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	01/29/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for storage, preparation, and sanitation.2.The facility failed to label and date 4 cans of evaporated milk stored in the dry storage area.3.The facility failed to ensure that 4 oz. cups of sherbert stored in the freezer were labeled and dated.These failures could place residents who store food items in resident refrigerators and who receive meal and/or snacks from the kitchen at risk for cross contamination if consumed and food-borne illnesses if consumed.The findings included:2. In an observation on 1/27/2026 at 10:30 AM, the initial tour of the kitchen accompanied by [NAME] G, revealed 4 cans of evaporated milk in the dry storage pantry without an out-of-the box date. The expiration date for the 4 cans was 1/7/27.3. In an observation on 1/27/2026 at 10:30 AM, the initial tour of the kitchen accompanied by [NAME] G revealed 7 4oz. sherbert cups that did not have an expiration date and no out-of-the box label.In an interview on 1/27/2026 at 10:35 AM with [NAME] G, she said it was important to label and date cans. She said if they were not labeled, it could cause harm to the residents. She said there was a designated kitchen staff member that oversees receiving and storing merchandise and labeling cans and foods. She said the designated kitchen staff member had just started one week before and that the dietary manager provides training on topics such as labeling, defrosting raw foods, rotating cans and discarding expired foods. [NAME] G said the box that contained the sherbert ice cream in the freezer was thrown out which contained the expiration date and open date.In an interview on 1/29/2026 at 4:19 PM with the Dietary Manager, said she was constantly observing and checking labeled cans and making sure food was stored properly. She said she provides the kitchen staff daily reminders on labeling, food storage, and food temperatures. The DM said she provides weekly in-services to the kitchen staff as well.In an interview on 1/29/2026 at 4:30 PM with [NAME] H, said she was designated staff for storing all the merchandise brought by in the vendor. She said her duties included rotating the cans in the food pantry by placing the older cans to the front and the newer cans to the back. She checked the expiration dates and placed labels on the items as she placed them on the shelves. [NAME] H said she cleaned out the refrigerators and freezer, disposed of poorly looking produce and changed out boxes that contained produce. She said she had thrown out the box, which was dated, that contained the evaporated milk, to make room for new merchandise. She said she was supposed to label the cans with the date when she removed the cans from the box but did not. [NAME] H said she received daily reminders from the DM about labeling. Record review of the facility policy titled Food Receiving and Storage dated November 2022, indicated Dry Food Storage .3. Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. 4. Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by dare). Such foods are rotated using a first in - first out system. Refrigerated/Frozen Storage 1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). Record review of In-Service Summary and Attendance dated 12/26/25, Description of Training Session: Label and Restocking, indicated 11 kitchen staff signatures on the attendance record. Record review of In-Service Summary and (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Attendance dated 1/1/26, Description of Training Session: Labeling and Dating, Temp. Logs, indicated 10 kitchen staff signatures on the attendance record. Record review of In-Service Summary and Attendance dated 1/28/2026, Description of Training Session: Label and Dating Food Items, indicated 10 Kitchen staff signatures on the attendance record.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice for 1 (Resident #54) of 2 residents reviewed for parenteral fluids.The facility failed to ensure that Resident #54's intravenous medication bag was labeled with the resident's name.The facility failed to ensure the dressing on Resident #70's peripheral intravenous line (a short flexible tube inserted into a vein to administer fluids and medications) was dated and initialed.This failure could place residents at risk for medication errors and delay in medication administration.The findings included:Record review of Resident #54's admission record, dated 1/28/2026, indicated the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. The resident had diagnoses which included: Chronic Respiratory Failure (long-term condition where the lungs cannot properly exchange gases, leading to low oxygen or high carbon dioxide in the blood), Heart Failure (the heart cannot pump enough oxygen-rich blood to meet the body's needs), Chronic Obstructive Pulmonary Disease (a progressive and irreversible lung disease that makes breathing difficult by damaging airways and air sacs and causing inflammation).Record review of Resident # 54's MDS assessment, dated 1/25/2026, indicated Resident #54's BIMS score was 12 (indicating moderately impaired cognition). Section I8000 indicated Additional active diagnoses included