STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676465	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Alturas Nursing & Transitional Care	4301 North Bartlett Avenue Laredo, TX 78041

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 51216 Based on observation, interview, and record review the facility failed to ensure resident environments remained free of hazards for four (602, 608, 610, 616) of 10 resident rooms in the 600 hall reviewed for environmental hazards. The facility failed to keep spray bottles with a yellow cleaning solution locked while not in use. This deficient practice could place residents at risk of an unsafe environment. The findings included: Record review of Resident #92's face sheet dated 11/19/24 revealed she was a [AGE] year-old female admitted [DATE] with a diagnosis of Dementia. During an observation on 11/19/24 at 8:41 AM, revealed in room [ROOM NUMBER] in the 600 hall, there was a spray bottle with a yellow cleaning solution labeled Halt Disinfectant, Cleaner, Deodorizer with approximately 3/4 full, was found out in the open on the floor next to the toilet. On 11/19/24 at 8:42 AM, Resident #92 was attemped to be interviewed however, she was not interviewable. Record review of Resident #386's face sheet dated 11/19/24 revealed he was a [AGE] year-old admitted [DATE] with a diagnosis of Dementia. During an observation on 11/19/24 at 8:45 AM, revealed in room [ROOM NUMBER] in the 600 hall, there was a full spray bottle with a yellow cleaning solution labeled Halt Disinfectant, Cleaner, Deodorizer was found out in the open on the counter next to the bathroom sink. On 11/19/24 at 8:46 AM, Resident #386 was attemped to be interviewed however, he was not interviewable. Record review of Resident #388's face sheet dated 11/19/24 revealed she was a [AGE] year-old admitted [DATE] with a diagnosis of Dementia (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/19/24 at 8:53 AM, revealed in room [ROOM NUMBER] in the 600 hall, a spray bottle with a yellow cleaning solution labeled Halt disinfectant, Cleaner, Deodorizer was found out in the open on the counter in front of Resident #388's bed. On 11/19/24 at 8:42 AM, Resident #388 was attemped to be interviewed however, she was not interviewable. Record review of Resident #391's face sheet dated 11/19/24 revealed she was a [AGE] year-old admiitted 11/06/24 with a diagnosis of Dementia During an observation on 11/19/24 at 8:53 AM, in room [ROOM NUMBER] in the 600 hall, there was a spray bottle, approximately 3/4's full, with a yellow solution labeled Super HDQ L10 Cleanser/Disinfectant/Detergent/Fundicide that was found out in the open on the counter in the bathroom. On 11/19/24 at 8:42 AM, Resident #391 was attempted to be interviewed however, she was not interviewable. In an interview with LVN F on 11/18/24 at 03:45 PM, he stated that the spray bottles were for disinfecting purposes used by the facility staff when needed. LVN F said there was a risk that a resident could get poisoned if drank, eye irritation or blindness if the chemical was swollowed or spilled. In an interview with the housekeeping supervisor, HSKS, on 11/19/24 at 4:14PM, she stated the contents inside the spray bottles were used for disinfecting. The HSKS stated if ingested it could be harmful. The HSKS then stated that the Administrator asked for the spray bottles were to be available to staff. All other chemicals used to clean are locked in the housekeeping carts. In an interview with the DON on 11/20/24 at 04:08 PM, he stated all 4 spray bottles filled with disinfectant were removed immediately from the resident bathrooms that contained them. The DON stated the liquid in the bottles was used mainly for disinfecting beds, not a general disinfectant for all items. The DON said the bottles were stored in the bathrooms for a couple of weeks. He stated the spray bottles were stored in the bathrooms only the in 600 hall which was used for new admissions. The DON stated it depended if the resident had risky behaviors and dementia, they would not leave anything close to the resident that would pose a risk to him or her. The DON stated The disinfectant could cause harm to the resident if it was ingested. I do not think there are any residents in the facility currently that would ingest or spray the disinfectant inappropriately. In an interview with Administrator on 11/20/24 at 04:30 PM he stated he was unaware there were spray bottles in the bathrooms. He stated that every single one was removed from bathrooms to his knowledge. He stated the spray bottles were normally stored in a storage closet in the housekeeping closet secured. The DON stated a person with a mental condition could get harmed if they got a hold of the spray bottle and potentially ingested it or came in contact with eyes or skin. Record review of the facility's Cleaning and Disinfection of Resident Care Items and Equipment Policy and Procedure revised January 2023 revealed the policy did not include a procedure to store disinfecting products.