STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675606	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harlingen Nursing and Rehabilitation Center	3810 Hale St 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 3 of 4 medication carts (Hall 400 Med-Aide cart, Hall 300 Med-Aide cart, and Hall 100 Nurse Med-Cart) reviewed for pharmacy services.1. The facility failed to ensure medications in Hall 400 Med-Aide cart, Hall 300 Med-Aide cart, and Hall 100 Nurse Med-cart were labeled with an Open Date on 2/23/2026.2. The facility failed to ensure medication in Hall 300 Med-Aide cart were free of loose pills on 2/23/2026.These deficient practices could place residents at risk for adverse effects and not receiving the therapeutic effects of the medication or treatment. The Findings included: 1. An observation on 2/23/2026 at 2:11 PM of the Hall 400 Med-Aide medication cart, revealed that two boxes of Cyclosporine Ophthalmic emulsion 0.05% for two different residents did not have an Open Date label. Both boxes contained open pouches which included eye drop vials.An observation on 2/23/2026 at 2:28 PM of the Hall 300 Med-Aide medication cart, revealed a box of Xiidra 5% ophthalmic solution did not have an Open Date. The box contained an open pouch which included eye drop vials. An opened box of Sevelamer Carbonate 2.4 g pouches did not have an Open Date.An observation on 2/23/2026 at 3:04 PM of Hall 100 Nurse medication cart, revealed two opened boxes of Ipratropium/Albuterol 2.5 MG Inhalation Solution did not have an Open Date and an open box of Fluticasone Propionate nasal spray did not have an Open Date.In an interview on 2/23/2026 at 2:26 PM with CMA G, he said he checked his cart daily at the beginning of his shift for expired medications and dates on medication. He said he was in a hurry and did not label a box of eye drops that he had just opened. He said he overlooked the date not written on the other boxes of medications. He said the nurses and the DON gave him daily reminders to check for open dates and to label when opening a new medication. He said it was the responsibility of all the medication aides to check the medications carts. He said the medications can expire by not having an Open Date written.In an interview on 2/23/2026 at 3:04 PM with LVN H, he said that all shifts and nurses were responsible for checking medication labels, Open Dates, and expiration dates. He said he had just started his shift and was supposed to check for labels. He said management provided weekly reminders to check medications. LVN H said negative outcomes were not knowing if the medication was new or old. He said if a medication was old, it would not be as effective and it would not provide the therapeutic effect to the resident.In an interview on 2/23/2026 at 3:41 PM with the DON, she said that the nurses and medication aides were responsible for dating when opening a new medication. She said that every time a nurse or medication aide opens a medication, they were to label it. She said every shift is responsible for labeling the medication. The DON said that by not having an Open Date, a resident may have possible negative effects.2. An observation on 2/23/2026 at 2:28 PM of Hall 300 Med-Aide medication cart, revealed five loose pills identified as sertraline 25 mg, memantine 5 mg (2 pills), losartan 5 mg, and furosemide 40 mg, inside the medication cart.In an interview on 2/23/2026 at 2:24 PM with CMA G, said, he said losartan was for blood pressure, memantine was used for dementia. He said if a resident did not receive the medication their blood pressure can go up and was not sure what (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would happen to the resident if medication for dementia was not given. He said he had been a CMA for two months and had training last month regarding labeled and checked open dates on medication.In an interview on 2/23/2026 at 3:41 PM with the DON, she said medication aides were responsible for cleaning the medication carts. She said if CMAs found loose pills, they notified the nurse, and the medications were destroyed. She said if pills were accidentally dropped inside the medication cart, they would notify the nurse and pulled the medication again. The DON said there was always a backup in the E kit. She said a negative outcome of having loose pills in the medication cart would be that the medication count could be off. She said another possible negative outcome was that the residents did not get their medication and therapeutic effects were not available.Record review of the facility's policy and manual titled: Pharmacy Provider Requirements with a revision date:10/01/2019 indicated .E. Labeling all medications dispensed in accordance with the medication labeling policy with state and federal requirements.

