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	04/18/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, for 1 of 5 residents (Resident #1) reviewed for abuse and neglect, in that: The facility did not implement their abuse policy related to reporting a major injury when Resident #1 had an unwitnessed fall that resulted in multiple rib fractures, T5 vertebral fracture and lumbar transverse fracture. This failure could place residents at risk of abuse and neglect.The findings were: Record review of Resident #1's face sheet, dated 4/17/2026, revealed an [AGE] year-old female with an admission date of 3/07/2026 with diagnoses which included: osteoarthritis (protective cartilage cushioning the ends of bones wears down over time, causing joints to become painful, stiff and swollen), osteoporosis (disease that makes bones weak, brittle, and porous, resembling a sponge), Alzheimer's Disease (progressive brain disease, which causes a slow decline in memory, thinking, and reasoning skills), hypertension (high blood pressure), stable burst fracture of unspecified thoracic vertebra (a broken back bone in the upper/mid-back where the vertebra collapses under high pressure but stays in alignment), spinal stenosis (narrowing of the spaces within the spine, which puts pressure on the nerves and spinal cord traveling through it). Record review of Resident #1's MDS assessment, dated 3/14/2026 revealed a BIMS score of 3 which indicated Resident # 1 had severe cognitive impairment. Record review of Resident #1's MDS assessment, dated 3/14/2026, revealed Resident #1 required substantial/maximal assistance for toilet transfer. Resident #1 required substantial/maximal assistance for chair/bed-to-chair transfer. Record review of Resident #1's care plan, dated 3/24/2026, revealed Resident #1 required assistance with ADLs R/T decreased mobility, weakness, unsteady gait, unsteady balance with transitions, poor safety awareness, HX of falls, S/P spinal surgery R/T fracture of spine, multiple fractures D/T fall. Goals included will receive assistance as needed and maintain the highest level of independence and interventions included, assist resident as needed with ADLs. Record review of Resident #1's progress notes revealed a progress note written by LVN A, on 3/01/2026 at 1:05 AM stating, .resident was noted sitting up on the floor in the restroom doorway. Resident states she was walking back to bed after using the restroom and fall back onto her bottom and back, denies hitting head. Voices pain to right heel, right hip and lower back. Right heel is noted with redness, no visible discoloration to hips, and red scrape noted to lower back. Resident shows ROM to all extremities and guarding to right hip. Resident was assisted up, was able to bear weight to legs but was unable to ambulate. Resident was assisted to bed, head to toe assessment completed, PRN APAP was given and NP was notified of incident. Record review of Resident #1's progress notes revealed a progress note written by LVN B, on 3/07/2026 at 6:30 p.m. stating, .ribs multiple fx's, T5 vertebral fx, lumbar transverse fx. Record Review of TULIP (HHSC online incident reporting application) on 4/18/2026 at 11:50 a.m. revealed the facility had not made a self-reported incident involving Resident #1. Observation on 4/17/2026 at 10:01 a.m., Resident #1 was seen in the dining area, actively participating in activities. Resident # 1 was observed sitting in her wheelchair eating no facial expressions of discomfort were observed. During an interview on 4/18/2026 at 11:35 a.m., the DON stated Resident #1's unwitnessed fall (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	happened on 3/01/2026. The DON stated the Administrator was made aware. The DON stated an incident report was completed on 3/02/2026 and concluded unfounded ANE.The DON stated the appropriate time frame to report allegations of abuse, neglect, exploitation, or injury of unknown injury was two hours. The DON stated Resident #1's unwitnessed fall was not reported to any state agency because there were no radiology exams done at the facility that indicated fractures. Regarding the facility procedures, the DON stated the facility would self-report any unwitnessed falls with injury, injury of unknown origin or when they suspected abuse, neglect to the state. The DON stated the facility did not report Resident #1's unwitnessed fall. During an interview on 4/18/2026 at 12:03 p.m., the Administrator stated the date of the unwitnessed fall involving Resident #1 was on 3/01/2026 and she was made aware by the DON on 3/01/2026. He stated regarding facility procedures, the facility would report to the state unwitnessed falls with injury, injuries of unknown origin and suspected abuse or neglect. The Administrator stated the facility did not make a self-report to the state regarding Resident #1's unwitnessed fall. The Administrator stated the injuries were made known to the facility when Resident #1 was re-admitted . The administrator stated the reporting time frames for allegations of abuse, neglect, and exploitation and injury of unknown origin was two hours. The Administrator stated Resident #1's unwitnessed fall was not reported to within the two-hour time frame of learning about the injuries. The Administrator stated Resident #1's unwitnessed fall was not reported because the facility did not know of the injuries until the resident was re-admitted back and a report was received from the hospital nurse, which included chronic and acute fractures. Record review of the facility policy titled Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property undated, stated under section Reporting and Response, subtitle Serious Bodily Injury Reporting- 2 hour limit: If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but no later than 2 hours after forming the suspicion. External Reporting: Initial reporting of allegations: if an incident or allegation is considered reportable, the administrator or designee will make an initial (immediate or within 24 hours) report to the State Agency.'