Pneumonia (common lung infection that causes inflammation) and Sepsis (the body's extreme reaction to an infection causing the immune system to go into overdrive and starts harming tissues and organisms).Record review of Resident #54's Order summary indicated Vancomycin HCl Intravenous Solution 1000 MG/ 200 ML Use one application intravenously at bedtime, start date: 1/20/2026.Record review of resident #54's Care Plan dated 1/20/26 indicated: Receiving ABT TX R/T Dx: Leukocytosis 1/20/2026 Vancomycin HCl IV Dx Elevated [NAME] Blood Count. Goal: Infection will be resolved. Resident will not have any adverse effects. Interventions: Administer medications as ordered.In an observation on 1/27/2026 at 4:35 PM, an empty bag of Vancomycin 1000 MG/200 ML was hanging on an IV pole in resident #54's room. The label on Vancomycin IV revealed another resident's name. The DON and LVN A were made aware of the Vancomycin and was removed from Resident # 54's room by the DON.In an interview on 1/29/2026 at 4:44 PM with LVN A said he had given resident #54 the medication and that there were 3 bags of the same Vancomycin IV medication. He said he accidentally grabbed the medication that belonged to another resident (Resident #78). He said both residents had the exact medication ordered and only saw the first name on the bag and grabbed it. LVN A said the 5 rights of medication administration were the right drug, dose, patient, time and route. He said the importance of following the 5 rights of medication administration is to avoid medication errors. He said the only negative outcome was that it was a mistake for this resident, but he did receive the right medication and the right dosage. We try to avoid errors as much as possible and not commit errors. LVN A said no new orders were given by resident # 54's physician.In an interview on 1/29/2026 at 5:45 PM with the DON, He said medication administration in-services were ongoing which began he began on 1/27/26 and with the emphasis on the 6 rights of medication administration. He said LVN A was suspended until the facility concluded its investigation. The DON said LVN A will need to complete a skills check-off list and a 1:1 in-service/education with the DON and the Executive Director before returning to work.In an interview on 1/29/2026 at 6:10 PM with the LNFA, she said nursing in-services and a plan of correction were started immediately. She said spot checks were being done to ensure interventions were carried out. The LNFA said clinical meetings were held every morning to discuss each resident and address problems, interventions and solutions. She said QAPI meetings were held monthly to discuss referrals, admissions/discharges, infection control, incidents, and falls. 2. Record review of Resident #70's admission record dated 1/29/2026 indicated at [AGE] year-old male with an admission date of 1/22/2026. His diagnoses included Sepsis (body's extreme reaction to an infection causing the (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immune system to harm tissue and organs) and Anogenital (Venereal) Warts (bumps on the skin around the genitals and anus, caused by a sexually transmitted infection).Record review of Resident #70's MDS assessment dated [DATE], indicated a BIMS score of 8 which indicated moderate cognitive impairment.Record review of Resident #70's order summary with a start date of 1/23/2026 indicated Assess IV site (right back of hand) Q shift for infiltration or S&S of infection every shift.Record review of Resident #70's order summary with a start date of 1/22/2026 indicated Change Hep-Lock (a small, capped-off IV tube inserted into the vein that allows nurses to give medications of fluid) every 72 hours and PRN, may change PRN if hard stick. In an observation on 1/27/2026 at 11:35 AM, Resident #70 had an IV access to his left forearm and covered with a dressing that was not labeled or dated.In an interview on 1/27/2026 at 12:04 PM with LVN D, he said the IV access was only good for 72 hours, unless otherwise ordered by the physician. He said not knowing how long the IV has been inserted can cause possible infection to the site or infiltration (occurs when an IV tube slips out of the vein, causing fluids or medicine to leak into the surrounding tissue instead of the bloodstream).In an interview on 1/29/2026 at 5:23 PM with LVN I, he said he had replaced Resident #70's IV access to the left posterior (back) forearm and used a 22-gauge needle. He said he flushed the IV access, placed tape, and dated it for 1/23/2026. LVN I said not having a label on the IV dressing can cause a risk for phlebitis, infection, and possible sepsis. He said he had an in-service on IV medication and labeling of the IV dressings about 3 months ago.In an interview on 1/29/2026 at 5:45 PM with the DON, he said during each shift, the nurses were to check the IV flush order before and after infusion and at the same time checking that the IV site was secured and checking for S&S of infection. He said the facility policy states to label the IV site. He said standing orders were given to change IV site every 72 hours and for a midline IV site, was every week.Record review of policy titled Policies and Practice-Infection Control dated October 