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50039 Based on observation, interviews, and record reviews the facility failed to review the resident ' s total program of care, including medications and treatments, at each visit for 1 of 8 residents (Resident #50) reviewed for resident records. The facility failed to ensure the physician's order was accurate and appropriate for Resident #50's levothyroxine order. The levothyroxine was ordered for 1:00 PM, when professional standards and practices for that medication indicated it should be given early in the morning before breakfast. This failure could place residents at risk for incorrect treatment decisions, evaluation, and plans compromising patient safety due to ineffective levels of thyroid hormone. The findings included: Record review of Resident #50's face sheet dated 11/21/24 reflected an [AGE] year-old female with an admitted [DATE]. Pertinent diagnoses included Acute Kidney Failure and dysphagia (difficulty swallowing). Record review of Resident #50's Quarterly MDS assessment section C, cognitive patterns, dated 11/05/24 reflected a BIMS score of 15 (no cognitive impairment). Record review of Resident #50's care plan revealed the problem I have a feeding tube in place r/t dysphagia initiated on 02/11/24 and revised on 11/11/24. Interventions listed to treat the problem revealed the following: Enhanced barrier precautions when in contact with feeding tube initiated on 11/18/24. HOB should be elevated when in bed, avoid flat while providing water flushes initiated on 02/11/24 and revised on 11/11/24. Provide local care to G-Tube site as ordered and monitor for s/sx of infection initiated on 02/11/24. RD to evaluate as indicated initiated on 11/11/24. Report to MD all abnormal findings as indicated initiated on 11/11/24. Further record review of Resident #50's care plan revealed the problem I have chronic health conditions & co-morbid conditions that have affected my physical function and may further affect my quality of life. Heart Disease, Thyroid Disorder initiated on 02/11/24 and revised on 11/11/24. Interventions listed to treat the problem revealed the following: Refer to skilled therapy services for strengthening, mobility as well as oxygen conservation techniques as indicated initiated on 02/11/24. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer my medications, treatments, respiratory treatments/therapy and diet as recommend by physician. Provide care as tolerated and needed initiated on 11/11/24. Labs as ordered & report abnormal findings to MD as indicated initiated on 11/11/24. Monitor my vital signs & weights as indicated initiated on 11/11/24. Report all changes in condition to doctor and resident representative as indicated initiated on 11/11/24. Notify MD PRN any s/sx of complications of extremities: coldness of extremity, pallor [pale appearance], rubor [redness of the skin], cyanosis [shortage of oxygen in the blood] and pain initiated on 11/11/24. Observe MD PRN and s/sx of hypotension: dizziness, fainting, syncope [fainting or passing out], blurred vision, lack of concentration, nausea, fatigue, cold clammy pale skin initiated on 11/11/24. Record review of Resident #50's order summary revealed an active order dated 02/29/24 for Levothyroxine Sodium Oral Tablet 50 MCG, Give 1 tablet by mouth one time a day for Hypothyroidism signed by MD on 03/01/24. Further review of Resident #50's order summary revealed an active order dated 05/09/24 for Regular diet, Regular Texture texture [sic], Thin/Regular consistency. Record review of progress notes for Resident #50 revealed a progress note dated 02/29/24 from Therapy that reflected ST note: Diet recommendation: puree/thin with *assisted dining* for all meals. Med pass: crushed medications PO. Further review of progress notes for Resident #50 revealed a progress note dated 02/29/24 from Nursing that reflected received recommendation from ST for pureed texture meals with thin liquids, meds crushed, MD notified, approved recommendation, orders carried through, RP, DON notified. Record review of Resident #50's MAR dated 11/21/24 revealed Levothyroxine Sodium Oral Tablet 50 MCG was administered to the resident every day in March 2024 at 1:00 PM. Record review of Resident #50's MAR dated 11/21/24 revealed Levothyroxine Sodium Oral Tablet 50 MCG was administered to the resident every day in November 2024 up to 11/20/24 at 1:00 PM. Record review of Resident #50's laboratory results dated [DATE] revealed a TSH of 74.50 mIU/mL (TSH is thyroid stimulating hormone produced in the pituitary gland. TSH signals to the thyroid to produce more T3, or thyroxine, and T4, triiodothyronine. An elevated TSH indicates hypothyroidism, or and underactive thyroid). Review of the ranges listed on the laboratory results for TSH revealed the normal range to be 0.47 - 4.68 mIU/mL. During an observation of Resident #50 on 11/21/24 at 1:49 PM revealed the resident was administered Levothyroxine Sodium Oral Tablet 50 MCG by MA B. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with MA B on 11/21/24 at 1:55 PM, MA B stated Resident #50 had received levothyroxine after lunch for as long as she could remember. MA B stated it was unusual, since every other resident that received levothyroxine always received it in the morning before breakfast. During an interview with the DON on 11/21/24 at 2:44 PM, the DON stated he had already spoken to the MD about the levothyroxine administered after lunch, and the MD had approved a new order to move it to be given at sunrise starting 11/22/24. The DON stated Resident #50 had not shown any symptoms of hypothyroidism since her admission at the facility. The DON stated Resident #50 received her medications via G-tube when she first arrived at the facility. The DON stated she received levothyroxine at 1:00 PM when she first arrived because that was her fasting time between receiving her feeding formula. The DON stated once she was able to eat a little, the levothyroxine was switched to be taken by mouth. The DON stated the timing of the levothyroxine order did not change. The DON stated levothyroxine was typically given in the morning before breakfast to best help with its absorption into the body. The DON stated that it was best practice to receive