

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455802	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Spanish Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969</p> <p>Based on interviews and record reviews the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made to the State Survey Agency for 1 of 4 residents reviewed for abuse (Resident #1).</p> <p>The facility did not immediately report an incident involving alleged physical abuse to Resident #1 by an unknown staff member to the state agency.</p> <p>This failure placed resident at increased risk for delayed treatment and investigation for abuse and neglect.</p> <p>Findings Included:</p> <p>Record review of Resident #1's face sheet revealed a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses including, but not limited to, unspecified dementia without behavioral disturbance, depression, hypertension, hypotension, chronic kidney failure and falls.</p> <p>Record review of the MDS assessment for Resident #1, dated 2/28/24 revealed no BIMS score as Resident #1 was cognitively unable to complete the brief interview for mental status. She was not coded for any behaviors. She required substantial/maximal assistance of one person for toilet use. She was frequently incontinent of bladder and occasionally incontinent of bowel.</p> <p>Record review of a progress note for social services dated 4/1/2024 revealed that a grievance was filed on Resident #1's behalf by the social worker, but record review of the grievance log does not show this grievance was documented in the log.</p> <p>Record review of the Provider Investigation Report revealed the allegation of abuse was reported to HHSC on 4/2/24, and the abuse assessment was completed on 3/31/24, and assessment revealed no injuries or bruising to hands, as well as no change in behavior. The Provider Investigation Report also revealed that the incident was reported to the facility on [DATE], but that it occurred on 3/18/24. Resident #1 was unable to recall the staff or CNA's name. Facility investigation report also revealed that Abuse, Neglect, and Exploitation in-service was conducted with all staff on 4/2/24.</p> <p>(continued on next page)</p>		

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with Resident #2 on 10/23/24 at 9:26 AM, she stated Resident #1 got mad easily whenever anyone spoke to her, and she would sometimes try to hit the staff. Resident #2 stated she had never seen her roommate Resident #1 get abused physically or verbally. Resident #2 stated the staff treated her with dignity and respect. They always knock on her door before they come in her room. Resident #2 denied having any complaints about the facility.</p> <p>In an interview with the Social Worker (SW) on 10/22/24 at 11:40 AM, she stated she did not think a grievance was done since a report was filed with the state, but it should have been so that it would be listed on the grievance log. The SW does not remember Resident #1 ever accusing anyone of abuse prior to this event or after, and the SW denied seeing any bruising or other marks to Resident #1's body.</p> <p>In an interview with the ADON on 10/22/24 at 12:15 PM, she stated Resident #1 accused a CNA, who was trying to pull up her brief, of abuse, and either Resident #1 stopped the CNA and pushed her hand away or the CNA pushed Resident #1's hand away. ADON stated she doesn't remember exactly what occurred or how, but incident was reported. The ADON stated Resident #1's roommate was present and denied seeing the incident occur. ADON denied ever having any complaints on either of the CNAs that were working on that shift. The ADON denied seeing any bruising or any redness to Resident #1's hands or arms around that time.</p> <p>In an interview with the DON on 10/22/24 at 12:35 PM, he stated he would have to look into the investigation for Resident #1 and review it again, but obviously the dates are wrong as the provider investigation and assessment should read 3/31/24 and not 4/31/24. Also, he stated that how and when they reported depended on the allegation or situation, but typically with resident abuse it is reported to the state immediately.</p> <p>In an interview with the Administrator on 10/22/24 at 12:40 PM, he stated that the dates on the facility investigation were wrong because the incident did not occur or happen on 4/31/24, and then get reported on 4/2/24, as that would be impossible. He also stated with physical abuse they typically reported immediately, and he was not sure why they didn't in this case.</p> <p>In an interview with CNA - F on 10/23/24 at 3:11 PM, stated if she remembered correctly, the CNA grabbed Resident #1's diaper to fix it, and Resident #1 reached down to help her, and the CNA playfully swatted her hand telling her don't grab that. CNA - F felt that Resident #1 took it the wrong way, and that Resident #1 had never made complaints such as that before that she was aware of. CNA - F stated if she ever witnessed abuse, she would report it to the charge nurse and Administrator.</p> <p>In an interview with CNA - J on 10/22/24 at 3:21 PM, stated she did not remember Resident #1 ever making any claims of abuse, and never noticed bruising or redness to her hands or arms. CNA - J stated that she checked Resident #1's blood pressure daily, so she always saw her arms and hands. CNA - J denied ever hearing about staff slapping or swatting any residents' hands, but if she ever witnessed abuse, she would report to charge nurse and administrator.</p> <p>Record review of facility's Abuse and Neglect Policy, revised April 2021, revealed the facility would identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property, and investigate and report any allegations within timeframes required by federal requirements.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969</p> <p>Based on interviews and record reviews, the facility failed to send a copy of the notice of transfer or discharge, and the reasons for the transfer or discharge, in writing to the resident, resident representative, or the Office of the State Long-Term Care Ombudsman at least 30 days before transfer or discharge (or as soon as practicable before transfer or discharge when the safety of the individual is endangered, the health of the individual would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required for urgent medical needs, or a resident has not resided in the facility for 30 days) for one of four residents (Resident #3) reviewed for transfer and discharge.