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property were reported immediately, but no later than 2 hours after the allegation was made, if the alleged violation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (which included to the State Survey Agency) in accordance with State law through established procedures for 1 of 5 residents (Resident #1) reviewed for reporting injuries of unknown origin.The facility failed to report when Resident #1 was readmitted to the facility from the hospital after having sustained a fall at the facility, of multiple fractures to the ribs, T5 vertebral fracture, and lumbar transverse process fracture. The facility failed report to the State Agency when Resident #1 had an unwitnessed fall on 03/01/2026, and sustained fractures to the ribs, T5 vertebral fracture and lumber traverse process fracture.This failure could place residents at risk for undetected abuse, neglect, and/or decline in feelings of safety and well-being.The findings included:Record review of Resident #1's face sheet, dated 4/17/2026, revealed an [AGE] year-old female with an admission date of 3/07/2026 with diagnoses which included: osteoarthritis (protective cartilage cushioning the ends of bones wears down over time, causing joints to become painful, stiff and swollen), osteoporosis (disease that makes bones weak, brittle, and porous, resembling a sponge), Alzheimer's Disease (progressive brain disease, which causes a slow decline in memory, thinking, and reasoning skills), hypertension (high blood pressure), stable burst fracture of unspecified thoracic vertebra (a broken back bone in the upper/mid-back where the vertebra collapses under high pressure but stays in alignment), spinal stenosis (narrowing of the spaces within the spine, which puts pressure on the nerves and spinal cord traveling through it). Record review of Resident #1's MDS assessment, dated 3/14/2026 revealed a BIMS score of 3 which indicated Resident # 1 had severe cognitive impairment. Record review of Resident #1's MDS assessment, dated 3/14/2026, revealed Resident #1 required substantial/maximal assistance for toilet transfer. Resident #1 required substantial/maximal assistance for chair/bed-to-chair transfer. Record review of Resident #1's care plan, dated 3/24/2026, revealed Resident #1 required assistance with ADLs R/T decreased mobility, weakness, unsteady gait, unsteady balance with transitions, poor safety awareness, HX of falls, S/P spinal surgery R/T fracture of spine, multiple fractures D/T fall. Goals included will receive assistance as needed and maintain the highest level of independence and interventions included, assist resident as needed with ADLs. Record review of Resident #1's progress notes revealed a progress note written by LVN A, on 3/01/2026 at 1:05 AM stating, .resident was noted sitting up on the floor in the restroom doorway. Resident states she was walking back to bed after using the restroom and fall back onto her bottom and back, denies hitting head. Voices pain to right heel, right hip and lower back. Right heel is noted with redness, no visible discoloration to hips, and red scrape noted to lower back. Resident shows ROM to all extremities and guarding to right hip. Resident was assisted up, was able to bear weight to legs but was unable to ambulate. Resident was assisted to bed, head to toe assessment completed, PRN APAP was given and NP was notified of incident. Record review of Resident #1's progress notes revealed a progress note written by LVN B, on 3/07/2026 at 6:30 p.m. stating, .ribs multiple fx's, T5 vertebral fx, lumbar transverse fx. Record Review of TULIP (HHSC online incident reporting application) on 4/18/2026 at 11:50 a.m. revealed the facility had not made a self-reported incident involving Resident #1. During an interview on 4/18/2026 at 9:01 a.m., LVN A stated the Administrator was the abuse coordinator. LVN A stated Resident #1's unwitnessed fall happened on 3/01/2026. LVN A stated he entered Resident #1's room and saw Resident ##1 sitting on the floor in the bathroom's doorway. He stated Resident #1's heel had redness and she had a red scrape to the lower back. LVN A stated the resident had pain but was able to stand (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and she was assisted back to bed after an assessment was completed. LVN A stated he notified the NP and Resident #1 was transferred to the hospital. He said he informed the DON and ADON of Resident #1's fall. LVN A stated he asked Resident #1 what happened