levothyroxine in the morning, but that given Resident #50's clinical picture, he could not say if the timing of the medication resulted in Resident #50's elevated TSH. During an interview with the MD on 11/21/24 at 3:19 PM, the MD stated the best time to take levothyroxine was 30 to 45 minutes before the first meal of the day. The MD stated the reason the medication should be taken at that time was because that was the best time for the medication to be absorbed into the body. The MD stated if there was a resident that was switching from taking meds and eating via G-tube to by mouth, he would move the levothyroxine timing to 30-45 minutes before the first meal of the day. The MD stated a lack of good absorption of levothyroxine into the body could result in weight gain and slowed movements. The MD stated he had not noticed any clinical sign or changes in Resident #50 demonstrating hypothyroidism. Record review of the facility policy titled Physician Services: Medical Director implemented on 02/17 and revised on 01/23 revealed the following: The medical director's responsibilities include but are not limited to: Directing and coordinating medical care in the organization; Participating in establishing policies, procedures, and guidelines designed to ensure the provision of adequate, comprehensive services; The medical director has administrative authority, responsibility, and accountability for the functions and activities of the medical staff at the community.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on observation, 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 each resident for 1 (Resident # 88) of 6 residents reviewed for pharmacy services. 1. The facility failed to ensure that MA A accurately documented Resident #88's blood pressure when administering or holding Resident #88's blood pressure increasing medication. 2. The facility failed to ensure that MA A did not administer Resident #88's blood pressure increasing medication when Resident #88's blood pressure was outside of administration parameters or when MA A did not document a blood pressure on 12 opportunities. 3. The facility failed to ensure that MA B accurately documented Resident #88's blood pressure when administering Resident #88's blood pressure increasing medication. 4. The facility failed to ensure that MA B did not administer Resident #88's blood pressure medication when Resident #88's blood pressure was outside of administration parameters or when MA B did not document a blood pressure on 10 opportunities. 5. The facility failed to ensure that MA C did not administer Resident #88's blood pressure increasing medication when Resident #88's blood pressure was outside of administration parameters on 5 opportunities. 6. The facility failed to ensure that LVN D did not administer Resident #88's blood pressure increasing medication when Resident #88's blood pressure was outside of administration parameters on 6 opportunities. These deficient practices could place residents at risk for not receiving the therapeutic effects of their prescribed medications. The findings included: Record review of Resident #88's admission record reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #88's diagnoses included incomplete quadriplegia c5-c7 (weakness or paralysis of all four limbs due to a cervical spinal cord injury), cervical region spinal stenosis (the space inside the bones of the neck becomes too narrow and press on the spinal cord and nerves), bed confinement status, hyperlipidemia (high cholesterol), and essential hypertension (high blood pressure). Record review of Resident #88's quarterly MDS assessment dated [DATE] reflected a BIMS score of 12 which indicated that Resident #88 was cognitively intact. Record review of Resident #88's care plan on 11/19/24 reflected the following problems: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. I have hypertension r/t CAD (narrowing of the arteries in the heart) and hyperlipidemia initiated on 7/30/21 and revised on 11/6/24. Interventions included the following: Obtain blood pressure readings QD (every day). Take blood pressure readings under the same conditions each time. For example, when I am sitting, use right arm initiated on 7/30/21. 2. I have chronic health conditions and comorbid conditions that have affected my physical function and may further affect my quality of life. Heart disease, neuropathic pain associated with other disease/ condition initiated on 10/9/24. Interventions included the following: Administer my medications, treatments, and diet as recommended by physician initiated on 10/9/24. Monitor my vital signs and weights as indicated initiated on 10/9/24. Notify MD PRN of any s/sx of hypotension: dizziness, fainting, blurred vision, lack of concentration, nausea, fatigue, and/or cold clammy pale skin initiated on 10/9/24. Record review of Resident #88's Order Summary Report on 11/19/24 reflected an active order dated 9/9/24 for Midodrine HCl Tablet 10mg, give 1 tablet my mouth three times a day for hypotension (low blood pressure). Do not give if systolic BP (the top number in a blood pressure) is 120mmHg or higher. Record review of Resident #88's BPS (Blood Pressure Summary) and MAR (Medication Administration Record) in PCC (the facility's electronic health record) dated 11/1/24 through 11/20/24 reflected the following: On 11/1/24 at 8:53pm BP was documented on the BPS as 156/89 by MA C. On 11/1/24 MA C documented on the MAR that the 7:00pm BP was 156/89 and the Midodrine was administered (even though it was outside of parameters for administration). On 11/2/24 at 6:45pm BP was documented on the BPS as 148/70 by MA C. On 11/2/24 MA C documented on the MAR that the 7:00pm BP was 148/70 and the Midodrine was administered (even though it was outside of parameters for administration). On 11/3/24 at 8:59am BP was documented on the BPS as 134/86 by MA A. On 11/3/24 MA A documented on the MAR that the 7:00am BP was 134/86 and the Midodrine was not administered due to BP being outside of parameters for administration. On 11/3/24 there was no documentation of the BP on the BPS between 8:59am and 7:33pm. On 11/3/24 MA A documented on the MAR that the BP at 1:00pm was 134/86 and the 1:00pm dose of Midodrine was administered (even though the BP documented was the same as the 8:59am BP on the BPS and the 7:00am BP on the MAR, and it was outside of parameters for administration). On 11/3/24 at 7:33pm BP was documented on the BPS as 146/83 by MA C. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/3/24 MA C documented on the MAR that the 7:00pm BP was 146/83 and the Midodrine was administered (even though it was outside of parameters for administration). On 11/4/24 at 8:13am BP was documented on the BPS as 138/86 by MA A. On 11/4/24 MA A documented on the MAR that the 7:00am BP was 138/86 and the Midodrine was not administered due to BP being outside of parameters for administration. On 11/4/24 there was no documentation of BP on the BPS between 8:13am and 6:31pm. On 11/4/24 MA A documented on the MAR that the 1:00pm BP was 138/86 and the Midodrine was administered (even though the BP documented was the same as the 8:13am BP on the BPS and the 7:00am MAR, and it was outside of parameters for administration). On 11/4/24 at 6:31pm BP was documented on the BPS as 134/80 by LVN D. On 11/4/24 LVN D documented on the MAR that the 7:00pm BP was 134/80 and the Midodrine was administered (even though it was outside of parameters for administration). On 11/5/24 there was no BP documented on the BPS prior to 11:18am. On 11/5/24 MA A documented on the MAR that the 7:00am BP was 132/71 and the Midodrine was not administered due to BP being outside of parameters for administration (even though the BP documented was the same as the 11:18am BP on the BPS and the 1:00pm MAR) On 11/5/24 at 11:18am BP was documented on the BPS as 132/71 by MA A. On 11/5/24 MA A documented on the MAR that the 1:00pm BP was 132/71 and the Midodrine was administered (even though it was outside of parameters for administration). On 11/5/24 at 6:40pm BP was documented on the BPS as 122/70 by LVN D. On 11/5/24 LVN D documented on the MAR that the 7:00pm BP was 122/70 and the Midodrine was administered (even though it was outside of parameters for administration). On 11/6/24 there was no BP documented on the BPS prior to 5:17pm. On 11/6/24 MA A documented on the MAR that the 7:00am and 1:00pm BP was 122/70 and the Midodrine was administered (even though the BP documented for both 7:00am and 1:00pm were the same as the BP documented on 11/5/24 on the BPS at 6:40pm and on the MAR at 7:00pm, and it was outside of parameters for administration). On 11/6/24 at 5:14pm BP was documented on the BPS as 149/80 by MA C. On 11/6/24 MA C documented on the MAR that the 7:00pm BP was 149/80 and the Midodrine was administered (even though it was outside of parameters for administration). On 11/7/24 at 7:14am BP was documented on the BPS as 133/74 by MA B. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/24 MA B documented on the MAR that the 7:00am BP was 133/74 and the Midodrine was administered (even though it was outside of parameters for administration). On 11/7/24 there was no BP documented on the BPS between 7:14am and 7:12pm. On 11/7/24 MA B documented on the MAR that the 1:00pm BP was 133/74 and the Midodrine was administered (even though the BP documented was the same as the 7:14am BP on the BPS and the 7:00am MAR, and it was outside of parameters for administration). On 11/8/24 there was no BP documented on the BPS prior to 12:17pm. On 11/8/24 at 12:17pm BP was documented on the BPS as 140/86 by MA A. On 11/8/24 MA A documented on the MAR that the 7:00am BP was 140/86 and the Midodrine was not administered because it was outside of parameters for administration (even though there was no BP documented on the BPS prior to 12:17pm and the BP documented on the MAR was the same as the 12:17pm BP on the BPS). On 11/8/24 at 8:51pm BP was documented on the BPS as 132/70 by MA C. On 11/8/24 MA C documented on the MAR that the 7:00pm BP was 132/70 and the Midodrine was administered (even though it was outside of parameters for administration). On 11/9/24 at 8:41am BP was documented on the BPS as 137/86 by MA A. On 11/9/24 MA A documented on the MAR that the 7:00am BP was 137/86 and the Midodrine was not administered due to BP being outside of parameters for administration. On 11/9/24 there was no BP documented on the BPS between 8:41am and 8:52pm. On 11/9/24 MA A documented on the MAR that the 1:00pm BP was 137/86 and the Midodrine was administered (even though the BP documented was the same as the 8:41am BP on the BPS and the 7:00am MAR, and it was outside of parameters for administration). On 11/10/24 there was no BP documented on the BPS prior to 1:42pm. On 11/10/24 MA A documented on the MAR that the 7:00am BP was 132/79 and the Midodrine was not administered due to BP being outside of parameters for administration (even though the BP documented was the same as the 1:42pm BP on the BPS and the 1:00pm MAR). On 11/10/24 at 1:42pm BP on the BPS was documented as 132/79 by MA A. On 11/10/24 MA A documented on the MAR that the 1:00pm BP was 132/79 and the Midodrine was administered (even though the BP documented was the same as the BP on the 7:00am MAR, and it was outside of parameters for administration). On 11/10/24 at 6:15pm the BP was documented on the BPS as 130/76 by LVN D. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/10/24 LVN D documented on the MAR that the 7:00pm BP was 130/76 and the Midodrine was administered (even though it was outside of parameters for administration). On 11/11/24 at 6:49am BP was documented on the BPS as 142/87 by MA A. On 11/11/24 MA A documented on the MAR that the 7:00am BP was 142/87 and the Midodrine was not administered due to BP being outside of parameters for administration. On 11/11/24 there was no documentation of BP on the BPS between 6:49am and 6:41pm. On 11/11/24 MA A documented on the MAR that the 1:00pm BP was 142/87 and the Midodrine was administered (even though the BP documented was the same as the 6:49am BP on the BPS and the 7:00am MAR, and it was outside of parameters for administration). On 11/11/24 at 6:41pm BP was documented on the BPS as 140/78 by LVN D. On 11/11/24 LVN D documented on the MAR that the 7:00pm BP was 140/78 and the Midodrine was administered (even though it was outside of parameters for administration). On 11/12/24 at 6:59am BP was documented on the BPS as 122/84 by MA B. On 11/12/24 MA B documented on the MAR that the 7:00am BP was 122/84 and the Midodrine was administered (even though the BP was outside of parameters for administration). On 11/12/24 there was no documentation of BP on the BPS between 6:59am and 6:26pm. On 11/12/24 MA B documented on the MAR that the 1:00pm BP was 122/84 and the Midodrine was administered (even though the BP documented was the same as the 6:59am BP on the BPS and the 7:00am MAR, and it was outside of parameters for administration). On 11/12/24 at 6:26pm BP was documented on the BPS as 120/69 by MA B. On 11/12/24 MA B documented on the MAR that the 7:00pm BP was 120/69 and the Midodrine was administered (even though it was outside of parameters for administration). On 11/13/24 at 7:33am BP was documented on the BPS as 114/72 by MA B. On 11/13/24 there was no documentation of BP on the BPS between 7:33am and 7:00pm. On 11/13/24 MA B documented on the MAR that the 1:00pm BP was 114/72 and the Midodrine was administered (even though the BP documented was the same as the 7:33am BP on the BPS and the 7:00am MAR). On 11/14/24 at 7:52am BP was documented on the BPS as 117/62 by MA B. On 11/14/24 there was no documentation of BP on the BPS between 7:52am and 6:53pm. On 11/14/24 MA B documented on the MAR that the 1:00pm BP was 117/62 and the Midodrine was administered (even though the BP documented was the same as the 7:52am BP on the BPS and the 7:00am MAR).

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	676465	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Alturas Nursing & Transitional Care	4301 North Bartlett Avenue Laredo, TX 78041

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/15/24 there was no documentation of BP on the BPS prior to 12:03pm. On 11/15/24 MA A documented on the MAR that the 7:00am BP was 140/82 and the Midodrine was not administered due to BP being outside of parameters for administration (even though the BP documented was the same as the 12:03pm BP on the BPS and the 1:00pm MAR). On 11/15/24 at 12:03pm BP on the BPS was documented as 140/82 by MA A. On 11/15/24 MA A documented on the MAR that the 1:00pm BP was 140/82 and the Midodrine was administered (even though the BP documented was the same as the BP on the 7:00am MAR, and it was outside of parameters for administration). On 11/15/24 at 5:01pm the BP was documented on the BPS as 189/97 by MA C. On 11/16/24 there was no BP documented on the BPS prior to 7:00pm. On 11/6/24 MA A documented on the MAR that the 7:00am and 1:00pm BP was 189/97 and the Midodrine was administered (even though the BP documented for both 7:00am and 1:00pm were the same as the BP documented 11/15/24 on the BPS at 5:01pm and on the MAR at 7:00pm, and it was outside of parameters for administration). On 11/16/24 at 7:00pm BP was documented on the BPS as 120/79 by LVN D. On 11/16/24 LVN D documented on the MAR that the 7:00pm BP was 120/79 and the Midodrine was administered (even though it was outside of parameters for administration). On 11/17/24 there was no BP documented on the BPS between 9:39am and 8:00pm. On 11/17/24 there was no documentation on the MAR at 1:00pm of a BP or administration or non-administration of Midodrine. (Both the BP and the administration boxes were blank.) On 11/17/24 at 8:00pm BP was documented on the BPS as 137/79 by LVN D. On 11/17/24 LVN D documented on the MAR that the 7:00pm BP was 137/79 and the Midodrine was administered (even though it was outside of parameters for administration). On 11/18/24 at 7:53am BP was documented on the BPS as 119/66 by MA B. On 11/18/24 there was no BP documented on the BPS between 7:53am and 7:09pm. On 11/18/24 MA B documented on the MAR that the 1:00pm BP was 119/66 and the Midodrine was administered (even though the BP documented was the same as the 7:53am BP on the BPS and the 7:00am MAR). On 11/19/24 at 7:41am BP was documented on the BPS as 122/66 by MA B. On 11/19/24 MA B documented on the MAR that the 7:00am BP was 122/66 and the Midodrine was administered (even though it was outside of parameters for administration). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 1:58pm BP was documented on the BPS as 120/70 by MA B. On 11/19/24 MA B documented on the [NAME] that the 1:00pm BP was 120/70 and the Midodrine was administered (even though it was outside of parameters for administration). In an interview on 11/21/24 at 10:30am, MA A stated she had been an MA since 2012. MA A stated for the majority of the patients that had parameters, the parameters were in the system. MA A stated if the resident's BP was not within the parameters, she would let the nurse know, the nurse would tell her to hold the medication, and then she would document it on the MAR as held. MA A stated she checked the blood pressure before giving the medication and the BP got documented in the MAR and they were documented manually. MA A stated there was a box at the top of the page that had the last set of v/s, but they did not auto populate into the MAR. MA A stated she had never not checked the BP before giving a medication. In reference to Resident #88, MA A stated his BP was usually high in the morning then dropped lower in the afternoon. MA A stated on 11/16/24, she apparently failed to document the correct blood pressure when she administered the medication for the 7:00am and 1:00pm doses. MA A further stated on the days that it (the MAR) showed the same blood pressures for the 7:00am and 1:00pm doses that were the same as the night before (7:00pm dose), she just failed to document the correct BPs. MA A stated, I do always check the BP before I give or hold the medication and the BPs are documented as soon as I do them. MA A stated it was important to always check v/s because if someone was given a medication to raise their blood pressure and the blood pressure was already high, it could cause the resident to have a stroke, be hospitalized , or even pass away. MA A stated it was important to document correctly so that everyone knew what was going on with the resident, how he or she was doing and if the doctor was needing to make medication changes, they needed accurate documentation of vitals to be able to manage care appropriately. MA A stated the last in service on med admin was last month. In an interview on 11/21/24 at 10:55am, MA B stated if a resident was on medication that had vital sign parameters, she would check the v/s before she gave the medication, document it after she gave the medication, and if not within parameters, she would tell the nurse so she could hold the medication. MA B stated, I always check the v/s before I give the medication. I would not give the medication without checking the v/s to make sure it was within parameters, if there were any. In reference to Resident #88's Midodrine and the days that the same BPs were documented on the MAR at 7:00am and 1:00pm, MA B stated that she did check the BP on those days, but she guessed she did not document the BP, she just used the same ones as the morning check. MA B stated it was important to always document the BP because if there was a problem with it going up and down the doctor could change the medication if necessary. MA B stated it was important to always check it (the BP) first to make sure it was within the parameters to give. MA B stated if a BP was high, but it was not checked, and the resident was given this medication (Midodrine), it could cause them to have a heart attack or stroke, go the hospital, and possibly die. MA B stated the last in service on medication administration was sometime this year. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/21/24 at 11:54am the ADON stated that v/s were supposed to be checked right before a medication was given that had parameters for v/s. The ADON stated the v/s and the administration or hold of the medication was supposed to be documented right away. The ADON stated it was not appropriate to use v/s that were done with previous administrations or holds. The ADON stated it was important to check the v/s before administration because you had to know if the resident needed the medication or not and if a medication was given that was outside of parameters, it could cause the resident to have an adverse reaction, be hospitalized , or if the blood pressure went too high it could cause a hypertensive crisis, stroke, or death. The ADON further stated it was important to document v/s accurately and timely so the provider could make adjustments if needed, based on the correct information. The ADON stated, My expectation is for everyone to assess their residents and check their v/s as ordered by the provider and on the MAR. The ADON stated the last in-service on medication administration was within the last 3 days and that she would be doing another in-service with each medication aide and nurse to address these specific issues. The ADON stated usually when the BP was documented on the MAR, it would transfer to the v/s (BP) section of PCC (Point Click Care, the facility's electronic health record) and she was not sure why it did not transfer. In an interview on 11/21/24 at 12:15pm, the DON stated he talked to corporate about the v/s documentation on the MAR on 11/20/24 to see if there was a way to get the system to send an alert if any of the vital signs were outside of parameters. The DON stated, My expectation is for the MAs or the nurses to check the BP before giving the medication and to document immediately the v/s and whether it was administered or held. The DON further stated if the blood pressure was high and the Midodrine was given it could cause the resident's blood pressure to be higher which could lead to harm. The DON stated the last in-service on medication administration was 11/20/24 and that they would be doing another one today (11/21/24). The DON stated, In terms of oversite, we will be looking at which residents are getting meds that have parameters and reviewing their MARs to ensure that the medications and v/s are being done and charted appropriately. Record review of the facility's Medication Administration policy implemented March 2019 and revised January 2023 reflected in part: Compliance Guidelines: Resident medications are administered in an accurate, safe, timely, and sanitary manner. Responsible Disciplines: Licensed Nurses, CMAs 2. Verify the medication label against the medication sheet for accuracy of drug frequency, duration, strength, and route. a. The nurse/ medication aide shall be responsible to read and follow precautionary or instructions on prescription labels. 