</p> <p>The facility failed to send the notice of transfer or discharge within 30 days, or as soon as practicable, in writing to Resident #3s RP or the Ombudsman when Resident #3 was discharged home on 5/9/23 and 3/5/24.</p> <p>This failure could affect residents by placing them at risk of being discharged and not having access to available advocacy services, discharge/transfer options, and the appeal processes.</p> <p>Findings included:</p> <p>Record review of Resident #3's face sheet revealed she is an [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses including, but were not limited to, Hyperkalemia, Hypertension, Heart Failure, Acute Kidney Failure, Diabetes Mellitus, Falls, and Dehydration.</p> <p>Record review of discharge summary for Resident #3 dated 5/9/23 revealed resident was discharged home on this date.</p> <p>Record review Resident #3's discharge notes and summaries revealed no discharge notices for discharges on 5/9/23 or for discharge noted on 3/5/24. Only discharge notice found in Resident #3's chart was a verbal discharge notification via telephone noted on the Notice of Medicare Non-Coverage (NOMNC) form dated for 5/5/23.</p> <p>Interview with the ADON 10/22/24 at 2:20 PM she stated she could not find the written discharge notice for the most recent discharge of 3/5/24, and she was going to get with medical records to see if they could print it for her.</p> <p>Interview with DON 10/22/24 at 2:30 PM he stated he had a discharge summary, but he would get with medical records to try and find the written discharge notification.</p> <p>Interview with the Admissions Coordinator 10/23/24 at 4:00 PM, she denied having anything to do with written discharge or transfer notices to residents. She stated she tried to see residents and talk to them during business hours and asks for their insurance information.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Assistant Business Office Manager, 10/22/24 at 4:05 PM, he denied having or getting written discharge or transfer notices, and he thought nurses take care of that; he stated he only asks for information needed for business office such as bank information or bank statements when they are applying for Medicaid.</p> <p>Interview with the Administrator, 10/22/24 at 12:40 PM, he stated that he did not handle the written discharge or transfer notifications; he stated that would be the nursing department that would have copies of them or know how to find them.</p> <p>Interview with the Social Worker, 10/22/24 at 11:37 AM, she stated the nursing department handled discharge and transfer education and notifications, so they would be able to get a copy of a written discharge notification or know where to find it.</p> <p>Interview with DON, 10/23/24 at 4:00 PM, he stated he had spoken with medical records about looking for this specific discharge notification, but he was just going to admit he already knew they will not find it because he was sure there wasn't one.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828</p> <p>Based on observation, interview, and record review the facility failed to ensure that residents maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range, for 1 of 5 Residents (Resident #19) reviewed for nutritional status in that:</p> <p>The facility failed to initiate timely intervention to prevent weight loss when Resident #19 experienced severe weight loss of -8.2% (9 pounds) between the dates 09/27/2024 and 10/24/2024.</p> <p>This failure could place residents who are dependent on staff for their nutrition and hydration at risk for nutritional deficit, weight loss, skin breakdown, and overall decline in quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #19's Face Sheet, dated 10/24/2024, reflected an [AGE] year-old resident admitted to the facility on [DATE] and an original admitted [DATE] with diagnoses including sepsis (a life threatening complication of an infection), pressure ulcer of sacral region-stage 2 (an open wound that has broken through the top layer of skin and part of the layer below), acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), anorexia (eating disorder causing people to obsess about weight and what they eat), and unspecified dementia (group of thinking and social symptoms that interferes with daily functioning).</p> <p>Record review of Resident #19's MDS assessment, dated 10/03/2024, reflected a BIMS score of 08, indicating moderate cognitive impairment. Further review reflected that Resident #19 had no or unknown weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months.</p> <p>Record review of Resident #19's Care Plan, dated 10/03/2024, reflected Resident #19 had a focus of being at risk for dehydration and malnutrition for having a diagnosis of anorexia. Goal was for him not to lose more than 5 % weight per month by next review in 90 days (target date 10/04/2024). His interventions included to monitor weight monthly and report a 5% weight loss or gain to MD and to monitor labs and meds for possible side effects causing weight loss and to give diet/feedings as ordered, refer to dietician to evaluate diet/feeding as needed. Resident #19 also had a focus of having a non-beneficial weight loss of 10.8% in 1 month. Weight on 08/20/24 was 127 pounds, weight on 09/2024 was 113.2 pounds. Weekly weights for four weeks. Goal was for him not to lose more than 5% within next review in 30 days (target date:10/04/2024). Interventions included to monitor labs and meds for possible side effects causing weight loss/gain, weekly weights for 4 weeks.</p> <p>Record review of Resident #19's weight record reflected that on 09/27/2024 he weighed 110 pounds and on 10/24/2024 he weighed 101.4 pounds.</p> <p>Record review of Resident #19's meal ticket reflected he was on a mechanical soft diet with special notes to add shakes to all meals. The order to add a shake to all meals was from a standing order from his physician.