

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER Orchard Park Post Acute Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 721 Airport Dr Weslaco, TX 78596	

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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278</p> <p>Based on interviews and record review the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 (Resident #216) of 8 residents reviewed for baseline care plans.</p> <p>The facility failed to include Resident #216's use of insulin and anticoagulant medications in her baseline care plan.</p> <p>This failure could result in residents not receiving needed care and treatment.</p> <p>Findings Included:</p> <p>Record review of Resident #216's Admission Record dated 05/20/2025 revealed she was a [AGE] year-old female admitted [DATE] with diagnoses which included Type 2 Diabetes Mellitus, Heart Failure, Peripheral Arterial Disease (an accumulation of plaque (fats and cholesterol) in the arteries in your legs or arms), Hyperlipidemia (high cholesterol), Muscle Wasting and Atrophy (decrease in muscle size and wasting of muscle tissue), and Dysphagia (difficulty swallowing).</p> <p>Record review of Resident #216's 5-day MDS assessment dated [DATE] revealed a BIMS score of 15, indicating intact cognition.</p> <p>Record review of Resident #216's Baseline Care Plan initiated 05/11/2025 revealed medications insulin and anticoagulant were not included.</p> <p>Record review of Resident #216 's Physician Orders dated 5/11/2025 revealed, Tresiba Flex Touch Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Degludec) inject 32 units subcutaneously in the morning for DM #2 hold if BS less than 100 and Eliquis Oral Tablet 2.5mg (Apixaban) Give 1 tablet by mouth two times a day for PAD.</p> <p>Record review of Resident #216's electronic Medication Administration Record for May 2025 revealed Eliquis oral tablet 2.5mg 1 tablet by mouth was administered twice a day, started 05/12/2025 and Tresiba Flex Touch Subcutaneous solution Pen injector 100 unit/ml (Insulin Degludec) 32 units injected subcutaneously in the morning, started 05/12/2025.</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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with MDS nurse on 05/19/25 at 3:05 p.m., stated that the baseline care plan was to be completed within 48 hours. She stated that the admitting floor nurses were responsible for completing the baseline care plan upon admission and the registered nurses sign it off. The MDS nurse stated the essential information that should be included in the baseline care plan should be the resident ' s cognition status, ADLs, respiratory, and medications. The MDS stated that it was important to have that information in the baseline care plan because the resident could fall, elope or have a reaction to a medication.</p> <p>During an interview with LVN A on 05/19/25 3:15 p.m., she stated the baseline care plan was completed between 24-48 hours. He stated the baseline care plan should include information such as medications like insulin, anticoagulants, antidepressants, and code status. LVN A stated insulin should be in baseline care plan to manage the resident ' s diabetes, so they won ' t go into hypoglycemia or hyperglycemia. To make sure we were not giving too much insulin. He stated that the anticoagulants were important to be on the baseline care plan, so they won ' t bleed out. This information was important for better patient care. The admitting nurse was responsible for completing the baseline care plan.</p> <p>During an interview with the DON on 05/19/25 at 3:18 p.m., the DON stated that the nurses were responsible for completing the baseline care plan. She stated that she overlooks the baseline care plans and signs them off. The DON stated the baseline care plans were to be completed within 72hours, but she signs them off before 24hours. She stated that by signing them she acknowledges that it was complete. She stated that the baseline care plan should include the advance directive, allergies, and medications. The DON looked at Residents #216 baseline care plan and under medications, she confirmed that the insulin and anticoagulants were not checked off. She stated that if the resident was currently taking them then the medications needed to be on the baseline care plan. The DON stated the negative outcome was that it would not be care planned and the resident would not have a proper plan of care.</p> <p>Record review of the facility policy titled Baseline Care Plan reviewed 10/05/2023 revealed, Policy: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>The baseline care plan will:</p> <p>Be developed within 48 hours of a resident's admission.</p> <p>Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:</p> <ul style="list-style-type: none"> i. Initial goals based on admission orders. ii. Physician Orders . 		