5. If applicable and/ or prescribed, take vital signs or tests prior to administration of the dose. 6. Administer medications as ordered by the physician. Documentation: Initial the electronic administration record after the medication is administered to the resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969 Based on observation, interviews, and record reviews the facility failed to ensure drugs and biologicals were stored securely for 1 (Resident #34) of 5 residents reviewed for storage of medications. The facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards. As a result, this failure placed residents at risk of not getting ordered medications, and/or medications could have been diverted or ingested by another resident. Findings Included: Record review of Resident #34's face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with an original admitted [DATE]. Diagnoses included Unspecified Dementia, Type 2 Diabetes, Primary Osteoarthritis, Osteoporosis, Stiffness of Joint, and Pain in Right Shoulder. Record review of Resident #34's MDS dated [DATE] revealed a BIMS score of 11. BIMS score 13-15 suggests resident's cognition is intact. Resident #34's care plan does not indicate that resident is allowed to administer own medications. Record review of care plan initiated 6/26/24 revealed Resident #34 had impaired cognitive function or impaired thought process related to dementia. Record review on 11/20/24 of physician's orders revealed no order for a pain cream for Resident #34's pain. The physician's orders also revealed there were multiple medications that the two tablets could have been, such as Metformin, Tylenol, Multivitamin, Potassium and Gabapentin. Observation 11/19/24 09:00 AM revealed Resident #34 was in bed rubbing her arm and shoulder. Bedside table was noted to have 2 large, white, oblong pills sitting on a napkin next to a souffle cup that had a thick, white paste in it. Interview on 11/19/24 at 09:15 AM with Resident #34, she stated she did not know what the pills were or where they came from. She stated the nurse probably left them there for her to take, but she did not like to take pills because they make her sick to her stomach. Resident #34 was also complaining of pain to her right arm and right shoulder. She stated the nurse was supposed to bring her a cream to put on it, but never brought it. Resident #34 stated she asks for the cream all the time, but they never bring her anything. She stated sometimes she can take Tylenol for the pain, but other times it upsets her stomach. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN - E on 11/19/24 at 09:30 AM, she stated she had not passed any medication to Resident #34, and she wasn't sure if they were Resident 34's medication as they look like many other medications, so she would not have left the medications at the bedside. If the patient had refused them, she would have discarded them in her trash on her cart. She also stated Resident #34 does not have an order for a cream for pain, but that she would reach out to the provider to get an order. Interview with MA - J on 11/19/24 at 09:45 AM, she stated she never noticed the two white tablets or a cream sitting at the resident's bedside table, but stated they did not come from her because she actually watched the resident swallow her morning pills. If the resident had refused, she would have disposed of the medication appropriately in the trash or sharps container. Interview with LVN - I on 11/19/24 at 10:30 AM, she stated she doesn't remember seeing the pills or the cream at the bed side, but she didn't place them there because the resident took all the medication that she administered to her. She stated that if the resident had refused the medication, she would dispose of it properly. Interview with the Administrator on 11/20/24 at 04:45 PM, he stated that nurses are not supposed to leave medications at bedside. If medications are refused by resident, they should be disposed of properly. If medications are left at bedside a lot of things could happen like another resident could take them. Interview with the DON on 11/21/24 at 09:58 AM, he stated medications should never be left at bedside, and if a resident refused medication the nurse should dispose of meds appropriately in the sharps or use the chemical that is designated to dispose the medication in. If medications are left at bedside another resident could end up swallowing them. Record review of Medication Administration Policy revealed never administer medications from an unmarked container, never administer medications supplied for one resident to another resident, administer medications as ordered and according to the established medication administration schedule, avoid leaving medications with the resident to self-administer, and follow the medication/pharmacy guidelines for storage.