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	04/09/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and misappropriation for 1 of 3 residents (Resident #1) reviewed for developing and implementing abuse and neglect policies and procedures. 1) RN D did not report Resident#1's injury of unknown source to the facility management. 2) The facility did not report an incident of possible neglect to the state agency within the given time frame. These failures could place all residents residing in the facility at risk of abuse/neglect. Based on interviews and record reviews, the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and misappropriation for 1 of 3 residents (Resident #1) reviewed for developing and implementing abuse and neglect policies and procedures. 1) RN D did not report Resident#1's injury of unknown source to the facility management. 2) The facility did not report an incident of possible neglect to the state agency within the given time frame. These failures could place all residents residing in the facility at risk of abuse/neglect. Findings included: Record review of Resident #1's face sheet dated 04/08/2026 reflected an [AGE] year-old female with an admission date of 02/11/2026 with pertinent diagnoses that included Unspecified Dementia, Unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (when a dementia diagnosis is made (e.g., Alzheimer's, unspecified), but the subtype, severity, or associated behavioral/psychological symptoms are not defined), muscle weakness. Record review of Resident #1's comprehensive care plan with date initiated 02/12/2026 revealed she was dependent x2 for chair/bed to chair toilet transfers and was dependent x1 person to bathe self, including washing, rinsing, and drying self. Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS was 3 which indicated Resident #1 had severe impaired cognition. Resident #1 was dependent for showers/bathing self and chair/bed to chair transfers. Record review of Resident #1's administration record dated March 2026, reflected Tramadol Oral tablet 50 mg give 1 tablet by mouth every 8 hours as needed for moderate to severe pain was administered on 3/23/26 at 9:10 a.m., and 7:24 p.m., for pain to surgical site Record review of Resident #1's progress notes on her electronic medical record dated 03/24/2026 at 2:23 p.m., authored by LVN A reflected: NP rounding with resident. Patient c/o pain to bilateral ribs at this time, new order obtained for x-ray to bilateral ribs at this time. Patient refused pain medication for pain at this time, patient transferred to w/c for comfort. Family member at bedside visiting with resident. Will continue with plan of care. Record review of Resident #1's progress notes on her electronic medical record dated 03/24/2026 at 6:19 p.m., authored by DON reflected RN assessed resident, resident denies pain or discomfort. Resident is able to move all extremities full ROM. No discoloration noted at this time. Resident is in good spirits. Even and unlabored respirations. Resident is able to move in bed with assistance. Record review of Resident #1's progress notes on her electronic medical record dated 03/24/2026 at 9:21 p.m., authored by DON reflected Left ribs x-ray results sent to NP for review and new orders. Record review of Resident #1's progress notes on her electronic medical record dated 03/25/2026 at 12:14 a.m., authored by LVN A reflected NP gave order for CBC CMP labs to be drawn and Augmentin 875mg PO bid and Doxycycline 100mg PO BID for 5 days to be started after labs are drawn. Scheduled (continued on next page)

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tylenol 650mg q8hrs x5 days. Incentive spirometer q2hrs while awake. Duo Nebs q8hrs x6days. Record review of Resident #1's progress notes on her electronic medical record dated 03/25/2026 at 12:19 a.m., reflected authored by LVN A Pt declined Tylenol 650 mg states pain is 0 out of 10 and does not want them Record review of Resident #1's progress notes on her electronic medical record dated 03/25/2026 at 5:56 p.m., authored by DON reflected New order for MD to send the resident to ER for eval and treatment. Record review of Resident #1's hospital records revealed a CT of the chest dated 03/25/2026 at 10:29 p.m., reflected chest wall and bones: subacute and chronic bilateral rib fracture deformities. Correlate for point tenderness to exclude acute on subacute/chronic injury. Impression: bilateral pleural effusions with adjacent airspace disease and atelectasis. Subacute and chronic bilateral rib fracture deformities. Correlate for point tenderness to exclude acute on subacute/chronic injury. Record review of Resident #1's administration record dated March 2026, reflected Acetaminophen 325mg give 2 tablets by mouth every 8 hours for pain for 5 days was administered on 3/25/26 at 6:00 a.m., 2:00 p.m., and 10:00 p.m. Record review of Resident #1 administration record dated march 2026, reflected Tramadol Oral tablet 50 mg give 1 tablet by mouth every 8 hours as needed for moderate to severe pain was administered on 3/23/26 at 9:10 a.m., and 7:24 p.m., for pain to surgical site During a phone interview on 4/7/2026 at 11:09 a.m., CNA