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<p>F 0680</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the activities program is directed by a qualified professional.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828</p> <p>Based on interview and record review the facility failed to ensure the activities program was directed by a qualified professional who was a qualified therapeutic recreation specialist or an activity professional for 61 of 61 residents.</p> <p>The facility did not have a qualified Activities Professional to direct their activities program.</p> <p>This deficient practice could affect any resident and could result in residents not receiving activities that were individualized to match the skills, abilities, and interests/preferences of each resident.</p> <p>The findings were:</p> <p>Record review on 05/20/25 at 10:30 a.m. of the facility's Administrative and other licensed professional staff Licensure audit revealed the current Activity Director was not certified.</p> <p>In an interview on 05/20/25 at 12:00 p.m., the HR Coordinator said the facility's Activity Director was not certified.</p> <p>In An interview on 05/20/25 at 12:38 p.m., the AD, said she had been hired as the Activity Director on 01/15/25. She said when she was hired, she was advised by the facility's Administrator she needed to enroll in an AD program within 6 months of being hired. She said she had no previous experience in being an AD. She said she had recently (not sure of date) submitted the required paperwork and fee to enroll in an online AD program. She said as of 05/20/25, she had not been officially enrolled. She said the program consisted of 180 hours to be completed at her own pace.</p> <p>In an interview on 05/20/25 at 1:30 a.m., the Administrator said the qualifications to be an Activity Director were to have their AD certificate or be an occupational therapist. She said the current AD started working at the facility on 01/15/25 and did not have the required qualifications. She said she, the current AD, had signed an agreement that stated she would enroll in and begin an AD program within 6 months of her hire date. She said it was her responsibility to ensure the AD had enrolled in an AD program within 6 months. The Administrator said during the morning meeting she had made it a point to ask the current AD on the status of her enrollment in an AD program. The Administrator said the facility did not have a policy on the requirements for an AD, only a job description. The Administrator said the current AD did not have any of the following state requirements:</p> <p>licensed or registered,</p> <p>eligible for certification as a therapeutic recreation specialist, or</p> <p>an activities professional by a recognized accrediting body on or after October 1, 1990,</p> <p>had 2 years of experience in a social or recreational program with the last 5 years, one of which was full-time in a therapeutic activities program; or</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761</p> <p>Based on observation, interview, and record review, the facility failed to ensure that each resident received adequate supervision to prevent accidents for one resident (Resident #10) of five residents reviewed for supervision.</p> <p>The facility failed to ensure Resident #10, who required assistance of 2 staff for bed baths, was not given a bed bath by 1 staff.</p> <p>These failures could place residents at risk of being in an unsafe environment and at risk for accidents and injury.</p> <p>Findings included:</p> <p>Record review of Resident #10's face sheet dated 05/20/25 revealed a [AGE] year-old female with an original admitted [DATE]. Diagnoses included paraplegia (a condition characterized by the partial or complete loss of movement and sensation in the lower half of the body, specifically both legs), mood disorder (a serious mental illness that causes persistent and intense changes in a person 's mood, energy, and behavior), and schizoaffective disorder (diagnosed when a person experiences symptoms of both schizophrenia and a mood disorder [like depression or mania] concurrently).</p> <p>Record Review of Resident #10's Quarterly MDS Assessment, dated 02/14/25, reflected,</p> <ul style="list-style-type: none"> - BIMS score was blank which indicated the resident had severe cognitive impairment. - Always incontinent of bladder and bowel. - She took antipsychotic and antidepressant medications. <p>- Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.