2018, indicated .Contact Precautions can occur: with indirect contact with environmental surfaces or resident-care items in the resident's environment such as door handles, table surfaces, mobile phone or TV remotes. Transmission-Based Precautions include: Contact Precautions.Record review of In-service and Attendance dated 1/27/2026, Topic: The 6 rights to med pass, Trainer: Executive Director, indicated 16 employee signatures.Record review of the facility's policy dated April 2019 titled: Administering Medications indicated Policy Interpretation and Implementation.10. The individual administering the medication checks the label THREE (3) times to verify the right resident, the right medication, right dosage, right time, and right method (route) of administration before giving the medication.Record review of the Annual Bloodborne Pathogens & Hazard Communication Awareness Training Employee Attendance Record dated 10/13/2026, indicated training was done on the following: .3. Modes of Transmission . 7. Personal Protective Equipment, 8. Selection of PPE . 13. Signs and Labeling included 48 employee signatures noted.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 (Resident #23) of 3 residents reviewed for respiratory care.The facility failed to ensure Resident # 23's oxygen was administered at the correct setting of 2 liters per minute on 1/27/2026 as ordered by the physician.These deficient practices could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care.The findings included:Record review of Resident #23's admission record dated 1/29/2026 indicated a [AGE] year-old male with an admission date of 9/13/2025. The resident had diagnoses which included: Chronic Obstructive Pulmonary Disease (a progressive and irreversible lung disease that makes breathing difficult by damaging airways and air sacs, causing inflammation), Chronic Respiratory Failure (long-term condition where the lungs cannot properly exchange gases, leading to low oxygen or high carbon dioxide in the blood), Obstructive Sleep Apnea (common disorder when the airways are repeatedly blocked during sleep, causing brief to briefly stop breathing).Record review of Resident #23's Quarterly MDS assessment, dated 12/21/25, indicated Resident #23 had a BIMS score of 6 (indicated severe cognitive impairment). Section O- Special Treatments, Procedures, and Programs. Respiratory Treatments indicated Oxygen therapy was checked off.Record review of Resident #23's active orders as of 1/26/2026 indicated O2 at 2L/min. Via N/C continuously Via O2 Concentrator every shift. Order date: 9/17/2025.Record review of Resident #23's care plan dated 1/04/2026 indicated FOCUS: I have a BIPAP and am on continuous Oxygen per nasal cannula which I refuse to keep on a lot of the time. GOAL: I will have no shortness of breath daily by next review in 90 days. Interventions: .Give Oxygen as ordered: O2 at 2 LPM via N/C continuously.During an observation of Resident #23 on 1/27/2026 at 11:37 AM revealed the oxygen level on the oxygen concentrator machine was a 1 Liter Per Minute via nasal cannula. Observation of Resident #23 revealed the resident was sitting up in sitting up in his wheelchair. No signs of respiratory distress noted.In an interview on 1/27/2026 at 11:37 AM with Resident #23 said he did not move the setting on the oxygen concentrator and that he only knew that he was supposed to be on 2 liters.In an interview on 1/27/2026 at 11:43 with LVN D, he said he was the nurse for Resident #23. LVN D observed the setting was at 1 Liter Per Minute. He said the Oxygen setting was supposed to be at 2 Liters Per Minute as ordered by the physician. He was not sure who might have moved it. He said he did his round at 6 AM and observed the setting at 2 Liters. LVN B said that not receiving the prescribed dose of Oxygen can cause O2 de-saturation and the resident can go into respiratory distress. LVN D adjusted the Oxygen setting to 2 liters and assessed Resident #23In an interview on 1/29/2026 at 5:45 PM with the DON, said that oxygen settings are checked every shift and documented. He said that random rounds are done by the DON to check for compliance. The DON said RT perform spot checks and document O2 saturation every shift. He said annual skills check-off list includes O2 therapy and nebulizer use. He said a corporate level in-service was scheduled on 1/28/2026 for management related to Respiratory Services and then provide an in-service to the rest of the staff. In an interview on 1/29/2026 at 6:10 PM with the LNFA, she said nursing in-services and a plan of correction were started immediately. The LNFA said clinical meetings were held every morning to discuss each resident and address problems, interventions and solutions. She said QAPI meeting were done monthly to discuss referrals, admissions/discharges, infection control, incidents, and falls.Record review of the facility's policy titled Oxygen Administration dated October 2010 indicated Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation- 1.Review the physician's orders or facility protocol for oxygen administration. Steps in Procedure- .8. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #78) of 2 residents reviewed for pharmacy services.The facility failed to ensure discontinued medication prescribed for Resident # 78 were removed from medication storage room [ROOM NUMBER].This failure could place residents at risk of receiving wrong medications.The findings included:Record review of Resident #78's admission record dated 1/29/2026, indicated a [AGE] year-old male with an original admission date of 10/17/2024 and an admission date of 1/15/2026. Resident # 78's admission record included diagnoses of sepsis (body's extreme reaction to an infection, creating tissue and organ damage) and pneumonia (common lung infection that causes inflammation). Record review of Resident #78's order summary, dated 1/15/2026, indicated Vancomycin HCl Intravenous solution 1000 MG/ 200 ML, use one application intravenously every 18 hours related to pneumonia. Start Date:1/15/2026 and Discontinue date: 1/16/2026Record review of Resident # 78's medication administration record indicated Vancomycin was given on 1/15/2026 at and the second and last dose was given on 1/16/2026.In an observation on 1/27/2026 at 4:45 PM, revealed Vancomycin IV medication for Resident #78 was hanging in a clear plastic bag in Medication room [ROOM NUMBER]. Next to Resident # 78's IV medication was Resident #54's medication which was Vancomycin IV, same dose as Resident #78. The DON witnessed the current and discontinued IV medication hanging on the wall for both residents. In an interview on 1/27/2026 at 4:45 PM, the DON said there is a specific location in the medication room for discontinued medications. He said discontinued medications are to be placed in a bin designated for discontinued medication, located at the bottom of the shelf in the medication room. In a second interview on 1/28/2026 at 4:15 with the DON, he said the IV Vancomycin medication had not been inventoried, so it stayed in the medication storage room. He said a facility drug destruction log is filled out by the nursing staff or medication aide and is pulled out of the area and placed in a box designated for discontinued medication. He said the staff informed him of the discontinued medication and he retrieved the discontinued from the medication room and placed them under lock and key. The DON said once a month the pharmacy consultant will come into the facility and verify the discontinued medication and seal the box to prepare for destruction. He said the sealed boxes were picked up by a vendor for destruction. The DON said he was not told that there was Vancomycin in the medication room that had been discontinued.In an interview on 1/29/2026 at 10:59 AM with LVN F, she said she received the order from the NP to discontinue the Vancomycin IV for resident #78 on 1/16/2026. She said she made an entry in the progress notes and discontinued the medication on the MAR. She said she removed the medication from her med cart and placed the Vancomycin IV medication in the medication room in a box designated for discontinued medication. She said she did not remember seeing the Vancomycin hanging on the wall with the rest of the current medication. She said she did not fill out any form indicating the medication was discontinued. She said she did not have to notify the DON of discontinued medication.Record review of the facility's policy titled Discontinued Medication dated November 2020 indicated Policy Interpretation and Implementation .2. The nurse receiving the order to discontinue a medication is responsible for recording the information (e.g., writing discontinued date, dating and initialing MAR) and notifying the dispensing pharmacy of the discontinuation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure biologicals were stored in locked compartments and accessed by authorized personnel for 2 (Resident #54 and Resident #61) of 6 residents were reviewed for medication storage.The facility failed to ensure Resident #54's and Resident #61's did not have Normal Saline (a sterile mixture of water and 0.9% salt that closely matches the natural fluid balance in human blood) Prefilled syringe on top of the residents' bedside tables on 1/27/2026.This failure could place the residents at risk of having unauthorized access to prescription medications and biologicals and place residents at risk of access to hazards.The findings included:In an observation on 1/27/2026 at 12:27 PM, revealed an unpackaged prefilled 10 cc syringe of Normal Saline on top on Resident #61's bedside table.In an observation on 1/27/2026 at 4:35 PM, revealed an unpackaged, prefilled 10 cc syringe of Normal Saline on top of Resident #54's bedside table.Record review of Resident #61's face sheet, dated 1/29/2026, indicated a [AGE] year-old female with an original admission date of 1/16/2026. Her diagnoses included Sepsis (the body's extreme reaction to an infection which creates tissue and organ damage), Incisional Hernia with Obstruction (a condition where part of the intestine pushes through a weak spot in the abdominal wall and becomes trapped and blocked), Perforation of the Intestine (a hole, tear, or rupture in the wall of the small or large intestine).Record review of Resident #61's physician orders indicated PICC Line to right upper extremity flush with 10 cc of saline Q-shift and with ABT therapy, dated 1/17/2026.In