B stated that Resident #1 required 2 person assist for transfers and 1 person assist for shower and that she and CNA C transferred resident from bed to shower chair on 3/21/2026 because it was her shower day. CNA B said that she asked Resident #1 if she wanted to shower and she responded yes. CNA B stated that after she took Resident #1 to the shower room and CNA C stayed in the room fixing the bed. CNA B showered Resident #1 and she took her back to the room and she and CNA C transferred Resident #1 back to bed. CNA B said that Resident #1 did not complain of pain during the transfers. CNA B said that she showered resident on the shower chair and that she did not transfer or that resident was standing up in the shower room. During a telephone interview on 4/7/2026 at 11:37 a.m., CNA C stated that Resident #1 was not able to transfer by herself and that she required 2 person assistance for transfers and 1 person assist for shower. CNA C stated that she did help with the transfer on 3/21/26 to the shower chair. CNA C stated that after the transfer she stayed in the room to fix the bed. CNA C said that when CNA B came back with Resident #1 from the shower she did help transfer the resident back. CNA C stated that resident did not complain of pain during the transfers. During a telephone interview on 4/7/2026 at 1:00 p.m., RP stated that her Resident #1 told her that on Saturday 3/21/2026, after the shower, that the CNAs pulled her. RP stated that Resident #1 started complaining about pain to her right side that afternoon. RP stated that she notified the nurses but was not able to recall who she mentioned to. RP stated that she asked her mom what had happened and that her mom was not able to tell her what happened until next day on 3/22/26. RP stated that her mom received pain medication. RP said that on 3/25/26 the NP came to the room and she told her that her mom had been complaining of pain to the right side of her body and RP said that the NP ordered X-rays. RP said that the next day on 3/25/26 her mom was sent out to the hospital for clarification on the x rays results. During a phone interview on 4/7/2026 at 2:30 p.m., Resident #1 stated that the ladies picked her up from the bottom of her arm. Resident #1 stated that she was standing up in the shower and that she felt pain to her ribs at that time. Resident #1 said that she showered standing up and when she felt the pain she did not tell anyone. During an interview on 4/7/2026 at 4:05 p.m., LVN A stated that Resident #1 was 2 person assist for transfers and 1 person assist for shower. LVN A stated that Resident #1 had complained of pain before to her amputation site. LVN A stated that on 3/24/26 the NP was rounding in the facility and that she went with NP to Resident #1's room. The NP stated that the family member was in the room and she told the NP that Resident #1 was complaining of pain to her right side of her body. LVN A stated that NP assessed the resident and that NP gave her orders for chest x ray, CMP, and CBC. LVN A stated that she did assess Resident #1 and she did not see any discolorations or abnormalities to her skin on her right side. LVN A stated that she called the x rays to notify them about the new orders and gave report to (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the incoming nurse. During an interview on 4/7/26 at 4:20 p.m., RN D stated that she got report from LVN A. RN D said that she got informed that Resident #1 had complained of pain to her right side of body and that x rays were done. RN D stated that resident had complained of pain to her amputation site but not to her right side. RN D stated that she got the x rays report and she forward the results to the NP. RN D stated that she missed the results of the fracture to right ribs and that she saw the results of pneumonia (an infection that inflames the air sacs in one or both lungs, causing them to fill with fluid or pus). RN D stated that this could affect Resident #1 because there was a delay of treatment. During an interview on 4/8/26 at 10:35 a.m., the DON stated that Resident #1 was an alert resident with episodes of confusion and that she was aware of name and she was able to communicate and verbalized her needs. The DON stated that Resident #1 needed assistance with transfers and repositioning. The DON stated she was notified by the ADON on 3/25/25 that the report on the x rays done on 3/24/26 showed a fracture . The DON stated that she reviewed the report and noted that the results did not specify if the fracture was acute or chronic. The DON stated that she called mobile x rays for clarification and she requested a second reading on the x rays done on 3/24/26. The DON stated that when she received the second reading there were different ribs mentioned on the report and she called mobile x rays for a third reading. The DON stated that the report was still showing different ribs mentioned on the report and then she contacted the NP. The DON stated that she got orders to transfer Resident #1 to the hospital for further evaluation. The DON stated that she did not know how the results were missed and addressed until the next day. The DON stated that nurses