</p> <p>Record review of Resident #10's quarterly care plan dated 02/17/25 reflected:</p> <p>FOCUS: I require assistance with all my ADLS due to impaired mobility and cognitive impairment. Date Initiated: 02/25/2024 Revision on: 02/25/2024</p> <p>GOALS: I will have self-care needs met and have few, if any, complications through the review date. Date Initiated: 02/25/2024 Revision on: 05/18/2025 Target Date: 05/28/2025</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>INTERVENTIONS/TASKS: FUNCTIONAL PERFORMANCE: BATHING: Shower/ bathe self: Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. Tub/ shower transfer: Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. Date Initiated: 02/25/2024 Revision on: 02/25/2024 LN CNA.</p> <p>Observation on 05/20/25 at 09:15 AM, revealed Resident #10 was getting a bed bath with CNA B in attendance. Resident #10 was uncovered, brief tabs detached and pulled down. The bath water was murky with soap bubbles.</p> <p>In an interview on 05/20/25 at 09:45 AM, CNA B stated Resident #10 was a 2-person assist for bed bath. CNA B stated she was the only one in Resident #10's room giving a bed bath when the surveyor came in to the room. CNA B stated CNA C went in to help her with Resident #10 's bed bath a few seconds after the surveyor left the room. CNA B stated she already knew if a resident was a 1- or 2-person assist, but if a resident was new, she would ask the nurse if the new resident was a 1- or 2- person assist. CNA B stated if 1 person went in to assist Resident #10, if you closed the curtain and Resident #10 could not see her tv, she would hit the CNA. CNA B stated she did not know if they had any in-servicing on 1- or 2- person assists.</p> <p>In an interview on 05/20/25 at 09:45 AM, CNA D stated if a resident required a mechanical lift, they were a 2-person assist. She said with Resident #10, it depended on how she was behaving whether she was a 1- or 2-person assist. CNA D stated therapy was asked if a new resident were a 1- or 2- person assist. She said sometimes the nurse would tell them if a resident were a 1- or 2-person assist. CNA D stated sometimes she would check the POC when a resident was new. She said if a resident who required a 2-person assist was helped by only 1 person, the resident could fall.</p> <p>In an interview on 05/20/25 at 09:50 AM, RN E stated Resident #10 was a 2-person assist. RN E stated the resident's Care Plan tells whether a resident was a 1- or 2-person assist. RN E stated the charge nurse was responsible for monitoring the CNA for 1- or 2-person assist. RN E stated, I have seen a couple of in-services going around for 1- or 2-person assist, but I do not know when. When RN E was asked what could happen if a resident was a 2-person assist and only one person was assisting, RN stated, That sounds like hypothetical, and I do not want to answer. RN E then stated, 1- or 2-person assists are geared to safety reasons.</p> <p>In an interview on 05/20/25 at 01:27 PM, CNA C stated she assisted CNA B with bed bath for Resident #10 that morning (05/20/25). CNA C stated she was outside the door when the surveyor was in asking questions. CNA C stated Resident #10 was a 2-person assist because she kicked and hit. CNA C stated they had an in-service on 1- or 2-person assist about a month ago. CNA C stated she would check the Kardex (a concise, quick -reference system for resident information) when she had questions about a patient and when there was a new patient.</p> <p>In an interview on 05/20/25 at 02:55 PM, LVN A stated the nurses or CNAs can check the care plan or Kardex to see if a resident is a 1- or 2-person assist. He said the 24-hour report can also be checked for changes in assist. LVN A stated it was the nurse ' s responsibility to notify the CNAs of any changes. He said it was the nurse ' s responsibility to monitor the CNAs to make sure they were following the care plan. LVN A stated injury to either the resident or CNA can occur if a 2-person assist is only done by one CNA.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/20/25 at 03:05 PM, the DON stated the charge nurse, and all licensed nurses are responsible to supervise CNAs. She said the CNAs are in-serviced at least monthly on 1- or 2-person assists. The DON stated the Kardex should be checked when providing care. She stated that the nurses are notified of changes in resident's condition and the nurses notify the CNAs. She said if a resident who was a 2-person assist had only a 1-person assist, the resident could fall or get injured.</p> <p>In an interview on 05/20/25 at 03:35 PM, the Administrator and ADON F stated they had a policy on ADLs, but not on supervision, Kardex or CNAs responsibility on whether a resident was a 1- or 2-person assist.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828</p> <p>Based on interviews and record review the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week, for 1 ([DATE]) of 90 days reviewed for RN hours, for the months [DATE], through [DATE]</p> <p>The facility failed to have RN coverage for 1 day on Saturday, [DATE].