an observation on 1/27/2026 at 12:27 PM, revealed an unpackaged prefilled 10 cc syringe of Normal Saline on top of Resident #61's bedside table.Record review of Resident # 54's face sheet, dated 1/28/2026, indicated a [AGE] year-old male with an original admission date of 7/18/2025. His diagnoses included Sepsis (body's extreme reaction to an infection, creating tissue and organ damage) and Pneumonia.Record review of Resident # 54's physician orders indicated Flush IV line with 10 cc of NS before and after medication administration Q shift, dated 1/15/2026.In an observation on 1/27/2026 at 4:35 PM, revealed an unpackaged, prefilled 10cc syringe of Normal Saline on top of Resident #54's bedside table.In an interview on 1/27/2026 at 12:38 PM with LVN F said she was not sure why the syringe was left on top of Resident # 61's bedside table. She said she disposed the syringes in the medication cart's sharps container or in the trash can. She said she made rounds every 1 to 2 hours and did not see the syringe on the bedside table. LVN F said a negative outcome could be that the resident could pick it up and use it for another purpose.In an interview on 1/29/2026 at 5:45 PM with the DON, he said that nursing administration performed rounds and checked the overall cleanliness of the resident's rooms and looking for objects that are not supposed to be at bedside. He said in-services were given to staff on 1/27/2026 and were ongoing, regarding IV supplies at bedside including NS.Record review of the facility's policy titled Medication Labeling and Storage, dated February 2023 indicated Medication Storage .2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. 5. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption for 1 of 2 resident refrigerators reviewed for refrigerator sanitation. The facility failed to ensure resident's personal refrigerators were maintained. Resident #90's refrigerator had 4 small individual cartons of orange juice and an individual container of gelatin that were all expired.This failure could place residents who store food items in resident refrigerators, at risk for cross-contamination and food-borne illnesses if consumed.Findings were:Record review of Resident #90's admission Record dated 01/29/26 revealed [AGE] year-old female with diagnoses of Alzheimer's Disease (brain disorder causing decline in memory, thinking, and daily functioning), Unspecified, Heart Failure, Unspecified, and Essential (Primary) Hypertension (high blood pressure).Record review of Resident #90's MDS dated [DATE] had a BIMS Score of 06 suggesting severe cognitive impairment.In an observation on 01/27/26 at 12:05 pm, surveyor observed 4 small orange juice cartons and an individual cup container of gelatin with expired date 01/21/26 inside Resident # 90's personal refrigerator in her room. In an observation on 01/27/26 at 12:06 pm a Resident Refrigerator Temperature Log had been taped on the top of the resident refrigerator. It had been noted that the refrigerator had last been checked on 01/27/26 in the AM. In an interview on 01/27/26 at 12:06 pm Resident #90 said she has drank orange juice and does eat gelatin but could not recall when it was brought in or who put it in the refrigerator in her room.In an interview on 01/27/26 at 12:24pm LVN D said the managers are the one's in charge of checking refrigerators in resident's rooms. He said they are checked daily to make sure the temperature has been set appropriately and there should be no expired food left in the refrigerator.In an interview on 01/27/26 at 1:28pm the DON said the managers are in charge of checking the refrigerator in the residents room. He said the administrator assigned which resident rooms each manager was in charge of. He said the managers checked resident rooms including their refrigerators every morning. The DON said Manager E was in charge of Resident #90's room.In an interview on 01/27/26 at 6:07 pm Manager E said he checked Resident #90's room including the refrigerator. He said he had not seen any juices or gelatin in the refrigerator. Manager E said he had checked Resident #90's refrigerator in her room some time in the morning, he did not remember what time exactly but had not seen any of those items in there. Manager E said he had been assigned to check Resident #90's room daily. He said he was required to check the refrigerator temperature and if there was any food in there that was expired. Manager E said he did not know what could have happened if any of those foods were consumed by Resident #90 because he was not a doctor.In an interview on 01/29/26 at 5:46 pm the Administrator said the facility has angels or ambassadors who are managers and are required to do rounds on resident rooms daily. She said they were responsible for making sure the residents rooms were clean and if they had a refrigerator in the room, they needed to make sure the temperature was appropriate for the food kept inside and ensure that it was labeled and was not expired. The managers do their rounds before their morning meeting between 8:00 am and 9:00pm. She said Manager E was assigned to Resident #90. The Administrator said Manager E does his rounds in the morning, daily. She said all staff are reminded what to do when they do their rounds. The Administrator said Resident #90 could have gotten an upset stomach had she consumed those expired items.Record review of the facility's policy Foods Brought by Family/Visitors revision date March 2022; Policy Statement: Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. Policy Interpretation and Implementation 6. The nursing staff will discard perishable foods on or before the use by date.