were capable of reading the x ray reports. The DON stated that because of the confusion of the ribs mentioned on the reports that was why the treatment was delayed. The DON stated that nurses are expected to identify and read the x rays reports. She stated the incident was not reported to HHSC because the facility was verifying the x ray results that were not clear. The DON stated that this incident should have been reported to the Administrator and to herself as soon as RN D received the x rays report. During a telephone interview on 4/8/2026 at 11:06 a.m., the NP stated that she was rounding on 3/24/26 in the facility and went to visit Resident #1 and the family member requested x rays because Resident #1 had complained of pain to her right ribs. The NP stated that she assessed the resident and she did not see any bruises or deformation to resident's right side of body. The NP stated that she gave orders for the x rays. The NP stated that she reviewed the x ray results and after she saw the results she saw the possible pneumonia and gave orders to start the resident on antibiotics. The NP stated that the next day on 3/25/26 she received a call from the DON to let her know that on the x ray report there was a fracture and that the DON asked the mobile x rays for clarification because the report mentioned different ribs and that the facility received 2 more readings on the x ray done on 3/24/26. The NP stated that she contacted the MD and decided to send Resident #1 to the hospital for further evaluation. The NP stated that Resident #1 had osteoporosis. During an interview on 4/9/26 at 2:20 p.m., the Administrator said that he was notified on 3/25/26 by the DON. The Administrator said that as soon as the x rays were clarified he reported the incident to HHSC. The Administrator said that incidents like injury of unknown origin should be reported within 2 hours. Record review of facility's policy titled Abuse: Prevention of and Prohibition Against with a revision date 4/2025 reflected: .H. Reporting/Response. 1. All allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator. 2. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure allegations of abuse, neglect, exploitation, or mistreatment, including injury of unknown origin, were reported immediately, but not later than 2 hours in accordance with State law through established procedures for one (Resident #1) of 3 residents reviewed for abuse. The facility failed to ensure Resident #1's Injury of Unknown origin, discovered on 3/24/26, was immediately, but no later than two hours, reported to the State Survey Agency. These failures could place residents at risk of delays in the investigations of incidents of abuse and neglect. Findings included: Record review of Resident #1's face sheet dated 04/08/2026 reflected an [AGE] year-old female with an admission date of 02/11/2026 with pertinent diagnoses that included Unspecified Dementia, Unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (when a dementia diagnosis is made (e.g., Alzheimer's, unspecified), but the subtype, severity, or associated behavioral/psychological symptoms are not defined), muscle weakness. Record review of Resident #1's comprehensive care plan with date initiated 02/12/2026 revealed she was dependent x2 for chair/bed to chair toilet transfers and was dependent x1 person to bathe self, including washing, rinsing, and drying self. Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS was 3 which indicated Resident #1 had severe impaired cognition. Resident #1 was dependent for showers/bathing self and chair/bed to chair transfers. Record review of Resident #1's administration record dated March 2026, reflected Tramadol Oral tablet 50 mg give 1 tablet by mouth every 8 hours as needed for moderate to severe pain was administered on 3/23/26 at 9:10 a.m., and 7:24 p.m., for pain to surgical site Record review of Resident #1's progress notes on her electronic medical record dated 03/24/2026 at 2:23 p.m., authored by LVN A reflected: NP rounding with resident. Patient c/o pain to bilateral ribs at this time, new order obtained for x-ray to bilateral ribs at this time. Patient refused pain medication for pain at this time, patient transferred to w/c for comfort. Family member at bedside visiting with resident. Will continue with plan of care. Record review of Resident #1's progress notes on her electronic medical record dated 03/24/2026 at 6:19 p.m., authored by DON reflected RN assessed resident, resident denies pain or discomfort. Resident is able to move all extremities full ROM. No discoloration noted at this time. Resident is in good spirits. Even and unlabored respirations. Resident is able to move in bed with assistance. Record review of Resident #1's progress notes on her electronic medical record dated 03/24/2026 at 9:21 p.m., authored by DON reflected Left ribs x-ray results sent to NP for review and new orders. Record review of Resident #1's progress notes on her electronic medical record dated 03/25/2026 at 12:14 a.m., authored by LVN A reflected NP gave order for CBC CMP labs to be drawn and Augmentin 875mg PO bid and Doxycycline 100mg PO BID for 5 days to be started after labs