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #19's order dated 09/26/2024 for 10 ml of megestrol acetate oral suspension to be given once a day which started on 09/27/2024. The purpose of this medication was to act as an appetite stimulant.</p> <p>Record review of Resident #19's order for admission weight monitoring was weekly times 4 weeks starting on 09/27/2024.</p> <p>An interview on 10/21/2024 at 3:20 p.m., LVN C said Resident #19 had recently been readmitted after being sent to hospital for rectal bleeding. She said Resident #19 preferred eating in his room but recently she noticed he was not eating well in his bed. So, she recommended for him to be taken to the dining room to see if he could get some encouragement while eating. LVN C said Resident #19 was being weighed weekly as he was considered a new admission. LVN C could not say if she had notified the ADON of Resident #19's weight loss. She said Resident #19 was prescribed megestrol acetate oral suspension as an appetite stimulant and was on a health shake with meals. She said she had also advised his RP to bring him soups from home as those were his favorites. LVN C said she had also advised the DM to include soups in his daily meal trays.</p> <p>An interview and observation on 10/24/2024 at 10:30 a.m., revealed the DM said she had no interventions for Resident #19 due to his weight loss. She said it was not her responsibility to assess residents for weight loss. The DM said it was the responsibility of the Dietician to assess residents and make recommendations. The DM was observed checking PCC to see if the Dietician had made any recent recommendations and said no the last one that was done was in January 2024. The DM called the Dietician during the interview and asked about any recommendations for Resident #19. After the phone call ended, the DM said the Dietician told her she was going to work on Resident #19 on 10/24/2024.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview and observation on 10/24/2024 at 11:05 am, revealed the ADON was in charge of keeping track of residents weights. She said Resident #19 had been readmitted on [DATE]. She said because he was a considered a new admit, his weights were being monitored weekly for four weeks until 10/25/2024 as a standard protocol. The ADON was observed reviewing Resident #19's weight history on PCC. She said Resident #19 had a weight loss of -8.2% from 09/18/2024 to 10/18/2024 which was a loss of 13 pounds. The ADON said when a resident was weekly weight checks, the assigned CNA would weigh the residents and enter their weight on Kardex. She said the CNA would also notify the resident's Charge Nurse so the weight could be entered on PCC. The ADON said she herself would not review the weekly weights until the 1st of each month. She said in Resident #19's case, he was currently on weekly weight checks from 09/26/2024 to 10/25/2024 and she would not have checked his weights until 11/01/2024. She said she had not been prompted by Resident #19's charge nurse. She said the only thing she remembered was LVN C verbally telling her about Resident #19 not eating well in bed and so she instructed LVN C to eat his meals in the dining room when possible. The ADON said interventions for Resident #19 were an appetite stimulant, a house shake with each meal, and to be taken to the dining room for all his meals. The ADON said she had not notified the Dietician yet of his weight loss because she had not yet reviewed his weights and would not have done so until 11/01/2024. The ADON said the facility's protocol when a resident had weight loss was to notify the Dietician, conduct weekly weight checks for 4 weeks, and notify the physician and family. The ADON said Resident #19's physician had provided a standing order for his residents which instructed the facility on what to do in case of weight loss. The ADON said Resident #19 had significant weight loss and the facility should have started him on other interventions, notify the Dietician, physician, and family. The ADON said the Dietician should do quarterly assessments or as needed on all residents and stated the last time the Dietician did an assessment was in January 2024. She said PCC showed an assessment in April 2024, but it appeared as a draft. She said what draft meant was that the Dietician had not finalized the assessment and the facility was not able to review her assessment and/or any recommendations. The ADON was asked to have Resident #19 weighed on 10/24/2024. She said if she had waited until 11/01/2024 to review Resident #19's weight loss, it could have a result of continued weight loss and put the resident at risk of his wounds not healing properly.</p> <p>An interview on 10/24/2024 at 11:45 a.m., the DON said it was obvious the proper protocol was not followed for Resident #19's continued weight loss. He said the ADON should have reviewed Resident #19's weights since his re-admission to identify any weight loss trends, and if so, the Dietician should have been contacted. He said he would be looking in Resident #19's weight loss and would make sure the Dietician assessed him. The DON was not able to say how Resident #19's weight loss could affect his health.</p> <p>Observation on 10/24/2024 at 12:35 p.m., Resident #19 was observed in the dining room eating lunch. A house shake and a soup was on the resident's meal tray, and he was being fed by a staff member. Resident #19 was not non interviewable. Resident #19 did not appear to be frail or emaciated.</p> <p>Record review of Resident #19's weight history on 10/24/2024 revealed his weight was 101.4.</p> <p>Record review of Resident #19's standing order for weight loss (no date) revealed:</p> <p>Weight loss: Step 1-Fortified cereal in the AM (if diabetic) sugar free, snacks between meals and at HS, place at feeder/cueing table, update food preferences, 60 cc of vital cuisine QID with med pass, weekly weights, and dietary consult.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Weight loss: Step 2- continued weight loss: 60 cc (or increase to 120 cc) of vital cuisine supplement QID with med pass</p> <p>Record review of the facility's weight assessment and intervention policy revised on September 2008, revealed:</p> <p>Policy statement: The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents.</p> <p>Policy Interpretation and Implementation: Weight assessment .3. any weight loss of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing. 4. The dietician will respond within 24 hours of receipt of written notification. 5. The dietician will rereview the unit weight record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met. 6. The threshold for significant unplanned and undesirable weight loss will be based on the following criteria: a. 1 month- 5% weight loss is significant; greater than 5% is severe.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301</p> <p>Based on observations, interviews, and record review the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 3 residents (Resident #38) reviewed for respiratory care.</p> <p>The facility failed to ensure staff remained with Resident #38 while he received his nebulizer treatment.</p> <p>This failure could place residents at risk for respiratory distress.</p> <p>The findings included:</p> <p>Record review of Resident #38's face sheet dated 10/23/24 reflected the resident was a 72 -year-old male admitted to the facility on [DATE] with an original admitted [DATE]. Resident #38 had diagnoses which included the following: dementia (loss of cognitive functioning which interferes with daily life and activities), dysphagia (difficulty swallowing, and peripheral vascular disease (circulation disorder caused by narrowing, blockage or spasms in blood vessels).</p> <p>Record review of Resident #38's Quarterly MDS assessment, dated 9/21/24, reflected the resident had a BIMS score of 1 which suggested severe cognitive impairment. Self-care assessment reflected he was dependent on staff for all ADLs.</p> <p>Record review of the most recent Care Plan for Resident #38 reflected the resident require respiratory treatments due to cough and congestion and would have no shortness of breath by the next review. Target Date Initiated: 12/20/2024. Interventions included: administer albuterol as per MD order, administer ipratropium as per md order, monitor breathing/lung sounds before treatment and afterwards, and monitor for sob/congestion and administer treatments as ordered.</p> <p>Record review of the Doctor's Order Summary reflected Resident #38 was prescribed Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083% (Albuterol Sulfate) 1 dose inhale orally via nebulizer every 6 hours related to cough. Start Date 10/06/2023.</p> <p>Record review of the MAR/TAR for October 2024 reflected the resident was prescribed Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083% 1 dose inhale orally via nebulizer every 6 hours related to cough. -Start Date- 10/06/2023.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 10/21/24 at 12:10 PM revealed Resident #38 was in bed with head of bed elevated. Resident was receiving a nebulizer treatment via mask. The mask was not completely covering nose and mouth, and was slanted towards the left side of face. Resident began coughing, so the State Surveyor notified the floor nurse, LVN B. LVN B came to Resident #38's room and said RTs were responsible for providing nebulizer treatments to the residents, and he was not informed by the RTs when the treatment was started or that the resident was left alone. RT K and RT L arrived shortly after and asked if there was something going on. LVN B provided the RT K and RT L with report. The RTs went into the room with the resident. LVN B came out of the room and informed me that RTs were suctioning Resident #38 and adjusting his mask.</p> <p>In an interview on 10/21/24 at 12:15 pm with RT K, she said she was the RT for Resident #38. She said they started the nebulizer treatments for residents, then checked on other residents with tracheae or ventilators. She said they stayed nearby so not to leave the resident completely alone. The State Surveyor asked if their facility protocol or policy allowed them to leave a resident unattended while receiving a nebulizer treatment, and she said they are allowed to leave the resident alone to check on other residents.</p> <p>In an interview on 10/21/24 at 4:46 pm, conducted follow-up interview with RT K. She said when they started a nebulizer treatment on a resident, they made sure the head of bed was elevated and stayed in the area. She said, we left them alone maybe 2 to 3 minutes. We left to care for residents on ventilators or started other nebulizer treatments. The State Surveyor asked a second time if the facility's protocols or policies allowed them to leave a resident unattended while receiving a nebulizer treatment and she said, honestly I don't know if that is part of the protocol. She said the facility completed a skills check-off at hire but she had not had another training or skills check off since. She said a negative effect of leaving a resident unattended with a nebulizer treatment was their heart rate could go up. She said the nurses should be first to respond, but RTs went if it was something the nurse could not take care of. She said they let the nurses know when they left the resident's room. She said she was not sure if RT L in-training let LVN B know, she was tasked with the assignment.</p> <p>In an interview on 10/21/24 at 12:20 pm with RT L in training, she said they did not step out of the resident's room for long. She said they went to check on residents with ventilators and then came back. She said she was unaware of the facility's protocol or policy because she had been in training for 3 or 4 days.</p> <p>In an interview on 10/21/24 at 4:38 pm with RT L at 4:38 pm. She said they don't completely leave the resident alone. She said they went and checked on ventilators to ensure they were not beeping. She said that RT K trained her that day and told her the responsibility of providing nebulizer treatments were given to the RTs. She said she did not think she let Resident #38's nurse know they left resident with nebulizer going but doesn't remember. She said a negative effect of leaving a resident unattended with a nebulizer treatment is that they can throw up, but that is why they leave the head of bed elevated, so that they cannot aspirate.</p> <p>In an interview on 10/21/24 at 12:29 PM with the DON, he said the RT could leave a resident alone while receiving a nebulizer treatment. The State Surveyor requested the DON provide a copy of the facility's policy on respiratory care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455802	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Spanish Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 440 E Ruben Torres Blvd Brownsville, TX 78520	