and she said she was going back to bed after using the bathroom but had fallen back and landed on her bottom. LVN A stated he would report any ANE and injuries to the ADON and DON. LVN A said not reporting allegations of ANE or injury of unknown source could negatively affect the resident because they could have a serious injury. During an interview on 4/18/2026 at 9:55 a.m., LVN B stated the administrator was the abuse coordinator. LVN B stated she was provided with re-education and reminders of ANE during monthly meetings and as needed. She said the Administrator and the IP were the ones that proved training on ANE. LVN B stated she received report from the hospital nurse on 3/07/2026 which included Resident #1 having sustained fractures to her ribs, T5 vertebral fracture and lumbar transverse process fracture. LVN B stated she did not remember if she had notified the administrator or the DON of the hospital report received. LVN B stated it was the responsibility of administration to notify state agency of allegations of ANE, or injuries of unknown source. She said would immediately notify her supervisors of any falls or ANE. LVN B stated a resident could be impacted negatively by not reporting ANE or injuries of unknown source which would create an unsafe environment and the resident would not be protected. During an interview on 4/18/2026 at 11:35 a.m., the DON stated it was the Administrator's responsibility to report allegations of abuse, neglect, exploitation, and injuries of unknown source. The DON said if the Administrator was not available, he would report to state agency allegations of ANE. The DON stated staff were required to complete training on ANE and reporting monthly and as needed. The DON stated Resident #1's unwitnessed fall happened on 3/01/2026. The DON said Resident # 1 was cognitively impaired and when asked what happened by the staff, she said she was heading back to bed after using the bathroom when she lost her balance and fell. The DON said the fall was unwitnessed and the resident was assessed and sent to the emergency room. The DON said the Administrator was made aware of Resident #1's fall and transferred to the hospital by him, on 3/01/2026. The DON stated the appropriate time frame to report allegations of abuse, neglect, exploitation, or injury of unknown source was two hours. The DON stated the incident, which involved Resident #1, was not reported to any state agency because the fractures were not confirmed at the facility. The DON stated the facility's policy on reporting allegations in which bodily injuries occurred was within the allotted time. During an interview on 4/18/2026 at 12:03 p.m., the Administrator stated she was the abuse coordinator and responsible for reporting any allegations of abuse, neglect, exploitation, and injuries of unknown origin which resulted in serious bodily injuries.The Administrator stated staff were trained at least annually in reporting any allegations that resulted in serious bodily injury. The Administrator stated Resident #1 sustained the fall on 3/01/2026 and was notified by the DON later in the day. The Administrator stated the initial injury was a scratch to Resident #1's back and redness to the heel and Resident #1 was able to verbalize she was trying to go back to bed after using the bathroom. The Administrator stated she interviewed LVN A, who found and assessed Resident #1. The Administrator stated Resident # 1 was sent out to the hospital, but no reports of fractures were made until the resident was readmitted on [DATE]. The Administrator stated on 3/06/2026, the hospital referral did make mention of multiple fractures. The Administrator stated the reporting time frames for allegations of abuse, neglect, exploitation, and injuries of unknown origin was two hours. The Administrator stated the incident was not reported within the two-hour time frame. The Administrator stated there would be no negative effect to the resident by not reporting a bodily injury to state agency. The Administrator stated she could not remember what the facility's ANE policy stated in regards to reporting incident of bodily injury to state agency. Record review of the facility policy titled Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property undated, stated under section Reporting and Response, subtitle Serious Bodily Injury Reporting- 2 hour limit: If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report (continued on next page)

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