STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455802	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Meadows	440 E Ruben Torres Blvd Brownsville, TX 78520

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 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)

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 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 incorporate the recommendations from the PASRR Level II determination and the PASRR evaluation report for 1 of 4 residents (Resident #1) reviewed for PASRR.The facility failed to initiate an NFSS within 20 business days following the date the services were agreed upon in the IDT meeting.This failure could cause residents with mental health disorders and psychiatric conditions to have a delay in services or not receive specialized services or equipment that may be needed.Findings include: Record review of Resident #1's face sheet, dated 09/17/25, revealed a [AGE] year-old male originally admitted [DATE], and most recent admission date of 12/11/23. His diagnoses included dementia (a loss of cognitive functioning such as thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), severe intellectual disabilities (a significant impairment with intellectual and adaptive functioning which may affect intelligence, learning, and everyday life skills), cognitive communication deficit, muscle wasting and atrophy (gradual wasting away or shrinkage of an organ, tissue or muscle), and muscle weakness. Record review of Resident #1's Quarterly MDS assessment, dated 09/06/25, revealed a BIMS score of 02, indicating severely impaired cognition. The MDS assessment also revealed Resident #1 had impairment to lower extremities on both sides and utilized a wheelchair, as well as Resident #1 required partial/moderate assistance with eating, substantial/maximal assistance with oral hygiene, upper and lower body dressing, putting on/taking off footwear, personal hygiene and dependent on toileting hygiene and shower/bathing self. Record review of Resident #1's undated care plan revealed resident was identified as having PASSR positive status related to severe intellectual disabilities with a goal of maintaining highest level of practicable wellbeing. Interventions included provide service coordination with Behavioral Health, invite TTBH and RP to the quarterly care plan meetings to discuss resident's function and report any need to evaluate for habilitative services and/or durable medical equipment to maintain the resident's current level of function, PT/OT/ST as ordered, obtain order to evaluate for physical and occupational therapy, and once the evaluations were complete, submit form 2466 to request habilitative PT and OT services. Record review of Resident #1's Form 1057 - LIDDA Habilitation Service Plan, with plan date of 08/20/24, revealed an annual meeting was held in person. Services agreed upon: . OT and PT. In an interview with Resident #1 on 9/15/25 at 3:40 pm, the resident was unable to answer any questions using words. He was able to nod yes or shake head no. Resident was unable to answer any questions pertaining to receiving PASSR services or attending PASSR meetings. Resident nodded yes when asked if receiving therapy. In an interview via email on 09/09/25 at 9:34 AM with the HHSC PASSR Unit Program Specialist, she said, I call before I send the email and they said they would work on getting the NFSS request submitted. are because they were late or did NOT submit or initiate and get approved for service. In an interview on 9/16/25 at 9:50 am the MDS nurse said he was responsible to complete the PL1 upon a resident's initial admission. The MDS nurse said once it was complete, the DON takes over with any follow-ups. The MDS nurse said he was not responsible for submitting the NFSS in the LTC Online Portal. The MDS nurse said the DON deals with that. In an interview on 9/16/25 at 3:50 pm the DON said he was responsible for PASSR submission in the online portal. He said once the original meeting was done by TTBH, they must notify the MD. Once they received the MD order for services such as PT, PT would then evaluate for habilitation services, then the NFSS would be completed with the recommended services, and he would submit the NFSS in the online portal. The DON said to his understanding, the submission of the NFSS form in the online portal were submitting within 21 business days of the IDT meeting. The DON said he recently took over the task in March of this year. The DON said the previous MDS/RN Coordinator oversaw the NFSS submissions in the online portal in collaboration with the DOR. The DON said they submitted the NFSS for Resident #1 and it was denied. The DON said he talked to someone in March, but he could not remember who, and he was told to submit the NFSS within a certain time frame, but it was denied because it was submitted incorrectly. The DON said the resident did receive the PT and OT services, but not through PASSR. The DON said they had a recent IDT meeting on the 3rd of September. The DON said PT and OT already did their assessments and they were pending MD signature. The DON said he the NFSS would be submitted within the 20 business calendar days. In an interview on 9/16/25 at 4:47 pm with the Administrator, he said it was his understanding that upon approval of services for PASSR, they had 20 business days to update that information onto the online portal. He said he believed the DON was in charge