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/23/24 at 10:03 am with the DON, he said he was caught off guard when I asked him if the RT could leave a resident alone while receiving a nebulizer treatment. The DON said the RT or nurse must stay with a resident until the nebulizer treatment was completed. He said they already in-serviced the RTs and nurses that same day, they ensured RT K was there, and they had the updated policy on hand. He said they had a certification for nurses and RTs on nebulizer treatment in the past. He said RT L just started training, so she has not been checked off on her skills yet. He said a negative effect of leaving a resident unattended with a nebulizer treatment is the resident could become anxious, tachycardic (a heart rate that is faster than 100 beats per minute) or could have removed the mask and not received the whole treatment. He said Resident #38 would not be able to adjust his mask on his own. He is also not able to completely cough up phlegm on his own.</p> <p>In an interview on 10/22/24 at 1:55 pm with LVN B, he said he was the floor nurse for the north wing where Resident #38 resided. He said he was not told by RT K or RT L that they had started the nebulizer treatment on Resident #38. He said RT K nor RT L asked him to keep an eye on the resident because they would be leaving him unattended for a short amount of time. He said that anytime a nurse or RT provided a nebulizer treatment for a resident, they stayed with the resident until the treatment was completed. He said we did not leave the resident alone. He said they all received respiratory care training annually which included nebulizer treatment. He said a negative effect of leaving a resident unattended with a nebulizer treatment could be that the resident goes into respiratory distress or tachycardia. He said he had checked on Resident #38 earlier and he was doing well. He said Resident #38 received nebulizers due to a chronic forceful cough.</p> <p>Record review of the Administering Medications through a small Volume (Handheld) Nebulizer policy, revised October 2010, reflected:</p> <p>Purpose:</p> <p>The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway.</p> <p>Steps in the Procedure .</p> <p>17. Remain with the resident for the treatment.</p> <p>Documentation .</p> <p>6. Pulse during treatment</p> <p>7. Amount and characteristics of sputum production.</p> <p>8. The resident's tolerance of the treatment.</p> <p>9/ Any adverse effects of the medication and/or treatment .</p> <p>Reporting .</p> <p>2. Notify the Physician if nausea or vomiting occurs during treatment.</p> <p>(continued on next page)</p>		

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

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the Physician if the resident experiences adverse effects from the medication.</p> <p>4. Notify the Physician if the pulse rate during treatment increases 20 percent above baseline.</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301</p> <p>Based on observations, interviews, and record review, the facility failed to ensure nurse staffing data was posted and readily accessible to residents and visitors with all required information for 4 (10/21/24, 10/22/24, 10/23/24, and 10/24/24) of 4 days reviewed for nurse staffing information.</p> <p>The facility failed to ensure the daily staffing information was posted on a form or spreadsheet, with all the required information on 10/21/24, 10/22/24, 10/23/24 and 10/24/24.</p> <p>This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts.</p> <p>Findings included:</p> <p>Upon entrance to the facility on [DATE] at 8:30 am, The State Surveyor observed a dry erase board to the top right of the wall next to the front desk with the current date, and the total number of CNAs, LVNs, and RNs written in dry erase marker. No other staffing information was posted on the dry erase board.</p> <p>During a walkthrough of the facility on 10/23/24 at 8:00 am, The State Surveyor observed a dry erase board on the north wing behind the nurse station with the current date, nurses' names and rooms assigned, CNAs names and rooms assigned for shifts 6:00 am to 2:00 pm and 2:00 pm to 10pm, written in dry erase marker. No information noted for night shift 10:00 pm to 6:00 am. No other staffing information was observed posted on the dry erase board. No dry erase board or other staff posting was located on the south wing.</p> <p>In an interview on 10/23/24 at 8:35 am with LVN B, he said the dry erase board behind the nurse station where he was, only pertained to the north wing. He said he always ensured the information on the board was accurate when he entered his shift. He said the CNAs updated the information daily, and the nurses reviewed and updated the information as needed when they entered their shift.</p> <p>In an interview on 10/23/24 at 8:42 am with the ADON, she said she oversaw both wings, north and south. She said she was told by the DON the staffing that was required for both wings. She said they were supposed to post staffing information for residents and visitors. She said the posting information was located behind each nurse's station. She said the CNAs in charge of the task obtained the information from the schedules and placed the information on the board daily including the weekends. The State Surveyor requested the ADON point out the staff information posted on the south wing. She did not locate the information. She questioned staff and said the dry erase board was taken down when the walls were painted and were not replaced yet. She said the posting should have CNA and nurse information, shifts worked, current date, and that they also added RT information.