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	01/29/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #68) of 8 residents observed for infection control. The facility failed to ensure CNA A changed gloves after touching the bed remote during perineal care for Resident#68 on 01/28/2026. The facility failed to implement the required contact precautions sign on the room entrance doors for Resident #54 and Resident # 70 for Transmission Based Precautions.These failures place residents at risk for healthcare associated with cross contamination and infections. Findings included: 1.Record review of Resident #68's electronic face sheet dated 1/29/2026, reflected an [AGE] year-old male admitted to the facility on [DATE], original admission date of 08/17/2024. His diagnoses included Acute Ischemic Heart Disease (a sudden, dangerous shortage of blood and oxygen reaching the heart muscle), Hypertension (high blood pressure), Unspecified Dementia (group of thinking and social symptoms that interferes with daily functioning), and Benign Prostatic Hyperplasia (an enlargement of prostate). Record review of Resident #68's quarterly MDS assessment dated [DATE] revealed he scored a 04 on his BIMS which indicated he was severely cognitively impaired. During an observation on 01/28/2026 at 3:33 p.m., CNA A donned gloves and touched the bed remote to move the bed up to working height. She then proceeded to unfastened Resident #68's brief and grabbed the clean wipe. CNA A continued with pericare using the same pair of gloves. During an interview on 01/28/2026 at 3:47 p.m., CNA B stated that after touching the bed remote with gloves, she was to remove gloves, sanitize, and put on new gloves. She stated that everybody touches the bed remote, including the resident. CNA B stated that it was important to change gloves after touching the bed remote to protect the resident from cross contamination. During an interview on 01/28/2026 at 3:51 p.m., CNA A stated that she knew that she was supposed to change gloves after touching the bed remote but forgot. She stated that the bed remote could be contaminated with bacteria from the resident and other staff. She stated that she was a recent hire, and she did get infection control training upon hire. CNA A stated that it was important for her to change gloves after touching it to prevent infection. During an interview on 01/28/2026 at 4:05 p.m., ADON C stated that staff was to remove gloves after touching the bed remote due to the remote being contaminated. She stated that they have had infection control training several times. ADON C stated that staff were to change gloves after touching the bed remote to prevent any infection. During an interview on 01/29/2026 at 5:15 p.m., the DON stated that infection control in-services were done frequently depending on the situation. They do them quarterly and as needed. She stated that the staff were to change gloves after touching the bed remote to prevent cross contamination. The DON stated that the negative outcome would be that the resident can get an infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Competency Evaluation Form Perineal Care revealed #7. Raise bed height to your comfort level and lower resident's head. #8. Wash your hands Record review of the facility's Infection Control Policy and Practices revised date October 2018 revealed Policy Statement: This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Policy Interpretation and Implementation: 1. This facility's infection control policies and practices apply equally to all personnel, consultants, contractor, residents, visitor, volunteer workers, .) 2. The objectives of our infection control policies and practices are to: a.prevent, detect, investigate, and control infections in the facility; b.maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. 4. All personnel will be trainined on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. 2. Record review of Resident #54's admission record dated 1/28/2026, revealed a [AGE] year-old male with an admission date of 1/15/2026. His diagnoses included Sepsis (body's extreme reaction to an infection causing the immune system to harm tissue and organs) and pneumonia (common lung infection, leading tiny air sacs to fill with fluid or pus). Record review of Resident #54's MDS assessment dated [DATE], indicated a BIMS score of 12 which indicated moderate cognitive impairment. Record review of Resident #54's order summary dated 1/28/2026, indicated Contact Precautions D/T MRSA to Blood: Provide barrels for proper disposal of linen and waste in biohazard bags every shift Date ordered: 1/20/2026. In an observation on 1/27/2026 at 4:26 PM, there was a yellow bag hanging from Resident #54's room which contained gloves and gowns. The bag had an EBP sign affixed to it. There was a second sign located at the side of the door frame that stated, PLEASE SEE NURSE BEFORE ENTERING. In an interview on 1/29/2026 at 10:59 AM with LVN F, she said that contact precautions were discontinued today for Resident #54 and that not having the correct sign placed on the door can cause exposure to whatever organism was present. She said basic infection control training was given to her upon hire. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/29/2026 at 4:44 PM with LVN E, he said Resident #54 was positive for MRSA to the blood and had informed administration and housekeeping. He said housekeeping would bring the barrels and the yellow hanging bags with pockets and, depending on the type of precautions, they would provide the needed supplies. He said the signs were placed on the yellow bags by nursing. LVN E said that Resident #54 had an EBP sign on the yellow bag but did not know who placed it on there. He said, if people were not completely aware of the organism, it could cause cross contamination. In an interview on 1/29/2026 at 5:12 PM with the Housekeeping Supervisor, he said the nurses notify him when a resident is under precautions. He said housekeeping places the yellow bags with pouches and were filled with the supplies needed, according to the type of precautions the resident was under. He said if it's airborne precautions, then there is a special mask that needs to be added to the yellow bags, and they will add the sign or sometimes they get the signs from the nurses. He said the nurses inform housekeeping of the type of precautions the resident was under. He said he did not recall who had informed housekeeping of the type of precautions needed for Resident #54 and Resident #70. In an interview on 1/29/2026 at 5:45 PM with the DON, he said the same yellow bag was used for precautions and what differentiates if the sign on the door that reads SEE NURSE BEFORE ENTERING. He said the EBP signs were laminated and placed in the yellow bag's sleeve which included instructions on which type of PPE was used. He said Resident #53 was under EBP and then changed to contact precautions. The DON said not having the correct sign could have caused the possible spread of any communicable infection that the resident may have had. He said in-services were done and random rounds were done to ensure staff was wearing appropriate PPE. The DON said there was yearly infection control training and as needed. Record review of Resident #70's admission record dated 1/29/2026 indicated at [AGE] year-old male with an admission date of 1/22/2026. His diagnoses included Sepsis (body's extreme reaction to an infection causing the immune system to harm tissue and organs) and Anogenital (Venereal) Warts (bumps on the skin around the genitals and anus, caused by a sexually transmitted infection). Record review of Resident #70's MDS assessment dated [DATE], indicated a BIMS score of 8 which indicated moderate cognitive impairment. Record review of Resident#70's order summary dated 1/29/2026, indicated Contact Precautions D/T HPV (Anogenital warts): Provide barrels for proper disposal of linen and waste in biohazard bags every shift Date Ordered: 1/23/2026. In an observation and interview on 1/27/2026 at 11:35, there was a yellow bag hanging on Resident #70's door that contained gloves and gowns. There was no sign on the bag to indicate which type of precautions were in place. There was a sign on the door frame, facing forward, that stated PLEASE SEE NURSE BEFORE ENTERING. LVN D said Resident #70 was under contact precautions due to genital warts. In an interview on 1/29/2026 at 11:17 AM with the MDS Coordinator, he said he had reviewed Resident #70's history and physical which indicated the resident had anogenital viral warts. He said he had done some research and determined that the resident was to be placed under contact precautions for precautionary measures. He said he received the order from Resident #70's physician for contact precautions and informed LVN I. He said the yellow hanging bag was brought by housekeeping and the nurses placed the sign in the bag. The MDS Coordinator said in-services were held in December. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/29/2026 at 5:53 PM with LVN I said, contact precautions were initiated immediately after he was notified by his supervisor. He said when a resident was under EBP, the staff must wear a gown and gloves when providing care. He said when a resident was under contact precautions, the staff will use gowns and gloves upon entering the resident's room. He said the negative outcome of not knowing the resident was under contact precautions, can cause cross contamination. Record review of the Annual Bloodborne Pathogens & Hazard Communication Awareness Training Employee Attendance Record dated 10/13/2026, indicated training was done on the following: .3. Modes of Transmission . 7. Personal Protective Equipment, 8. Selection of PPE . 13. Signs and Labeling included 48 employee signatures noted. Reviewed U.S. Department of Health and Human Services Centers for Disease Control and Prevention form CS19-306149-A which is an example of a sign for Contact Precautions that can be posted outside a resident's room.