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	07/01/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preference for 2 (Resident #34 and Resident #60) of 25 residents reviewed for call lights. The facility failed to ensure Resident #34 and Resident #60 had the call light within reach while in bed in their room. This failure could place residents at risk of being unable to obtain assistance or help when needed and in the event of an emergency. Findings were: 1.Record review of Resident #34's admission record dated 06/29/25 reflected a [AGE] year-old male with diagnoses of Unspecified Dementia (decline in thinking, learning and reasoning), Muscle Wasting And Atrophy Multiple Sites, Need for assistance with personal care, Difficulty in Walking. Record Review of Resident #34's Annual MDS dated [DATE] reflected a BIMS score of 14 indicating no cognitive impairment. Resident #34 used a wheelchair. 2. Record review of Resident #60's admission record dated 06/29/25 reflected a [AGE] year-old male with diagnoses of Unspecified Dementia (decline in thinking, learning and reasoning), Muscle weakness, Need for assistance with personal care, Difficulty in Walking and History of falling. Record Review of Resident #60's Annual MDS dated [DATE] reflected a BIMS score of 9 indicating moderate cognitive impairment. Resident #34 used a wheelchair. During an observation and interview on 6/29/25 at 10:25 a.m. revealed Resident #34's and Resident #60's call light devices were on the floor, and Resident #34 and Resident #60 were not able to reach them. Resident #34 and Resident #60 said that they were not able to reach the call light. During an interview on 6/29/25 at 10:30 a.m. LVN B observed Resident #34's and Resident #60's call light devices were on the floor, and Resident #34 [and Resident #60 were not able to reach them. LVN B said Resident #34 and Resident #60 were supposed to have their call lights near so residents can call for help if they need to. LVN B said Resident #34 and Resident #60 usually used the call light on and off. LVN B said she checks all residents to make sure their call lights are within reach, and they are not in need of any other assistance. She said she does this at the beginning when she first begins working and throughout her shift. LVN B said a negative outcome of not having the call light within reach was that Residents could fall and Residents could not be able to call for help. During an interview on 6/29/25 at 11:35 a.m. LVN A said that Resident #34 and Resident #60 usually used the call light when they needed something. She said she always makes sure residents had it within their reach and reminds them to use it. LVN A said that if a resident cannot reach the call light, then they cannot get help, they may have a fall and be at risk of getting hurt. During an interview on 7/1/25 at 11:00 a.m. the DON said that if call lights were not within reach, residents might need help. The DON said that she did not think there was a negative outcome due to residents were able to get up by themselves. Record review of facility's policy titled Routine Resident Care with date implemented: 3/14/19 stated; Policy: Residents should receive the necessary assistance to maintain good grooming, personal/oral hygiene and safety. Steps are taken to provide that a resident's capacity for self-performance of these activities does not diminish unless circumstances of the resident's clinical condition demonstrate the decline is unavoidable. Care is taken to maintain resident safety at all times.Guidelines: 9. resident call lights should be answered timely and resident requests are addressed, if permitted. Call lights should be placed within easy reach of the resident. Specific types of call lights, i.e. call light pads etc. should be added to the resident plan of care based upon residents abilities and limitations.