</p> <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>In an interview on 10/23/24 at 8:52 am with the DON, he said they did not have the south side dry erase board up with staffing information because of the repairs being completed. He said the information included on the dry erase board included staffing for the day per shift for LVNs, CNAs, and RNs. He said the census was not posted, and he was not aware of that as being a requirement. He said if the information was not posted, it could cause miscommunication with anyone coming into facility. He said the staff posting should be there for visitors to be aware of daily staffing. He said CNAs entered at 6:00 am with their assignments and updated the dry erase board. He said the nurses then entered at the start of their shift and made sure information was accurate and updated, or made corrections as needed.</p> <p>In an interview on 10/24/24 at 1:35 am with the Administrator, he said staff postings were required and should include nursing information and census information. He said he normally looked at policy to ensure, what was required, was implemented. He said the information was for the building and internal. He said the DON told him it required the census but did not know that requirement was updated. He said he was not aware if the posting was required in form or spreadsheet format, but he would get it that way if required.</p> <p>Record review of the Posting Direct Care Daily Staffing Numbers policy, revised August 2022, reflected:</p> <p>Policy Statement:</p> <p>Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents.</p> <p>Policy Interpretation and Implementation:</p> <p>1. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.</p> <p>2.Shift staffing information is recorded on a form for each shift. The information recorded on the form shall include the following:</p> <ul style="list-style-type: none"> a. The name of the facility; b. The current date (the date for which the information is posted); c. The resident census at the beginning of the shift for which the information is posted; d. Twenty-four (24)-hour shift schedule operated by the facility; e. The shift for which the information is posted; f. Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift who are paid by the facility (including contract staff); <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>g. The actual time worked during that shift for each category and type of nursing staff; and</p> <p>h. Total number of licensed and non-licensed nursing staff working for the posted shift.</p>

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>47828</p> <p>Based on interview and record review, the facility failed to employ staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service for 5 of 11 dietary staff (Dietary Staff M, N, P, Q, and R) reviewed for food and nutrition services.</p> <p>The facility did not ensure Dietary Staff M, N, P, Q, and R had a current food handlers' certificate while working in the facility's kitchen.</p> <p>This failure could place residents who consumed food prepared from the kitchen at risk of food-borne illness.</p> <p>Findings included:</p> <p>Record review of the 11 Dietary Staff food handler's certificates revealed 5 of them (Dietary Staff M, N, P, Q, and R) did not have a food handler's certificate prior to 10/21/2024.</p> <p>Record review of facility's staff roster revealed Dietary Staff M's hire date was 09/19/2023, Dietary Staff N's hire date was 12/12/2021, Dietary Staff P's hire date was 07/31/2024, Dietary Staff Q's hire date was 10/09/2024, and Dietary Staff R's hire date was 07/21/2023</p> <p>An interview on 10/23/2024 at 8:45 a.m., the DM said she was hired on 01/03/2024. She said when she first met her staff, she asked them if they all had their food handlers certificate, and all said yes. She said she took their word and didn't bother asking them for a copy of their certificate. She said the person who was responsible for making sure dietary staff had their food handlers certificate was human resources. The DM said she called Dietary Staff M, N, P, R, and Q on 10/21/2024 after the surveyor's initial tour to request their food handlers certificate because she didn't have a copy in her records. She said Dietary Staff M, N, P, R, and Q told her they did not have a current food handlers certificate and she advised them to take the course as soon as possible and to provide her with the certificate. The DM said the residents could be at risk for food borne illness if the staff did complete training on proper food handling requirements as required by regulations. The DM said the facility did not have a policy indicating dietary staff needed a food handlers certificate.</p> <p>An interview on 10/23/2024 at 9:30 a.m., the HR Manager said she was responsible for hiring all staff and making sure all staff had the required credentials. She said she was not aware kitchen staff had to have a food handlers certificate within 30 days of employment. She said her main focus was on making sure CNA's, LVN's, and RN's had their credentials. She said, I'm going to be honest with you, I know for sure there are some kitchen staff that do not have a food handlers certificate. She was not able to say how not having a food handler's certificate could negatively affect the residents.</p> <p>An interview on 10/23/2024 at 3:00 p.m., the Administrator said, he would look into it and was not able to say if there were any negative effects to residents. A copy of the facility's policy indicating the dietary staff needed a food handlers certificate was requested but he did not provide one before exit.</p> <p>(continued on next page)</p>		

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