are drawn. Scheduled Tylenol 650mg q8hrs x5 days. Incentive spirometer q2hrs while awake. Duo Nebs q8hrs x6days. Record review of Resident #1's progress notes on her electronic medical record dated 03/25/2026 at 12:19 a.m., reflected authored by LVN A Pt declined Tylenol 650 mg states pain is 0 out of 10 and does not want them Record review of Resident #1's progress notes on her electronic medical record dated 03/25/2026 at 5:56 p.m., authored by DON reflected New order for MD to send the resident to ER for eval and treatment. Record review of Resident #1's hospital records revealed a CT of the chest dated 03/25/2026 at 10:29 p.m., reflected chest wall and bones: subacute and chronic bilateral rib fracture deformities. Correlate for point tenderness to exclude acute on subacute/chronic injury. Impression: bilateral pleural effusions with adjacent airspace disease and atelectasis. Subacute and chronic bilateral rib fracture deformities. Correlate for point tenderness to exclude acute on subacute/chronic injury. Record review of Resident #1's administration record dated March 2026, reflected Acetaminophen 325mg give 2 tablets by mouth every 8 hours for pain for 5 days was administered on 3/25/26 at 6:00 a.m., 2:00 p.m., and (continued on next page)

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	455925	A. Building B. Wing	04/09/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:00 p.m. Record review of Resident #1 administration record dated march 2026, reflected Tramadol Oral tablet 50 mg give 1 tablet by mouth every 8 hours as needed for moderate to severe pain was administered on 3/23/26 at 9:10 a.m., and 7:24 p.m., for pain to surgical site During a phone interview on 4/7/2026 at 11:09 a.m., CNA B stated that Resident #1 required 2 person assist for transfers and 1 person assist for shower and that she and CNA C transferred resident from bed to shower chair on 3/21/2026 because it was her shower day. CNA B said that she asked Resident #1 if she wanted to shower and she responded yes. CNA B stated that after she took Resident #1 to the shower room and CNA C stayed in the room fixing the bed. CNA B showered Resident #1 and she took her back to the room and she and CNA C transferred Resident #1 back to bed. CNA B said that Resident #1 did not complain of pain during the transfers. CNA B said that she showered resident on the shower chair and that she did not transfer or that resident was standing up in the shower room. During a telephone interview on 4/7/2026 at 11:37 a.m., CNA C stated that Resident #1 was not able to transfer by herself and that she required 2 person assistance for transfers and 1 person assist for shower . CNA C stated that she did help with the transfer on 3/21/26 to the shower chair. CNA C stated that after the transfer she stayed in the room to fix the bed. CNA C said that when CNA B came back with Resident #1 from the shower she did help transfer the resident back. CNA C stated that resident did not complain of pain during the transfers. During a telephone interview on 4/7/2026 at 1:00 p.m., RP stated that her Resident #1 told her that on Saturday 3/21/2026, after the shower, that the CNAs pulled her. RP stated that Resident #1 started complaining about pain to her right side that afternoon. RP stated that she notified the nurses but was not able to recall who she mentioned to. RP stated that she asked her mom what had happened and that her mom was not able to tell her what happened until next day on 3/22/26. RP stated that her mom received pain medication. RP said that on 3/25/26 the NP came to the room and she told her that her mom had been complaining of pain to the right side of her body and RP said that the NP ordered X-rays. RP said that the next day on 3/25/26 her mom was sent out to the hospital for clarification on the x rays results. During a phone interview on 4/7/2026 at 2:30 p.m., Resident #1 stated that the ladies picked her up from the bottom of her arm. Resident #1 stated that she was standing up in the shower and that she felt pain to her ribs at that time. Resident #1 said that she showered standing up and when she felt the pain she did not tell anyone. During an interview on 4/7/2026 at 4:05 p.m., LVN A stated that Resident #1 was 2 person assist for transfers and 1 person assist for shower . LVN A stated that Resident #1 had complained of pain before to her amputation site. LVN A stated that on 3/24/26 the NP was rounding in the facility and that she went with NP to Resident #1's room. The NP stated that the family member was in the room and she told the NP that Resident #1 was complaining of pain to her right side of her body. LVN A stated that NP assessed the resident and that NP gave her orders for chest x ray, CMP, and CBC. LVN A stated that she did assess Resident #1 and she did not see any discolorations or abnormalities to her skin on her right side. LVN A stated that she called the x rays to notify them about the new orders and gave report to the incoming nurse. During an interview on 4/7/26 at 4:20 p.m., RN D stated that she got report from LVN A. RN D said that she got informed that Resident #1 had complained of pain to her right side of body and