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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. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to formulate an advance directive for 1 (Resident #173) of 8 residents reviewed for Advance Directives. The facility failed to ensure Resident #173's OOH-DNR was completed. The OOH-DNR form did not have the physician's signature. 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 #173's electronic face sheet dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: Respiratory Failure, Metabolic Encephalopathy (any disease or disorder of the brain, characterized by changes in brain function or structure), Heart Failure, Chronic Obstructive Pulmonary Disease (a chronic lung disease that causes air flow limitation), Type 2 Diabetes Mellitus, Hypertension (high blood pressure), Acute Kidney Failure.Resident #173's electronic face sheet reflected Code Status: DNR. Record review of Resident #173's MDS assessment dated [DATE] reflected he scored a 0 on his BIMS which reflected he was severely cognitively impaired. Record review of Resident #173's undated comprehensive care plan reflected, Resident #173's Advanced Directives: Code Status: (DNR) Do Not Resuscitate Date Initiated: [DATE]. Honor my Advance Directives, care wishes, and Code Status will be respected and honored as indicated. Date Initiated: [DATE]. Refer to Social Services as indicated. Date Initiated: [DATE]. Record review of Resident #173's physician order dated [DATE] reflected ***Code Status: ***DNR*** Record review of Resident #173's OOH-DNR form dated [DATE] 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: spouse. The OOH-DNR revealed the form was not signed 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. In an interview on [DATE] at 11:15 a.m., Social Services stated that she was the one responsible for completing the OOH DNR form. She stated that upon admission, she informed the resident and/or family of their rights regarding the DNR status. If it was confirmed for the resident to be DNR, she provided them with the form, and obtained their signatures, and the doctor's signature. She stated that the OOH DNR form should be signed by the doctor as soon as possible. She called the doctor's office to notify her of needing a signature. She stated that it was important for the OOH DNR form to be signed by the doctor because it made the document official, a legal document that all parties signed. The Social Services stated the DNR was not official until the doctor signed it. She stated Resident #173's OOH DNR form was not signed because his doctor's NP had not come to the facility yet. In an interview on [DATE] at 1:05 p.m., LVN A stated that the DNR form was discussed upon admission. She stated residents who were DNR should have a completed and signed by all parties, the OOH DNR. She stated all parties were residents or family, witnesses, and the doctor. LVN A stated that until they have a completed signed OOH DNR, the resident was considered a full code (provide cardiopulmonary resuscitation) . They would have to provide CPR causing the resident harm. She stated that the DNR status of a resident was located on PCC (it serves as an electronic health record system). LVN A stated if it showed DNR on PCC that meant the OOH DNR form had been verified and completed. In an interview on [DATE] at 1:35 p.m., the DON stated that the social worker was responsible for completing the OOH DNR form. She stated the facility explains the document and if they say yes that they want to be DNR, the facility would obtain the resident/RP and witnesses signatures. They then called the MD for an order and changed the DNR status in PCC. The DON stated that it was important for the MD to sign the OOH DNR form to verify that they agreed to the process. She stated that it was an official legal form. She stated that they got the MD signature fast. Record review of the facility's Advance Directives policy date reviewed/revised 2017, 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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to send a copy of the residents' discharge notice, prior to discharge, to the representative of the Office of State Long-Term Care (LTC) Ombudsman of the residents' transfer or discharge and the reasons for the move for 2 of 3 (Resident #1, Resident #41) reviewed for notifying the LTC Ombudsman of the residents' discharge. 1.Resident #1 was discharged to the hospital on [DATE] without a notice to the LTC state ombudsman. 2.Resident #41 was discharged home on [DATE] without a notice to the LTC state ombudsman. These failures could place residents at risk of not knowing their rights and receiving the services of the state LTC Ombudsman. Findings were: 1. Record review of Resident #1’s admission record dated 07/01/25 revealed Resident #1 was a [AGE] year-old female with diagnoses of Acute Respiratory Failure with Hypoxia (lungs cannot supply oxygen to blood), Type 2 Diabetes Mellitus without Complications (high blood sugar levels), Chronic Obstructive Pulmonary Disease (lung disease that causes obstructed airflow from lungs), Essential (Primary) Hypertension (high blood pressure), Shortness of Breath, Muscle Weakness (Generalized). Record review of Resident #1’s latest MDS dated [DATE] revealed a BIM score of 13 indicating intact cognition. Record review of Resident #1’s electronic medical record revealed a progress note dated 04/09/25 stating Resident #1 had been discharged to the hospital. Record review of Resident #1’s electronic medical record from 03/29/25 to 04/09/25 revealed no evidence of notice given to the LTC Ombudsman pertaining to Resident #1’s discharge to the hospital. 