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the TAC chapter 228.31 .Certified Food Protection Manager and Food Handler Requirements. (d) All food employees, except for the certified food protection manager, shall successfully complete an accredited food handlers training course, within 30 days of employment. (e) The food establishment shall maintain on premises a certificate of completion of the food handler training course for each food employee. The requirement to complete a food handler training course for each employee.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47828</p> <p>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 sanitation in that:</p> <ol style="list-style-type: none"> 1. The facility failed to keep the kitchen and dish room walls and floors clean. 2 The facility failed to ensure the juice dispenser nozzles were clean. 3 The facility failed to ensure the ice machine was clean. <p>These failures could place residents at risk of foodborne illnesses.</p> <p>Findings included:</p> <p>An observation of the kitchen on 10/21/2024 at 8:45 a.m., revealed multiple broken floor tiles, the floor grout had a thick black substance adhered to it, the tiles on the corner edges of the floor bed were cracked and had a black substances collected in the corner. The walls in the kitchen and dish room had yellowish stains and, in some areas, there were black spots in the ceiling. The vinyl backsplash strip on the bottom of the walls throughout the kitchen had black spots and, in some areas, separated from the wall and the sheet rock was peeling.</p> <p>In an interview on 10/21/2024 at 9:15 a.m., the DM said the kitchen floors were cleaned daily by the dietary staff. She said the floors were swept and mopped daily with hot water and cleaning chemicals. The DM said the yellowish stains on the walls were water stains. She said whenever it rained the water would leak into the kitchen. The DM said the roof was in the process of being repaired due to the water damage from recent rains. The DM said she did not know what the black spots throughout the ceiling were. The DM said she had a cleaning schedule for her staff to follow and to ensure the kitchen was kept clean.</p> <p>An observation of the kitchen (follow-up) on 10/22/2024 at 2:00 p.m., revealed one juicer that had two nozzle dispensers that were not clean. One nozzle had a reddish and white slimy substance adhered to hit and the second nozzle had a reddish slimy substance adhered to it.</p> <p>In an interview and observation on 10/22/2024 at 2:12 p.m., Dietary [NAME] N said the juicer was cleaned daily. She said the staff member who cleaned the juicer would initial and date the log. Surveyor observed Dietary [NAME] N review a binder with different logs but said she was not able to find the daily cleaning schedule log in the binder. She said she didn't know where the daily cleaning schedule log was.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/22/2024 at 2:16 pm, the DM said staff were supposed to clean the juicer and both dispensers daily. She said she had a log where staff members would sign off after they cleaned the equipment. The DM said she would have to look for the log because she didn't have it readily available. The DM said if the juicer and its dispenser were not cleaned it could cause contamination and it would be an infection control problem.</p> <p>An observation and interview with the DM on 10/22/2024 at 2:30 p.m., of the facility's ice machine reflected a 2 to 2 1/2 inch oblong black spot on the plastic backsplash which could have direct contact with the ice when it fell into the holding area. The DM said her staff were not responsible for cleaning the ice machine. She said the responsibility fell on the Maintenance Director. The DM said she was not sure what the black spot was but said it should not be there as it could contaminate the ice.</p> <p>An interview and observation on 10/22/2024 at 2:45 pm, the Maintenance Director said he was responsible for cleaning the ice machine. He was observed checking the black spot on the ice machine and said, I must have missed that spot two weeks ago when I cleaned the ice machine. He said he cleaned the ice machine every 3 months or earlier if needed, he said he did not keep cleaning logs. He said when he cleaned the ice machine, he would first melt all the ice, then he would use a mixture of water and Clorox to clean it. He said he had never seen any black spots on the ice machine prior to 10/22/2024. He said he would immediately melt the ice and clean the ice machine. He was not able to say if the black spot caused had any negative effects on residents.</p> <p>An interview on 10/22/2024 at 3:00 p.m., the DON said the ice machine was not his responsibility but if the ice machine were not cleaned properly it could cause respiratory issues for residents.</p> <p>An interview on 10/23/2024 at 11:53 a.m., the Dietician said she was not responsible of making sure the dietary staff had their food handler's certification. She said she would visit the facility two times a month or as needed. She said during her visits, she would make sure the kitchen was sanitary. She said she would also inspect the ice machine and had never seen any black spots and the juicer did not have any slimy substance adhered to the nozzles. The Dietician said the facility's kitchen was kept in a sanitary condition.</p> <p>In an interview on 10/24/2024 at 3:00 p.m., the Administrator was asked if he were aware of the kitchen's walls, broken floor tiles, the sanitation of the juicer, and ice machine and he said, he would look into it and was not able to say if there were any negative effects to residents.</p> <p>Record review of the kitchen's daily cleaning schedule (provided on 10/23/2024) for the month of October 2024 (1st to 21st) revealed the floor had been cleaned but they did not include the juicer. The daily cleaning schedule from October 21-27, 2024, revealed the word juices had been added (handwritten) to the cleaning schedule.</p> <p>Record review of the kitchen's daily cleaning schedule for the months of September through October 19, 2024, revealed the juicer was not included in the daily cleaning schedule to be cleaned. The daily cleaning schedule for October 21-27, 2024, revealed the word juices had been added (handwritten) to the cleaning schedule.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/24/2024, the DM said even though the daily cleaning schedule prior to 10/19/2024 did not include the juicer as an item to be cleaned, she would make sure staff cleaned it daily.</p> <p>Record review of the ice machine manufacture's recommendations revealed, recommends cleaning your ice maker every six months to keep it working properly.