</p> <p>This failure could place residents at risk of harm by denying residents the advanced critical thinking skills a registered nurse could provide.</p> <p>The findings were:</p> <p>Record review of the facility's RN timesheets, no date, reflected the on Saturday [DATE]; the facility only had RN coverage for 3.91 hours.</p> <p>During an interview on [DATE] at 1:39 p.m., the DON said it was her responsibility to ensure the facility had RN coverage for 8 consecutive hours every day. She said if the scheduled RN were to call in then it would be her and the ADONs responsibility to look for another RN or one of them would have to cover the shift. The DON said she could not remember what happened on [DATE] that the scheduled RN only worked 3.91 hours. The DON said either she or the ADON might have covered the remainder of the shift on [DATE] but since they were salary, they were not required to clock in to document that day. The DON said the negative outcome of not having an RN in the facility for 8 consecutive hours could be that the certain tasks only an RN could do,(i.e., signing off on baseline care plans, removing midline/picc catheters, and/or pronouncing a resident deceased) could not be performed.</p> <p>In an interview on [DATE] at 1:46 p.m., the Administrator said it was the DON's responsibility to ensure she scheduled an RN for 8 consecutive hours every day but ultimately it was her responsibility the Administrator. The Administrator said the negative outcome of not having an RN work 8 consecutive hours every day could be that the tasks that only an RN could perform like administering certain medications and treatments would not be done. The Administrator said the facility had sufficient RNs to cover their 8 consecutive hours shift every day.</p> <p>Record review of the facility's Nursing Services-Registered Nurse (RN) policy dated [DATE] reflected:</p> <p>Policy:</p> <p>It is the intent of the facility to comply with Registered Nurse requirements as per Social Security Act 1919 and 1819.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>(continued on next page)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1.the facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days a week. (The requirement for 8 consecutive hours of RN services can be met by any RN or multiple RNs.) The hours worked by the DON would be considered applicable towards the requirement.</p> <p>Record review of the facility's policy Nursing Services and Sufficient Staff dated [DATE] reflected:</p> <p>Policy:</p> <p>It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and obtain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The Facility's census, acuity, and diagnoses of the resident population will be considered based on the facility assessment.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>8. Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761</p> <p>Based on interview and record review, the facility failed to ensure each resident's drug regimen was free of unnecessary drugs for one (Resident #10) of five resident reviewed for medications.</p> <p>The facility failed to have an adequate indication for the use of the medication risperdal (Risperdone - an antipsychotic) for Resident #10.</p> <p>This failure could put residents at risk of harm from adverse reactions or harmful side effects.</p> <p>Findings included:</p> <p>Record review of Resident #10's face sheet dated 05/20/25 revealed an [AGE] year-old female with an original admitted [DATE]. Diagnoses included paraplegia (a condition characterized by the partial or complete loss of movement and sensation in the lower half of the body, specifically both legs), mood disorder (a serious mental illness that causes persistent and intense changes in a person 's mood, energy, and behavior), and schizoaffective disorder (diagnosed when a person experiences symptoms of both schizophrenia and a mood disorder [like depression or mania] concurrently).</p> <p>Record Review of Resident #10's Quarterly MDS Assessment, dated 02/14/25, reflected her BIMS score was blank, which indicated the resident had severe cognitive impairment. She was always incontinent of bladder and bowel. Section I reflected Resident #10 had an active diagnosis of schizophrenia (e.g., schizoaffective disorder and schizophreniform disorders). She took antipsychotic and antidepressant medications.