STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455925	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veranda Rehabilitation and Healthcare	4301 S Expressway 83 Harlingen, TX 78550

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, the facility maintained medical records on each resident that were complete and accurately documented for 1 of 6 residents (Resident #1) reviewed for medical records accuracy. The facility failed to ensure Resident #1's January 2026 MAR accurately documented when her physician ordered Alprazolam was not given. This failure could place residents at risk for errors in care and treatment. The findings include: Record review of Resident #1's face sheet, dated 02/04/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Alzheimer's disease , (decline in thinking skills and causing issues with memory, planning, focus and mood) with late onset, Anxiety disorder (persistent, excessive fear or worry), unspecified, and mood disorder due to known physiological condition with manic (abnormally elevated mood, high energy, erratic behaviors) features. Record review of Resident #1's care plan, with an initiation date of 09/05/24, reflected a focus of Psychotropic medications use r/t.8/3/25 antianxiety - anxiety with intervention of, Administer medications as ordered with an initiation date of 09/06/24. Record review of Resident #1's physician's orders reflected an order for, alprazolam 1mg tablet to be given 1 time every day at bed time, with a start date of 10/29/25. Record review of Resident #1's significant change MDS assessment, dated 12/21/25, reflected Resident #1 had a BIMS score of 01, which indicated severe cognitive impairment. Record review of Resident #1's controlled drug record sheet reflected her order for alprazolam was not provided on 01/09/26. Record review of Resident #1's January 2026 medication administration record reflected her order for alprazolam 1mg tablet at bedtime was documented as administered by LVN A on 01/09/26 at 8:00 PM. During an interview with LVN A on 02/03/26 at 5:57 PM, she stated she worked with Resident #1 on 01/09/26 and was responsible for her medication administration and documentation. LVN A stated she signed off first on the MAR for Resident #1's order for Alprazolam and then went to check on Resident #1, but did not provide her with her medication due to her already being asleep. LVN A stated she never removed the alprazolam from the packaging and documented on the controlled drug record for Resident #'1 that none were given to her. LVN A stated the process she should follow was to check the resident, retrieve the medication from the packing and sign the controlled drug record, then administer the medication to the resident and sign off on the MAR as administered. LVN A stated she should have struck out her documentation on Resident #1's MAR and put in the correct documentation. LVN A stated she got mixed up did not do that and did not know why. LVN A stated she was previously trained over the process for medication administration and documentation by one of the pharmacists. LVN A stated accurate documentation was important to make sure residents received their medication and to inform the physician of any pattern they identified. LVN A stated residents could be negatively affected by inaccurate documentation because residents may not get their medication if staff think it (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was already given and could cause their behavior to be impacted. During an interview with the DON on 02/04/26 at 6:15 PM, she stated, on 01/09/26, LVN A was responsible for providing medication and documentation on the MAR and controlled drug record for Resident #1. The DON stated on 01/09/26 LVN A signed on Resident #1's MAR that she administered her Alprazolam and documented on the controlled drug record that she did not. The DON stated through her conversation with LVN A, she understood LVN A did not provide Resident #1 with her Alprazolam because she was asleep. The DON stated the narcotic count also reflected the medication had not been given. The DON stated correct documentation was important because it could demonstrate if a resident was refusing their medication. The DON stated LVN A was trained over documentation on both the controlled drug record and the MAR. The DON stated herself and the ADON were responsible for monitoring and ensuring documentation was correct and stated she did this at least weekly when reviewing the MAR and controlled drug record. The DON stated in this situation there was no negative impact due to inaccurate documentation on the MAR. Record review of the facility's, undated, policy titled, Documentation of Medication Administration reflected, Documentation pertaining to medication administration should include.G. Document on the Electronic Medication Administration Record (MAR) as the medications are administered, not before or sometimes afterwards.