</p> <p>Record review of FDA Code 2022, chapter 2, Mangement and Personnel reflected (8) Describing the relationship between the prevention of foodborne illness and the management and control of the following: (a) Cross contamination, Pf (b) Hand contact with READY-TO-EAT FOODS, Pf (c) Handwashing, Pf and (d) Maintaining the FOOD ESTABLISHMENT in a clean condition and in good repair;</p> <p>Record review of the kitchen's Sanitation policy dated 2001 and revised on 11/2022 revealed:</p> <p>Policy statement:</p> <p>The food service area is maintained in a clean and sanitary manner.</p> <p>Policy interpretation and implementation:</p> <p>1. All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects.</p> <p>2. All utensils, counters, shelves, and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. Seals, hinges, and fasteners are kept in good repair.</p> <p>10. Ice machines and ice storage containers are drained, cleaned and sanitized per manufacturer's instructions.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455802	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Spanish Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47828</p> <p>Based on observation, record review, and interview, the facility failed to establish and maintain an infection prevention and control program, designed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections, for 2 residents (Resident #14 and Resident # 69) of 30 residents that were reviewed for infection control and transmission-based precautions policies and practices, in that:</p> <p>The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Med-Aide T did not grab Resident #69's barbeque sandwich with bare hands while being fed. 2. Med-Aide T did not feed Resident #14 a pureed diet without sanitizing her hands. <p>These failures could place residents at risk for infection through cross contamination of pathogens.</p> <p>The findings include:</p> <p>During a lunch dining observation on 10/21/2024 at 12:15 p.m., Med-Aide T was observed sitting on a semi round table with four residents sitting in front of her. She grabbed Resident #69's barbeque sandwich with her bare hands and started feeding her. After feeding Resident #69 she moved over to Resident #14 and started feeding her puree diet without sanitizing her hands or wearing gloves. She did that several times and at one point she was feeding Resident #69 her barbeque sandwich with 1 bare hand while feeding Resident #19 her puree diet with her other bare hand at the same time.</p> <p>An interview and observation on 10/21/2024 at 12:20 pm, the DON said staff could feed up to 4 people at a time. The DON observed Med-Aide T feeding both Resident #14 and #69 and said Med-Aide T should not have touched Resident #69's barbeque sandwich with her bare hands without sanitizing or using gloves before and after. He said staff were supposed to be wearing gloves and/or sanitizing their hands when feeding residents. The DON was observed leaving the dining hall and coming back with four bottles of hand sanitizers: one for each table. The DON said staff were regularly in-serviced on infection control. The DON said when staff did not sanitize their hands while feeding residents, that was an infection control issue.</p> <p>An interview on 10/21/24 at 1:00 p.m., Med Aide T said she would assist in feeding residents during lunch time daily. She said during feeding times, she could have up to 4 residents on her table. She said she washed her hands prior to sitting down to feed Resident #14 and Resident #69. She said both Resident #14 and #69 were very demanding and she said she caught herself feeding both residents at the same time, but just wanted to feed them because they were hungry. Med-Aide T said she had received infection control in-services at least monthly. She said she was aware she had not followed proper infection control protocol and negative effects on residents would be cross contamination and infection control.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/24/2024 at 3:00 p.m., the Administrator was informed of what Med-Aide T had failed to do while feeding Resident #69 and #14, the Administrator said, I will look into it and was not able to say if there were any negative effects to residents.</p> <p>Record review of facility's Handwashing/Hand Hygiene policy dated 2001 and revised October 2023 revealed:</p> <p>Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.</p> <p>Policy Interpretation and Implementation:</p> <p>Administrative Practices to Promote Hand Hygiene: 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>47828</p> <p>Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for 1 of 2 halls (Halls) reviewed for environment.</p> <p>The facility failed:</p> <ol style="list-style-type: none"> Failed to maintain Resident #37's room in good condition. <p>This deficient practice could place residents at risk of not living in a safe, functional, sanitary, and comfortable environment.</p> <p>The findings included:</p> <p>An observation on 10/22/24 at 9:15 a.m., Resident #37's room revealed the wall behind the bed had the sheet rock peeling and the vinyl strip was separated from the wall.</p> <p>An interview on 10/23/2024 at 2:30 pm, the Maintenance Director stated the wall damage to Resident #37's room (wall) was caused when the bed was pushed against the wall. d He said the bed had a u shape metal rod that extended longer than the headboard and that's what caused the damage. He said that was a recurring problem in all the rooms and the only solution was to replace the vinyl strip and sheet rock.</p> <p>In an interview on 10/24/2024 at 3:00 p.m., the Administrator did not say if he was aware that some resident rooms wall were damaged. I will look into it and was not able to say if there were any negative effects to residents.</p> <p>Record review of facility's Maintenance Service policy dated 2001 and revised December 2009 revealed:</p> <p>Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment.</p> <p>Policy Interpretation and Implementation:</p> <ol style="list-style-type: none"> The maintenance department is responsible to maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personal include, but are not limited to: <ul style="list-style-type: none"> b) maintaining the building in good repair and free from hazards. 		