2.Record review of Resident #41's electronic face sheet dated 07/01/2025 reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with a discharge date of 06/11/2025. His diagnoses included Chronic Obstructive Pulmonary Disease (a sudden worsening in a chronic lung disease that causes air flow limitation), Peripheral Vascular Disease (reduced circulation of blood to a body part, other than the brain or heart), Acute Respiratory Failure with Hypoxia (a condition where you don’t have enough oxygen in your body), Dementia, Hypertension (high blood pressure), Gastrostomy Status (a surgical procedure used to insert a tube through the abdomen and into the stomach), Dysphagia (difficulty swallowing), Anxiety Disorder. Record review of Resident #41’s comprehensive MDS dated [DATE] revealed a BIMS score of 13 indicating intact cognition. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #41’s electronic medical record revealed a progress note dated 06/11/2025 stating Resident #41 had been discharged home with family. Record review of Resident #41’s electronic medical record from 06/02/2025 to 06/13/2025 revealed no evidence of notice given to the LTC Ombudsman pertaining to Resident #41’s discharge home. During an interview on 07/01/25 at 4:43 p.m. the SSD said she had been working at the facility for a year. She said she wasn’t aware that she needed to notify the ombudsman whenever a resident was discharged from the facility. She said she had not notified the ombudsman of any residents that had been discharged since she has been working at the facility. During an interview on 07/01/25 at 11:03 a.m. the state LTC Ombudsman representative for the facility stated he had not received any discharge notices from the facility for the past year. During an interview on 07/01/25 at 4:55 p.m. the Administrator, said he had contacted the ombudsman on recent discharges for the current month. Record review of the facility’s policy titled “Admission, transfer, and Discharge”, date revised: September 2022 stated: “Notification before transfer Before a transfer or discharge occurs, the community notifies the resident and, if known, the family member, surrogate, or representative of the transfer and the reasons for it. A copy or documentation of the notice is kept in the clinical record and a copy is sent to a representative of the Office of the State Long Term Care Ombudsman.”

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate assessments with the Pre-admission Screening and Resident Review (PASRR) program to the maximum extent practicable to avoid duplicative testing and effort for 2 of 8 residents reviewed for PASRR. (Resident #20, Resident #22)1. The facility failed to refer Resident #20 for PASRR Level II assessment when the facility incorrectly coded her PASRR Level I assessment.2. The facility failed to refer Resident #22 for PASRR review following new mental illness diagnosis of Major Depressive Disorder, added on 04/30/2025.These failures could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs.Findings include:1. Record review of face sheet dated 06/30/25 indicated Resident #20 was a [AGE] year-old male admitted on [DATE]. His diagnoses included post-traumatic stress disorder, need for assistance with personal care, cognitive communication deficit.Resident #20's admission Minimum Data Set (MDS) assessment dated [DATE] indicated her Brief Interview for Mental Status (BIMS) score was 8 out of 15 showing moderate cognitive impairment. She was coded as having post-traumatic stress disorder. Observation and interview with Resident #20 on 06/29/25 at 2:28 PM, indicated he was lying in bed watching television.During an interview on 06/30/25 at 9:15 a.m., MDS D said she completed the PASRR assessments for the facility. When MDS D was asked if bipolar disorder was a qualifying diagnosis for a positive PASRR Level 1, she stated, yes. MDS D said that she missed the diagnosis for this resident. MDS there was not a negative outcome because she submitted the form 1012 for the resident to be evaluated on 6/30/25 after surveyor asked for PASRR Level 2.During an interview on 7/1/25 at 11:40 a.m. with the Director of Nursing (DON) confirmed post-traumatic stress disorder was a qualifying diagnosis for PASRR and there should have been a Level 2 evaluation conducted. The DON said the MDS nurse should not have entered it in as negative and should have requested the Level 1 be recompleted. The DON said that PASRR was just extra help that the resident could benefit from. The DON said that the negative outcome was that the resident was not receiving the extra help.2. Record review of Resident #22's electronic face sheet dated 06/30/2025 reflected the resident was an [AGE] year-old female admitted to the facility on [DATE] and with an original admission date of 10/08/2024. Her diagnoses included Major Depressive Disorder, Metabolic Encephalopathy (any disease or disorder of the brain, characterized by changes in brain function