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44748 Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for storage, preparation and sanitation. The facility failed to ensure kitchen equipment was in good condition. The facility failed to ensure kitchen equipment was kept clean. The facility failed to ensure items in the refrigerator were labeled and dated. These failures could place residents at risk for complications from food contamination. Observation of the kitchen and initial tour on 11/19/24 at 8:35 AM revealed 2 non-stick pans on the clean rack that were eroded to the metal on the bottoms and sides. There was a metal spatula in use with sharp jagged edges and the handle was melted with deep crevasses that had brown and black substances in and around them. There was a plastic spatula in use that had jagged edges. There was a serving scoop that had a reddish substance on the inside in the clean drawer with other utensils. There were two glasses of milk in the refrigerator that were unlabeled and undated. In an interview with the RD on 11/19/24 at 8:40 AM, she said the eroded non-stick pans looked like they needed to be replaced because the coating should not be coming off. She said kitchen staff should not be using the eroded non-stick pans because bits of the coating could be coming off and getting into the resident s' food. She said if the resident ' s consumed the bits of non-stick coating, they could get sick. She said if the residents drank the milk that was unlabeled and undated, it could be potentially spoiled and make the residents sick. She said the spatulas looked dangerous because of the sharp edges on the metal one and the plastic one looked like bits of it could come off, get in the resident ' s food and make them ill. In an interview with the [NAME] on 11/19/24 at 8:45 AM, she said she was going to throw away the eroded non-stick pans but had not gotten to it. She said they used the eroded pans to make grilled cheese sandwiches. She said the coating on the eroded non-stick pans could get into the food and make residents sick or make the food taste differently. She said the metal spatula could cut someone with the jagged edges and she had not noticed it before. She said the melted plastic handle of the metal spatula had crud in the crevasses. She said touching the dirty handle of the metal spatula could cause cross contamination and make resident sick. She said she used the metal spatula and other metal utensils in the non-stick pans. She said she was unaware they were supposed to be using plastic or nylon utensils in the non-stick pans. She said the jagged edges on the plastic spatula could break off into the food and the residents could chew the bits of plastic and get them stuck in their teeth or hurt their gums. She said the dirty scoop in the clean drawer should not have been there because she did not know what the substance was that was in it. She said the scoop should have been removed and re-washed. She said she did not know how long the glasses of milk were in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the FSS food service supervisor since 11/2007 on 11/19/24 at 8:45 AM, she said all kitchen staff were responsible for making sure broken utensils and pans were taken out of service and discarded. She said she had 2 new non-stick pans (they were on the stove). She said the cooks were supposed to be using plastic or nylon utensils in the non-stick pans to avoid the coating from flaking into the food. She said the non-stick coatings were toxic and could get into the food and make residents sick. She said the dirty scoop in the clean drawer should not have been there. She said she was ultimately responsible for making sure equipment used in the kitchen was clean and in good condition. She said kitchen staff should know when utensils and equipment should be replaced and remove them from service so she could order replacements. She said the scoop should have been removed and re-washed. She said the metal spatula was an injury hazard because the jagged edges on the sides of it were very sharp and looked like bits of the metal were missing. She said all items in the refrigerator, freezer, and dry storage should be labeled and dated always. She said none of her staff knew how long the glasses of milk had been in the refrigerator because they were not labeled and dated. She said if items were not labeled and dated, they would not know when the item should be discarded. She said if a resident was to consume anything that was outdated it could make them sick because that was why they had use-by dates. The kitchen equipment policy was requested but not provided. Record review of the undated facility policy titled, Food Preparation and Handling revealed under Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be prepared and handled according to the state and US Food Codes and guidelines. Record review of the undated facility policy titled, Food Storage revealed under Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be prepared and handled according to the state and US Food Codes and guidelines. Under Procedure: 2. d. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent covered containers that are approved for food storage. e. Use all leftovers within 72 hours. Discard items that are over 72 hours old. References: FDA (Food and Drug Administration) Food Code Ch. 4-1-101.11 Characteristics. Materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be: (A) Safe; (B) Durable, corrosion- resistant, and nonabsorbent; (C) Sufficient in weight and thickness to withstand repeated ware washings; (D) finished to have a smooth, easily cleanable surface; and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. Ch. 4-101.18 Nonstick Coatings, Use Limitation. Multiuse kitchenware such as frying pans, griddles, saucepans, cookie sheets, and waffle bakers that have a perfluorocarbon resin coating shall be used with non-scoring or non-scratching utensils and cleaning pads.