STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455625	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta Vista Rehabilitation and Healthcare	510 Paredes Line Rd 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER Alta Vista Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 510 Paredes Line Rd 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 0641 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 ensure the assessment accurately reflected the resident's status for 2 (Resident #1 and Resident #2) of 11 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #1's fall on [DATE] was accurately coded in the MDS assessment.The facility failed to ensure Resident #2's fall on [DATE] was accurately coded in the MDS assessment.This failure could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included:1. Record review of Resident #1's face sheet dated [DATE] reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: cerebral infarction (stroke), muscle weakness, Alzheimer's disease (decline in memory, thinking, and behavior), heart disease, contractures of right knee/left knee, and other lack of coordination. Record review of Resident #1's MDS assessment dated [DATE] reflected Resident #1 did not have a BIMS conducted as he was rarely/never understood. Resident #1's fall (with no injury) on [DATE] was not reflected or coded in section J: health conditions - falls. No falls since previous quarterly MDS assessment noted.Record review of Resident #1's care plan dated [DATE] reflected [Resident #1] was at risk for falls due to poor safety awareness and impaired cognition related to dementia. [Resident #1] had bilateral lower extremities contractures which increased his risk due to poor posture, poor trunk control, and had a tendency to lean forward while up in the wheelchair. Date initiated: [DATE]. Record review of Resident #1's progress note dated [DATE] at 11:30 AM reflected informed [Resident #1] had fallen at dining room. Immediately walked to back of dining room where I noted locked wheelchair facing back window. Noted [Resident #1] face on floor with active bleeding to front forehead. Neck stabilized. [Resident #1] turned on his back, has contractures to bilateral lower extremities. Noted laceration approximately 3.5 centimeters long applied pressure, site covered with dry dressing. [Resident #1] conscious at all times, eyes opened. Neuro check done. [Resident #1] non-verbal, usual for him, no deviation from his norm. Neck stabilized during transfers and placed back to bed. At 11:39 AM, MD called with new order transfer [Resident #1] to the hospital for evaluation and treatment. At 11:40 AM, ambulance was called for emergency transfer. At 11:55 AM, hospital was called and gave report. Ambulance arrived to facility and transported [Resident #1] to the hospital. At 12:10 PM, RP called and informed of change of condition. Thanked for calling and verbalized understanding. Documented by LVN A. 2. Record review of Resident #2's face sheet dated [DATE] reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: Parkinson's disease (brain disorder that affects movement and causes tremors, stiffness, and slowness), Alzheimer's disease (decline in memory, thinking, and behavior), epilepsy (seizures), cerebral infarction (stroke), depression, muscle weakness, and other lack of coordination. Resident #2 expired on [DATE].Record review of Resident #2's MDS assessment dated [DATE] reflected Resident #2 had a BIMS score of 4, indicating severe cognitive impairment. Resident #2's fall (with a major injury) on [DATE] was not reflected or coded in section J: health conditions - falls. No falls since previous quarterly MDS assessment noted.Record review of Resident #2's care plan dated [DATE] reflected [Resident #2] was at risk for falls related to Parkinson's disease, unsteady gait, history of falls, poor balance, and behavior of not calling for assistance by using the call light. Date initiated: [DATE]. [Resident #2] had a fracture to right wrist related to a fall and was at risk for pain, discomfort, and limited range of motion to right upper extremity. Date initiated: [DATE].Record review of Resident #2's progress note dated [DATE] at 12:36 AM reflected CNA responding to call light. Noted [Resident #2] on the floor in sitting position next to bed. CNA called this nurse to room. Upon entering room, noted [Resident #2] sitting next to bed on floor and urine on floor under resident. [Resident #2] stated he was attempting to go to the bathroom but lost his balance and slid off bed to floor. No hematomas or skin tears noted. [Resident #2] was able to move extremities X 4, however, stated right wrist hurts a little. Pain medication given at this time. [Resident #2] did not use call light to call for assistance. Roommate put on call light. Educated [Resident #2] on calling for help but [Resident #2] used poor judgement and was forgetful. Assisted back to bed and incontinent care was rendered. Documented by LVN B. On [DATE] at 10:40 AM, an attempted interview and observation with Resident #1, revealed he was not interviewable. Resident #1 did not answer baseline questions or questions related to the incident. Resident #1 laid in bed with the call light within reach. There were no safety concerns and the bed was at its lowest position. Resident #1 appeared with good personal hygiene, no injury, and not in distress On [DATE] at