</p> <p>Record review of Resident #10's quarterly care plan dated 02/17/25 reflected:</p> <p>FOCUS: I have schizophrenia, I receive Risperdal to help control my symptoms (mood changes, yelling) Date Initiated: 02/25/2024 Revision on: 02/25/2024</p> <p>GOALS: I will receive my ordered medications and be free of psychotropic drug related complications through review date. Date Initiated: 02/25/2024 Revision on: 05/18/2025 Target Date: 05/28/2025</p> <p>INTERVENTIONS/TASKS: Black Box Warning: Risperdal Warning: Increased mortality in elderly patients with dementia-related psychosis Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Risperidone is not approved for the treatment of patients with dementia-related psychosis. Date Initiated: 02/25/2024 LN Monitor behaviors. Notify MD of new or worsening behaviors Date Initiated: 02/25/2024 LN SS Monitor/document/report PRN any adverse reactions of antipsychotic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Date Initiated: 02/25/2024 LN Pharmacy consultant to review medications per facility policy Date Initiated: 02/25/2024 Revision on: 02/25/2024 LN.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>FOCUS: I have a mood problem r/t Disease Process (SCHIZOPHRENIA) Date Initiated: 01/25/2025 Revision on: 01/25/2025</p> <p>GOALS: I will have improved mood state happier, calmer appearance, no s/sx of depression, anxiety or sadness through the review date. Date Initiated: 01/25/2025 Revision on: 05/18/2025 Target Date: 05/28/2025</p> <p>INTERVENTIONS/TASKS: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 01/25/2025 LN RN Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.) Date Initiated: 01/25/2025 LN RN Monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills Date Initiated: 01/25/2025 LN RN Monitor/record/report to MD prn mood patterns s/sx of depression, anxiety, sad mood. Date Initiated: 01/25/2025 LN RN Monitor/record/report to MD prn risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons Date Initiated: 01/25/2025 CNA LN RN.</p> <p>Record review of physician ' s diagnosis on 08/22/24 reflected, Schizoaffective Disorder.</p> <p>Record review of Nursing - Psychoactive Medication Quarterly Evaluation dated 08/23/24, reflected Medical Diagnosis warranting use F25.1 Schizoaffective Disorder, Depressive Type.</p> <p>Record review of physician ' s order dated 08/23/24 reflected, risperDAL Oral Tablet 1 MG (Risperidone) Give 1 tablet by mouth at bedtime for schizophrenia.</p> <p>Attempted interview on 05/20/25 at 01:40 PM, with PCP for Resident #10 who diagnosed Resident #10 with schizoaffective disorder on 08/22/24. Answering service to pass on message to doctor to call surveyor.</p> <p>Attempted interview on 05/20/25 at 02:00 PM, with NP who signed consent for Risperdal 1 mg at bedtime for Resident #10 on 08/23/24. Receptionist will pass a message along for NP to call surveyor.</p> <p>Attempted interview on 05/20/25 at 02:28 PM, with Medical Director of the facility whose name was on the order for Resident #10's Risperdal 1 mg at bedtime. No answer. Voicemail left.</p> <p>In an interview on 05/20/25 at 02:55 PM, LVN A stated that the nurse who took the physician ' s order was the one who put it in PCC (residents' charts system). LVN A stated the orders are double checked by two nurses and the ADONs and DON.</p> <p>In an interview on 05/20/25 at 03:05 PM, the DON stated the nurse who gets the order was the one who put it in PCC. The DON stated all orders were double checked. She said if the wrong diagnosis was put on the order, it would be an inappropriate regimen. She said if the wrong diagnosis was care planned, the interventions may be inappropriate.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER Orchard Park Post Acute Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 721 Airport Dr Weslaco, TX 78596	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/20/25 at 03:53 PM, the DON notified surveyor that schizophrenia was in the medical diagnosis. Surveyor checked and schizophrenia was added on 05/20/25 under medical diagnosis. DON stated the NP's notes on 10/05/24, 01/27/25, and 05/01/25 had schizophrenia in the note for a diagnosis.</p> <p>In an interview on 05/20/25 at 04:07 PM, NP stated she signed the Antipsychotic Consent for Risperdal for Resident #10 for schizoaffective disorder. NP stated Resident's PCP diagnosed Resident with schizoaffective disorder on 08/22/24. NP stated three of her notes on 10/05/24, 01/27/25, and 05/01/25 had the diagnosis of schizophrenia. The original diagnosis of schizoaffective disorder was given by PCP and not NP. NP stated schizophrenia was not on the medical diagnosis on any other paperwork except hers and the order the nurse put in PCC. NP stated the diagnosis should be schizoaffective.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761</p> <p>Based on interviews and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 resident (Resident #10) of 5 residents whose care plans were reviewed for accurate records.