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 3 residents (Resident #2) reviewed for medical records accuracy, in that: The facility failed to document Resident #2's physician ordered weekly skin assessment from 12/26/24 through 02/27/25 for a total of 10 out of 10 skin assessments that were not documented. This failure could affect residents whose records are maintained by the facility and could place them at risk for errors in care, and treatment. The findings included: Record review of Resident #2's face sheet, dated 09/16/25, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: psoriasis (skin cells build up and form scales and itchy, dry patches), unspecified dementia (loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), unspecified severity, without behavioral disturbance, psychotic disturbance mood disturbance, and anxiety, contracture, unspecified joint, and essential (primary) hypertension (high blood pressure) Record review of Resident #2's quarterly MDS assessment, dated 08/22/25, revealed Resident #2 had a BIMS score of 01, indicating severe cognitive impairment. Record review of Resident #2's care plan with an initiation date of 05/02/25 reflected a focus of I'M AT RISK FOR SKIN BREAKDOWN AS I HAVE: (1) Anemia (2) Major Depressive Disorder (3) Dementia (4) Bony prominences (5) I require partial/moderate assistance with bed mobility and substantialassistance with transfers (6) I am incontinent of Bowel and Bladder with no initiated date and interventions of, WEEKLY SKIN ASSESSMENT BY LISCENCED [licensed] NURSE with no initiated date. Record review of Resident #2's active physician's orders revealed orders for, WEEKLY ASSESSMENT DUE THURSDAY, with a frequency of every night shift every Thu (Thursday) with an order date of 08/06/20 and an order type of Standard Order Treatment - [TAR] Record review of Resident #2's December 2024, January, February and March 2025 TAR reflected her order for weekly skin assessment was signed by LVN A weekly from 12/26/25 through 02/27/25 as administered. Record review of Resident #2's weekly skin assessment record document that included more details such as a body diagram to indicate location and description of any skin issues reflected Resident #2's last weekly skin assessment record document was completed on 12/19/24. There were no weekly skin assessment record documents identified from 12/26/25 through 02/27/25. During an interview with Resident #2 on 09/09/25 at 10:17am she was unable to answer any related questions coherently. During an interview and record review with the DON on 09/15/25 at 4:32pm he stated skin assessments were completed weekly and stated an assessment should be completed whether a resident had anything new or not. The DON reviewed Resident #2's assessments and confirmed that there was a gap without skin assessments from December 2024 till March 2025 that should not be there. The DON stated he had not noticed they were missing. The DON reviewed Resident #2's TAR and stated LVN A had documented that she done the skin assessment in December 2024 till March 2025 but there were no skin assessments document populated. The DON stated the nursing staff was responsible for completing the weekly skin assessments and stated he did not know why they were not done and stated he had not spoken to LVN A yet and did not know if LVN A completed Resident #2's skin assessment and did not document them or if she had not done them. The DON stated completing weekly skin assessments were important to see if there was any abnormal development of skin issues and to make sure they were attended to properly. The DON stated staff had been trained over completely skin assessments weekly and stated they completed annual competencies that covered skin. The DON stated the wound care nurse was responsible for monitoring and reviewing skin assessments to ensure they were completed. The DON stated LVN B who was the previous wound care nurse was responsible for reviewing the skin assessments during the time of the identified gap. The DON stated LVN B no longer worked at the facility and stated their current wound care nurse had recently started but was still in training and had not yet been on the floor. The DON stated he and the ADON had weekly meetings where they wound go over documentation which included progress on wounds and the completion of their systems. The DON stated their facility policy stated staff should develop a new skin assessment document anytime one was scheduled and stated staff did not follow their policy in this situation. The DON stated he had reviewed Resident #2's chart and did not identify any deterioration of Resident #2's skin from December 2024 through March 2025 when no skin assessments were populated. The DON stated not completing skin assessments as ordered could negatively impact residents because