or structure), Acute Respiratory Failure with Hypoxia (a low level of oxygen in the blood), Type 2 Diabetes Mellitus, Heart Failure, Muscle Wasting and Atrophy (the decrease in size and wasting of muscle tissue), and Hypertension (high blood pressure).Record review of Resident #22's quarterly MDS assessment dated completed on 04/18/2025, Section C, revealed a BIMS score of 14, indicating intact cognition. Section I (Active Diagnoses) indicated Resident #22 had diagnoses included Depression (other than bipolar). Section N (Medications) indicated Resident #22 was on antidepressant medications.Record review of Resident #22's comprehensive care plan, dated 05/22/2025, reflected Resident #22 requires antidepressant medication. Interventions: administer medication per MD orders, educate me and/or my family regarding all potential side effects, and risks associated with psychotropic medications and obtain consent for medication use, Monitor for target behaviors/symptoms, monitor/document/report to MD prn ongoing s/s of depression unaltered by antidepressant meds .In an interview on 06/30/2025 at 3:43 p.m. with MDS D, she was responsible for completing the PASRR assessments for the facility. She confirmed Resident #22 had a diagnosis of Major Depressive Disorder and was a qualifying diagnosis for PASRR Level 1. She stated that she submitted form 1012 for Resident #22. She stated she spoke to a staff member from LIDDA this morning and was informed that they would notify her of when they can come to get it done. MDS D stated that it was important for the PASARR level 1 screening to be completed so they can get the LIDDA to do the evaluation to see if they were a true positive.In an interview on 07/01/2025 at 1:35 p.m. with the DON stated, the MDS D nurse was responsible for completing the PASSR assessments. She stated that Major Depressive Disorder was a qualifying diagnosis for PASRR. The DON stated that she was not aware that Resident #22 had a new diagnosis of Major Depressive Disorder. She stated that it was important for the residents to be screened again with new added diagnosis because they can render services if, they were positive.Record review of facility policy titled comprehensive assessments with an implemented date February 2017 and a revised date January 2014 reflected: Pre-admission screening and resident review (PASRR) screen was required of all individuals with mental illness or mental retardation regardless of the applicant ' s source of payment. These

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment for 1 of 22 residents (Resident #20) reviewed for care plans. The facility did not develop Resident #20's care plan related to diagnosis Post-Traumatic Stress Disorder. These failures could place residents at risk for unmet care needs and decreased quality of care. Findings included: Record review of face sheet dated 06/30/25 indicated Resident #20 was a [AGE] year-old male admitted on [DATE]. His diagnoses included post-traumatic stress disorder, need for assistance with personal care, cognitive communication deficit. Record review of Resident #20's admission MDS assessment dated [DATE] indicated his BIMS score was 8 out of 15 showing moderate cognitive impairment. He was coded as having post-traumatic stress disorder. Observation and interview with Resident #20 on 06/29/25 at 2:28 PM, indicated he was lying in bed watching television. Resident #20 said that he felt safe in this facility, and he was treated with respect and dignity. Record review of Resident #20's care plan, initiated on 5/25/2025, indicated Resident #20 did not have Post traumatic stress disorder in the care plan. During an interview on 6/30/25 at 1:40 p.m., MDS D said it was important to have Post traumatic stress disorder in the care plan to communicate with the floor nurses. MDS D said she was not sure what was the negative outcome because the resident was stable. MDS D said that she was not aware that Resident #20 had PTSD. During an interview on 7/1/25 at 2:30 p.m. the DON said she was not sure if post-traumatic stress disorder was supposed to be care planned. The DON said that staff followed the care plan. The DON said that the negative outcome was not giving the proper care to Resident #20. Record review of the facility's policy titled Care Plans implemented 02/2017, indicated, The community develops a comprehensive care plan for each resident that includes measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan should be reflective of the identified problem or risk, a measurable outcome objective and appropriate intervention in relation to the identified problem or risk, outcome objective and resident's ability, needs, medical condition, preventative measures. The care plan may also include the expressed preferences. The care plan in conjunction with the plan of care throughout the medical record is developed and or recommended to attain or maintain the resident's highest practicable physical mental, and psychosocial well-being.