that x rays were done. RN D stated that resident had complained of pain to her amputation site but not to her right side. RN D stated that she got the x rays report and she forward the results to the NP. RN D stated that she missed the results of the fracture to right ribs and that she saw the results of pneumonia (an infection that inflames the air sacs in one or both lungs, causing them to fill with fluid or pus). RN D stated that this could affect Resident #1 because there was a delay of treatment. During an interview on 4/8/26 at 10:35 a.m., the DON stated that Resident #1 was an alert resident with episodes of confusion and that she was aware of name and she was able to communicate and verbalized her needs. The DON stated that Resident #1 needed assistance with transfers and repositioning. The DON stated she was notified by the ADON on 3/25/25 that the report on the x rays done on 3/24/26 showed a fracture . The DON stated that she reviewed the report and noted that the results did not specify if the fracture was acute or chronic. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated that she called mobile x rays for clarification and she requested a second reading on the x rays done on 3/24/26. The DON stated that when she received the second reading there were different ribs mentioned on the report and she called mobile x rays for a third reading. The DON stated that the report was still showing different ribs mentioned on the report and then she contacted the NP. The DON stated that she got orders to transfer Resident #1 to the hospital for further evaluation. The DON stated that she did not know how the results were missed and addressed until the next day. The DON stated that nurses were capable of reading the x ray reports. The DON stated that because of the confusion of the ribs mentioned on the reports that was why the treatment was delayed. The DON stated that nurses are expected to identify and read the x rays reports. She stated the incident was not reported to HHSC because the facility was verifying the x ray results that were not clear. The DON stated that this incident should have been reported to the Administrator and to herself as soon as RN D received the x rays report. During a telephone interview on 4/8/2026 at 11:06 a.m., the NP stated that she was rounding on 3/24/26 in the facility and went to visit Resident #1 and the family member requested x rays because Resident #1 had complained of pain to her right ribs. The NP stated that she assessed the resident and she did not see any bruises or deformation to resident's right side of body. The NP stated that she gave orders for the x rays. The NP stated that she reviewed the x ray results and after she saw the results she saw the possible pneumonia and gave orders to start the resident on antibiotics. The NP stated that the next day on 3/25/26 she received a call from the DON to let her know that on the x ray report there was a fracture and that the DON asked the mobile x rays for clarification because the report mentioned different ribs and that the facility received 2 more readings on the x ray done on 3/24/26. The NP stated that she contacted the MD and decided to send Resident #1 to the hospital for further evaluation. The NP stated that Resident #1 had osteoporosis. During an interview on 4/9/26 at 2:20 p.m., the Administrator said that he was notified on 3/25/26 by the DON. The Administrator said that as soon as the x rays were clarified he reported the incident to HHSC. The Administrator said that incidents like injury of unknown origin should be reported within 2 hours. Record review of facility's policy titled Abuse: Prevention of and Prohibition Against with a revision date 4/2025 reflected: .H. Reporting/Response. 1. All allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator. 2. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered- care plan, and the resident's choices for 1 (Resident #1) of 3 residents reviewed for quality of care. The facility failed to recognize x-ray results done on 3/24/2026 that reflected There are acute appearing mildly displaced fractures of the right 4th and 5th ribs anterolaterally. Correlate with timing of trauma and pain for age of fractures. This failure could place residents at risk of delay in care, worsening of health conditions, adverse reactions, and hospitalization. Findings included: Record review of Resident #1's face sheet dated 04/08/2026 reflected an [AGE] year-old female with an admission date of 02/11/2026 with pertinent diagnoses that included Unspecified Dementia, Unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (when a dementia diagnosis is made (e.g., Alzheimer's, unspecified), but the subtype, severity, or associated behavioral/psychological symptoms are not defined), muscle weakness. Record review of Resident #1's comprehensive care plan with date initiated 02/12/2026 revealed she was dependent x2 for chair/bed to chair toilet transfers and was dependent x1 person to bathe self, including washing, rinsing, and drying self. Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS was 3 which indicated Resident #1 had severe impaired cognition. Resident #1 was dependent for showers/bathing self and chair/bed to chair transfers. Record review of Resident #1's administration record dated March 2026, reflected Tramadol Oral tablet 50 mg give 1 tablet by mouth every 8 hours as needed for moderate to severe pain was administered on 3/23/26 at 9:10 a.m., and 7:24 p.m., for pain to surgical site Record review of Resident #1's progress notes on her electronic medical record dated 03/24/2026 at 2:23 p.m., authored by LVN A reflected: NP rounding with resident. Patient c/o pain to bilateral ribs at this time, new order obtained for x-ray to bilateral ribs at this time. Patient refused pain medication for pain at this time, patient transferred to w/c for comfort. Family member at bedside visiting with resident. Will continue with plan of care. Record review of Resident #1's progress notes on her electronic medical record dated 03/24/2026 at 6:19 p.m., authored by DON reflected RN assessed resident, resident denies pain or discomfort. Resident is able to move all extremities full ROM. No discoloration noted at this time. Resident is in good spirits. Even and unlabored respirations. Resident is able to move in bed with assistance. Record review of Resident #1's progress notes on her electronic medical record dated 03/24/2026 at 9:21 p.m., authored by DON reflected Left ribs x-ray results sent to NP for review and new orders. Record review of Resident #1's progress notes on her electronic medical record dated 03/25/2026 at 12:14 a.m., authored by LVN A reflected NP gave order for CBC CMP labs to be drawn and Augmentin 875mg PO bid and Doxycycline 100mg PO BID for 5 days to be started after labs are drawn. Scheduled Tylenol 650mg q8hrs x5 days. Incentive spirometer q2hrs while awake. Duo Nebs q8hrs x6days. Record review of Resident #1's progress notes on her electronic medical record dated 03/25/2026 at 12:19 a.m., reflected authored by LVN A Pt declined Tylenol 650 mg states pain is 0 out of 10 and does not want them Record review of Resident #1's progress notes on her electronic medical record dated 03/25/2026 at 5:56 p.m., authored by DON reflected New order for MD to send the resident to ER for eval and treatment. Record review of Resident #1's hospital records revealed a CT of the chest dated 03/25/2026 at 10:29 p.m., reflected chest wall and bones: subacute and chronic bilateral rib fracture deformities. Correlate for point tenderness to exclude acute on subacute/chronic injury. Impression: bilateral pleural effusions with adjacent airspace disease and atelectasis. Subacute and chronic bilateral rib fracture deformities. Correlate for point tenderness to exclude acute on subacute/chronic injury. Record review of Resident #1's administration record dated March 2026, reflected Acetaminophen 325mg give 2 tablets by mouth every 8 hours for pain for 5 days was administered on 3/25/26 at 6:00 a.m., 2:00 p.m., and 10:00 p.m. Record review of Resident #1 (continued on next page)

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	04/09/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration record dated march 2026, reflected Tramadol Oral tablet 50 mg give 1 tablet by mouth every 8 hours as needed for moderate to severe pain was administered on 3/23/26 at 9:10 a.m., and 7:24 p.m., for pain to surgical site During a phone interview on 4/7/2026 at 11:09 a.m., CNA B stated that Resident #1 required 2 person assist for transfers and 1 person assist for shower and that she and CNA C transferred resident from bed to shower chair on 3/21/2026 because it was her shower day. CNA B said that she asked Resident #1 if she wanted to shower and she responded yes. CNA B stated that after she took Resident #1 to the shower room and CNA C stayed in the room fixing the bed. CNA B showered Resident #1 and she took her back to the room and she and CNA C transferred Resident #1 back to bed. CNA B said that Resident #1 did not complain of pain during the transfers. CNA B said that she showered resident on the shower chair and that she did not transfer or that resident was standing up in the shower room. During a telephone interview on 4/7/2026 at 11:37 a.m., CNA C stated that Resident #1 was not able to transfer by herself and that she required 2 person assistance for transfers and 1 person assist for shower. CNA C stated that she did help with the transfer on 3/21/26 to the shower chair. CNA C stated that after the transfer she stayed in the room to fix the bed. CNA C said that when CNA B came back with Resident #1 from the shower she did help transfer the resident back. CNA C stated that resident did not complain of pain during the transfers. During a telephone interview on 4/7/2026 at 1:00 p.m., RP stated that her Resident #1 told her that on Saturday 3/21/2026, after the shower, that the CNAs pulled her. RP stated that Resident #1 started complaining about pain to her right side that afternoon. RP stated that she notified the nurses but was not able to recall who she mentioned to. RP stated that she asked her mom what had happened and that her mom was not able to tell her what happened until next day on 3/22/26. RP stated that her mom received pain medication. RP said that on 3/25/26 the NP