</p> <p>Resident #10 was diagnosed with schizoaffective disorder but parts of her medical record inaccurately indicated she had schizophrenia.</p> <p>This failure could place residents at risk of not receiving appropriate care to meet their current needs.</p> <p>Findings included:</p> <p>Record review of Resident #10's face sheet dated 05/20/25 revealed a [AGE] year-old female with an original admitted [DATE]. Diagnoses included paraplegia (a condition characterized by the partial or complete loss of movement and sensation in the lower half of the body, specifically both legs), mood disorder (a serious mental illness that causes persistent and intense changes in a person ' s mood, energy, and behavior), and schizoaffective disorder (diagnosed when a person experiences symptoms of both schizophrenia and a mood disorder [like depression or mania] concurrently).</p> <p>Record Review of Resident #10's Quarterly MDS Assessment, dated 02/14/25, reflected her BIMS score was blank, which indicated the resident had severe cognitive impairment. She was always incontinent of bladder and bowel.</p> <p>Record Review of Resident #10's quarterly care plan dated 02/17/25 reflected:</p> <p>FOCUS: I have schizophrenia, I receive Risperdal to help control my symptoms (mood changes, yelling) Date Initiated: 02/25/2024 Revision on: 02/25/2024</p> <p>GOALS: I will receive my ordered medications and be free of psychotropic drug related complications through review date. Date Initiated: 02/25/2024 Revision on: 05/18/2025 Target Date: 05/28/2025</p> <p>INTERVENTIONS/TASKS: Black Box Warning: Risperdal Warning: Increased mortality in elderly patients with dementia-related psychosis Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Risperidone is not approved for the treatment of patients with dementia-related psychosis. Date Initiated: 02/25/2024 LN Monitor behaviors. Notify MD of new or worsening behaviors Date Initiated: 02/25/2024 LN SS Monitor/document/report PRN any adverse reactions of antipsychotic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Date Initiated: 02/25/2024 LN Pharmacy consultant to review medications per facility policy Date Initiated: 02/25/2024 Revision on: 02/25/2024 LN.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Orchard Park Post Acute Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 721 Airport Dr Weslaco, TX 78596	

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>FOCUS: I has a mood problem r/t Disease Process (SCHIZOPHRENIA) Date Initiated: 01/25/2025 Revision on: 01/25/2025</p> <p>GOALS: I will have improved mood state happier, calmer appearance, no s/sx of depression, anxiety or sadness through the review date. Date Initiated: 01/25/2025 Revision on: 05/18/2025 Target Date: 05/28/2025</p> <p>INTERVENTIONS/TASKS: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 01/25/2025 LN RN Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.) Date Initiated: 01/25/2025 LN RN Monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills Date Initiated: 01/25/2025 LN RN Monitor/record/report to MD prn mood patterns s/sx of depression, anxiety, sad mood. Date Initiated: 01/25/2025 LN RN Monitor/record/report to MD prn risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons Date Initiated: 01/25/2025 CNA LN RN.</p> <p>Record review of PCP 's diagnosis on 08/22/24 reflected, Schizoaffective Disorder.</p> <p>Record review of Nursing - Psychoactive Medication Quarterly Evaluation dated 08/23/24, reflected Medical Diagnosis warranting use F25.1 Schizoaffective Disorder, Depressive Type.</p> <p>Record review of physician ' s orders dated 08/23/24 reflected, risperDAL Oral Tablet 1 MG (Risperidone) Give 1 tablet by mouth at bedtime for schizophrenia.</p> <p>In an interview on 05/20/25 at 03:53 PM, the DON notified surveyor that schizophrenia was in the medical diagnosis. Surveyor checked and schizophrenia was added on 05/20/25 under medical diagnosis. DON stated the NP's notes on 10/05/24, 01/27/25, and 05/01/25 have schizophrenia in the note for a diagnosis.</p> <p>In an interview on 05/20/25 at 04:07 PM, NP stated she signed the Antipsychotic Consent for Risperdal for Resident #10 for schizoaffective disorder. NP stated Resident's PCP diagnosed Resident with schizoaffective disorder on 08/22/24. NP stated three of her notes on 10/05/24, 01/27/25, and 05/01/25 had the diagnosis of schizophrenia. The original diagnosis of schizoaffective disorder was given by PCP and not NP. NP was notified schizophrenia was not on the medical diagnosis on any other paperwork except hers and the order the nurse put in PCC. NP stated the diagnosis should be schizoaffective.</p>