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 5 residents (Resident #29) reviewed for tube feeding management. The facility failed to ensure there were labels or instructions on Resident #29' s enteral nutrition supplemental feeding bottle on 06/29/25. These failures could place residents at risk for non-therapeutic responses to enteral feeding, as well as receiving the wrong feeding or receiving a feeding at the wrong rate. Findings included: Record review of Resident #29's face sheet, dated 06/29/25, revealed a [AGE] year-old female with an original admission date of 08/20/24 and a current admission date of 12/25/24. Diagnoses included Gastrostomy Status (a surgical procedure that creates an opening into the stomach, allowing for access to the stomach for feeding). Record review of Resident #29's Significant Change MDS Assessment, dated 03/26/25, revealed a BIMS score of 1 as the resident was severely cognitively impaired. The MDS assessment also revealed Resident #29 had a feeding tube. Record review of Resident #29's care plan, initiated 08/20/24 and revised 6/25/25, revealed a care plan for tube feeding with a goal I will not experience any complication associated with my feeding tube or enteral nutrition/hydration through my next review date. Record review of Resident #29's physician orders, dated 06/29/25, revealed an order for Nepro (therapeutic nutrition) at 1.8 milliliters per hour for 18 hours via G-tube stationary pump. During an observation on 06/29/25 at 11:50 a.m. it was revealed Resident #29's enteral feeding bottle was not labeled, and there was no label on the ground. In an interview on 06/29/25 at 11:55 a.m. with LVN B, she stated the feeding bags were supposed to be labeled with the resident's name, the feeding type, the feeding rate, and the time and date the feeding was initiated. She stated sometimes the labels fell off because they did not stick very well. She stated if this information was not listed, then the nurse would not be able to verify if the feeding was correct, and this could cause the resident harm. In an interview on 07/01/25 at 10:45 a.m. with LVN C, she stated the feeding bottles should always be labeled so the nurses were aware the resident was receiving the correct feeding at the correct rate. She stated the bottle could not be checked with another nurse or verified against the order without a proper label on it, and this could cause the resident harm or the resident could not get the proper nutrition. In an interview on 07/01/25 at 11:35 a.m. with the DON, she stated the labels needed to be on the enteral feeding bottles so that nurses were aware the resident received the correct feeding because if it was not labeled appropriately, a resident could receive the wrong feeding., She said there was not a negative outcome but nurses needed to know when the feeding bottle was opened. Record review of the facility policy titled Medication Administration via Enteral Tube implemented on 3/15/19 stated the following: to administer medications through a enteral tube in an accurate, safe, timely and sanitary manner.

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	07/01/2025

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 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 such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 3 (Resident #61) residents reviewed for respiratory care. 1. The facility failed to ensure Resident #61's oxygen was administered at the correct setting of 2 liters per minute on 06/29/2025 as ordered by the physician. These deficient practices could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care. The findings included: 1.Record review of Resident #61's admission record dated 06/29/2025 reflected a [AGE] year-old female with an admission date of 01/16/2025. Pertinent diagnoses included Pulmonary Fibrosis (a lung disease characterized by the scarring and thickening of lung tissue, specifically the interstitium, which is the area between the air sacs), Muscle weakness, shortness of breath, and Need for assistance with personal care. Record review of Resident #61's person-centered care plan, initiated date 1/16/2025 reflected Resident #61 used oxygen therapy related to shortness of breath. Intervention included oxygen settings: Provide oxygen as ordered/recommended by my physician. Record review of Resident #61's physician order dated 06/29/2025, revealed oxygen at 2 liters per minute via nasal cannula every shift. Record review of Resident #61's Quarterly MDS assessment, dated 03/15/2025 revealed oxygen therapy while a resident. During an observation of Resident #61 on 06/29/2025 at 11:15 a.m. the oxygen level on the oxygen concentration machine was at 1.5Liters Per Minute via nasal cannula. Observed Resident #61 in bed with the head of the bed slightly elevated. No signs of respiratory distress were noted. In an interview on 06/29/2025 at 11:20 a.m. LVN B, stated she was the nurse for Resident #61. LVN B agreed that the Oxygen setting was set at 1.5 Liters Per Minute. She stated the oxygen setting was supposed to be at 2 Liters Per Minute per physician orders. She stated that she checked the settings at the beginning of her shift. She was not sure who might have moved it. LVN B stated that she checked Resident #61's oxygen tubing and saturation this morning. She stated that she usually checks the oxygen once a day and as needed. LVN B stated that the negative outcome to keeping Resident# 61's oxygen setting at 1.5 Liters Per Minute was that the resident could go into respiratory distress or her oxygen level might drop. In an interview on 07/1/2025 at 10:45 a.m. with the DON, she stated that the nurses assigned to that hall were responsible for checking the Oxygen settings. She stated that the nurses were to check the setting once per shift. The DON stated they were to follow oxygen settings on physician orders. The DON stated that the negative outcome could be the resident could have a respiratory distress and hypoxia (low oxygen levels). Record review of the facility policy named Oxygen Administration with an implemented date 2/14/19 and revised date January 2023, revealed: 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.