came to the room and she told her that her mom had been complaining of pain to the right side of her body and RP said that the NP ordered X-rays. RP said that the next day on 3/25/26 her mom was sent out to the hospital for clarification on the x rays results. During a phone interview on 4/7/2026 at 2:30 p.m., Resident #1 stated that the ladies picked her up from the bottom of her arm. Resident #1 stated that she was standing up in the shower and that she felt pain to her ribs at that time. Resident #1 said that she showered standing up and when she felt the pain she did not tell anyone. During an interview on 4/7/2026 at 4:05 p.m., LVN A stated that Resident #1 was 2 person assist for transfers and 1 person assist for shower. LVN A stated that Resident #1 had complained of pain before to her amputation site. LVN A stated that on 3/24/26 the NP was rounding in the facility and that she went with NP to Resident #1's room. The NP stated that the family member was in the room and she told the NP that Resident #1 was complaining of pain to her right side of her body. LVN A stated that NP assessed the resident and that NP gave her orders for chest x ray, CMP, and CBC. LVN A stated that she did assess Resident #1 and she did not see any discolorations or abnormalities to her skin on her right side. LVN A stated that she called the x rays to notify them about the new orders and gave report to the incoming nurse. During an interview on 4/7/26 at 4:20 p.m., RN D stated that she got report from LVN A. RN D said that she got informed that Resident #1 had complained of pain to her right side of body and that x rays were done. RN D stated that resident had complained of pain to her amputation site but not to her right side. RN D stated that she got the x rays report and she forward the results to the NP. RN D stated that she missed the results of the fracture to right ribs and that she saw the results of pneumonia (an infection that inflames the air sacs in one or both lungs, causing them to fill with fluid or pus). RN D stated that this could affect Resident #1 because there was a delay of treatment. During an interview on 4/8/26 at 10:35 a.m., the DON stated that Resident #1 was an alert resident with episodes of confusion and that she was aware of name and she was able to communicate and verbalized her needs. The DON stated that Resident #1 needed assistance with transfers and repositioning for transfers and 1 person assist for shower. The DON stated she was notified by the ADON on 3/25/25 that the report on the x rays done on 3/24/26 showed a fracture . The DON stated that she reviewed the report and noted that the results did not specify if the fracture (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was acute or chronic. The DON stated that she called mobile x rays for clarification and she requested a second reading on the x rays done on 3/24/26. The DON stated that when she received the second reading there were different ribs mentioned on the report and she called mobile x rays for a third reading. The DON stated that the report was still showing different ribs mentioned on the report and then she contacted the NP. The DON stated that she got orders to transfer Resident #1 to the hospital for further evaluation. The DON stated that she did not know how the results were missed and addressed until the next day. The DON stated that nurses were capable of reading the x ray reports. The DON stated that because of the confusion of the ribs mentioned on the reports that was why the treatment was delayed. The DON stated that nurses are expected to identify and read the x rays reports. She stated the incident was not reported to HHSC because the facility was verifying the x ray results that were not clear. During a telephone interview on 4/8/2026 at 11:06 a.m., the NP stated that she was rounding on 3/24/26 in the facility and went to visit Resident #1 and the family member requested x rays because Resident #1 had complained of pain to her right ribs. The NP stated that she assessed the resident and she did not see any bruises or deformation to resident's right side of body. The NP stated that she gave orders for the x rays. The NP stated that she reviewed the x ray results and after she saw the results she saw the possible pneumonia and gave orders to start the resident on antibiotics. The NP stated that the next day on 3/25/26 she received a call from the DON to let her know that on the x ray report there was a fracture and that the DON asked the mobile x rays for clarification because the report mentioned different ribs and that the facility received 2 more readings on the x ray done on 3/24/26. The NP stated that she contacted the MD and decided to send Resident #1 to the hospital for further evaluation. The NP stated that Resident #1 had osteoporosis. Record review of facility's policy titled Diagnostic Test Results Notification with a revision date 4/2025 reflected it is the policy of this facility to obtain laboratory and radiology services when ordered by a physician, Physician Assistant (PA), Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS) and to promptly notify the ordering provider of test results.