an order for Meropenem intravenous Solution Reconstituted 500 MG. Use 500 MG intravenously every 6 hours for Sacral Wound Infection for 5 weeks. Start date 7/30/2025, End date 9/02/2025. Record Review of Grievance Binder reflected Grievance/Concern Report dated 8/15/2025 Name and contact information of person expressing concern: LVN A and Family member. Department concern is related to: Nursing, Description of concern: Care concern, Other: Family member had concerns regarding medication concern. Date assigned: 8/15/25, Action Taken: 1:1 Inservice completed by DNS. Was the person expressing the concern notified of the results or concern resolution: Yes, In Person. Outcome: Person/Resident satisfied with community's response to concern. Administrator's signature and dated 8/16/25. Training/Retraining form dated 8/15/2025, Topic: 5 Rights of medication administration and Utilizing the StatSafe (automated medication management system) when medications are not available, for Employee: LVN A 2-10 shift. In a phone interview on 11/17/2025 at 4:11 PM with LVN A she said Resident # 1 was on an IV antibiotic, Meropenem. She said it was a very busy day and when she picked up the medication, she only saw the name of the medicine and the dosage but did not see the resident's name. She said that the Family member was rushing me and brought it to my attention that the resident's name was different. LVN A said that at that moment she stopped the machine and notified the DON and the physician. She said there were no new orders given by the doctor. She said she also called the pharmacy to order more medication. She said, I saw that it was the right dose and the right medication, but I didn't check the label for the name. Everybody was talking to me and asking questions. She said there was medication on hand for the resident and restarted the medication with the resident's own medication. She said the medication that was hung the first time had infused for less than five minutes. She said she had a 1:1 in-service on the 5 rights of medication administration. She said not following the 5 rights can cause a resident to have reaction and depending on the medication, could worsen an infection or could cause an interaction and have consequences. In an interview on 11/18/2025 2:10 PM with the DNS said, she received a phone call from LVN A at 3 AM that she had an issue grabbing the wrong IV. The DNS said she spoke to the family the following day and informed them that there was no harm to the resident as it was the same medication and dosage. She said she informed the family of the plan of correction regarding the incident, and they agreed. The DNS said she had a 1:1 in-service on the 5 rights of medication administration and what to do if medication is not available. She said she also informed the NP, and no new orders were given. The DNS said she held an in-service on medication administration in July for all staff and in-service on medication administration was done in September. She said by not following the 5 rights of medication administration would be based on a case-by-case scenario, and in this case, there was no potential harm to the resident because it was the same medication. She said LVN A is a good nurse and compassionate, there have been no customer complaints about her. The DNS said she frequently provides re-education on medication administration and reminders on the 5 rights of medication administration (The five fundamental rights are simple checks healthcare providers use to ensure patient safety, making sure you're giving the right person, right medicine, right amount, right method, and right time) to the staff. Record review of Training/Retraining</p>		