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, 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 1 of 4 Residents (Resident #39) that were observed for infection control in that: The facility failed to ensure CNA E performed proper hand hygiene during pericare (incontinent care) for Resident #39.The facility failed to ensure CNA F performed proper Foley catheter care for Resident #39. These deficient practices could place residents at risk for infections, healthcare associated cross contamination, and the spread of infection. Findings included: Record review of Resident #39's electronic face sheet dated 07/01/2025 reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Personal History of Urinary Tract Infections, Acute Kidney Failure, Unspecified Hydronephrosis (a condition that occurs when a kidney swells and cannot get rid of urine), Obstructive and Reflux Uropathy (a condition in which the flow of urine was blocked), Type 2 Diabetes Mellitus, Unspecified Dementia. Record review of Resident #39's quarterly MDS assessment, dated 04/18/2025, reflected a BIMS score of 00, indicating Resident #39 was severely cognitively impaired. Resident #39 had an indwelling foley catheter. Record review of Resident #39's comprehensive person-centered care plan, dated on 05/22/2025 reflected Focus Resident #39 at risk for infection or recurrent/chronic infection r/t compromised medical condition: Foley Catheter. Interventions: Report changes in condition to MD as clinically indicated. Monitor vital signs as indicated. Enhanced Barrier Precautions practices as clinically indicated. Observation on 06/30/2025 at 1:38 p.m. revealed CNA E grabbed the bed remote, while wearing gloves, to adjust the height of the bed to working level and with the same pair of gloves she proceeded to touch the clean wipe. CNA E handed the wipe to CNA F and used it to clean Resident #39's inner thigh. Throughout the entire pericare process, CNA E handed the clean wipes to CNA F with the same pair of dirty gloves that touched the bed remote. During catheter care, CNA F cleansed the catheter tubing line going upwards towards the vaginal opening instead of downwards. In an interview on 06/30/2025 at 1:55 p.m., CNA E stated that she should have changed her gloves and sanitized after touching the bed remote. She stated that she did not change them due to being nervous. CNA E stated the potential negative outcome was infection. She stated that they were to clean the foley catheter tube downward, away from the vaginal opening to prevent infection. CNA E stated that pericare and foley catheter care skill checks off were done about a month ago and skills were met. She stated infection control in-services were done frequently, but she could not remember the exact date that it was done. In an interview on 06/30/2025 at 2:02 p.m., CNA F stated that she cleansed the foley catheter tubing upward towards the vaginal opening instead of downward. She made this error because she got nervous and was standing on the opposite side of the bed so that threw her off. CNA F stated that proper cleansing of the foley catheter tubing was to prevent infection. She stated that CNA E should have changed her gloves after touching the bed remote to prevent infection. CNA F stated that pericare and foley catheter care skill checks off were done randomly and skills were met. She stated infection control in services were done monthly. In an interview on 07/01/2025 at 1:35 p.m., the DON stated CNA E should have changed her gloves prior to touching the clean wipes. This was important to prevent germs from spreading onto the wipes. The DON stated the proper way to cleanse foley catheter tubing was to start from the vaginal opening and go downwards. This was important to keep infections away from the site. The DON stated that they have monthly infection control in-services. She stated that they conduct sporadic skill check offs. Record review of CNA E's Competency Skills Checklist dated 06/09/2025 reflected skills for Pericare and Foley Catheter Care for both males and females were all met in accordance with the facility's standard of practice. Record review of CNA F's Competency Skills Checklist dated 02/11/2025 reflected skills for Pericare and Foley Catheter Care for both males and females were all met in accordance with the facility's standard of practice. Record review of the facility's Infection Prevention and Control Program Policy date revised 04/2024 reflected: Compliance Guidelines: 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 the infection prevention and control program consist of coordination/oversight, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. Prevention of Infection:Important facets of infection prevention include:(3) educating staff and ensuring that they adhere to