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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, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for sanitation in that: The facility failed to ensure the juicer's dispenser gun was clean. This failure could place residents at risk of foodborne illnesses. Findings included: During the initial tour of the kitchen on 02/22/26 at 8:30 a.m., the juice dispenser gun revealed a reddish slimy substance adhered to it and brownish stains on one side of the nozzle. Record review of the facility's kitchen Daily Cleaning Schedule for the month of February 2026 revealed the juicer had been cleaned every day from the 1st to the 21st. In an interview on 02/22/26 at 8:36 a.m., the DM said the juicer had been used earlier in the morning for breakfast. He said the juicer and its nozzle would be cleaned daily. The DM refused to say if the slimy substance found on the nozzle was a result of that day usage or if it was an accumulation of several days. He was not able to say what the negative outcome to residents was if the juicer nozzle was not clean. In an interview on 02/24/26 at 3:15 p.m. DA C said all kitchen staff were responsible to clean their assigned area at the end of their shift. He said after they cleaned their assigned areas, they assisted in cleaning all equipment which included the juicer and its nozzle. He said the DM had a daily cleaning schedule where they each had to initial what they had cleaned. In an interview on 02/24/26 at 3:25 p.m., DA D said all kitchen staff were responsible to clean their assigned area at the end of their shift. He said after they cleaned their assigned areas, they assisted in cleaning all equipment which included the juicer and its nozzle. He said the DM had a daily cleaning schedule where they each had to initial what they had cleaned. In an interview on 02/24/26 at 4:00 p.m., the Administrator said the kitchen staff would clean all appliances on a daily basis. He was not able to say what the negative outcomes to residents would be if the juicer nozzle was not clen. Record review of the facility's General Kitchen Sanitation policy dated 10/01/18 reflected:Policy: The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All Nutrition & Foodservice employees will maintain clean, sanitary kitchen facilities in accordance with the state and US Food Codes in order to minimize the risk of infection and food borne illness. Procedure: 1. Clean and sanitize all food preparation areas, food-contact surfaces, dining facilities, and equipment. After each use, clean and sanitize all tableware, kitchenware, and food-contact surfaces of equipment, except cooking surfaces of equipment and pots and pans that are not used to hold or store food and are not used solely for cooking purposes.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial need that were identified in the comprehensive assessment for 2 of 9 residents (Resident #1 and Resident #69) reviewed for comprehensive person-centered care plans.1.The facility failed to ensure Resident #69's care plan included her level of care for ADLs.2.The facility failed to ensure Resident #1's comprehensive care plan included activities to be done with resident.These deficient practices could place residents at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs. Findings included: Record review of Resident #1's admission Record dated 02/23/26 revealed a [AGE] year-old-female, admitted to facility on 01/02/26 with diagnoses of Metabolic Encephalopathy (brain dysfunction causing confusion, delirium), Tracheostomy (surgically opening a hole in neck to provide alternate airway for breathing), Cognitive Communication Deficit (impairment in communication), Muscle Weakness (Generalized), Down Syndrome (genetic condition resulting in mild to moderate intellectual disability), and Mixed Receptive-Expressive Language Disorder (struggle to understand and use language). Record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS of 00 indicating her cognition was severely impaired and functional abilities also revealed resident was dependent (helper does all of the effort, resident does none to complete the activity) on sit to lying on bed, chair/bed to chair transfer, and oral hygiene. Record review of Resident#1's Comprehensive Care Plan with an initiation date of 01/02/26 reflected no goals/interventions for Activities for Resident #1. Resident had an ADL self-care performance deficit r/t impaired cognition/down syndrome and required total x2 staff assistance for dressing, oral care, and transferring. Record review of Activities – Initial Review effective date 01/05/26 for Resident #1 revealed Instructions: Complete on admission. Use this data to design an activities program that meets the residents needs and preferences. Update the care plan upon completion. Resident #1 likes to watch cartoons and movies on tv and be close to her family. Resident is appropriate for in-room visits and would benefit from in-room visits. In an interview on 02/23/26 at 4:40 p.m., the AD said she had not added activities in Resident #1's care plan because she was not required to do that, it was MDS who was responsible for that task. The AD said she would update the MDS on resident activities and they would be the ones to add it to the care plan. In an interview on 02/24/26 at 2:19 p.m. MDS F said MDS is responsible for updating resident care plans. She said the AD discusses activities for each resident and she updates the care plans. She said it was an oversight on her part and had not added activities to Resident #1's care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/24/26 at 2:32 p.m. the DON said Resident #1 not having activities done could possibly would have had negative outcomes but was not sure. Record review of the facility's Comprehensive Care Plan Policy dated 10/24/22 reflected: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental psychosocial needs that are identified in the resident's comprehensive assessment. 2. Record review of Resident #69's admission record dated 02/22/26, reflected an [AGE] year-old female with an admit date of 04/09/21. Her relevant diagnoses included heart failure (a chronic serious condition where the heart cannot pump enough blood and oxygen to meet the body's needs, often causing fluid backup in the lungs and legs), dysphagia (difficulty swallowing, causing food or liquid to get stuck in the throat or chest), and bipolar disorder (a chronic mental health condition causing extreme intense mood swings). Record review of Resident #69's annual MDS assessment dated [DATE], reflected a BIMS score of 14, which indicated her cognition was intact. Her functional abilities reflected she required substantial/maximal assistance (helper does more than half the effort. with eating. Record review of Resident #69's comprehensive care plan dated 12/31/25, reflected no falls or incidents. In an interview on 02/22/26 at 10:14 a.m., CNA A said she had cared for Resident #69 for over 2 years. She said Resident #69 required a 1 person assist for all ADLs as she was able to assist the helper. She said resident #69 required assistance with all meals. In an interview on observation on 02/22/26 at 10:20 a.m., CNA B said she had care for Resident #69 for a long time. She said Resident #69 required a 1 person assist for all ADLs as she was able to assist the helper. She said Resident #69 required assistance with all meals. In an interview on 02/24/26 at 2:21 p.m., MDS E was observed as she reviewed Resident #69's electronic medical record and said her most recent MDS included her level of care for all ADLs. She said Resident #69's care plan had not included her level of care for her ADLS since 09/01/25. She said, someone had resolved the section which included the level of care for ADLs in error. MDS E said a negative outcome to Resident #69 not having her level of care included in her care plan would be that staff would not know the level of care she required. In an interview on 02/24/26 at 2:45 p.m., the DON said a resident's care plan should include their level of care for their ADLs. She said resident's care plans were updated quarterly by IDT and she was not sure why they did not see that Resident #69's care plan did not include her lever of care for ADLs. She said there were no negative outcomes to Resident #69 because the CNAs assigned to her hall were tenured and were familiar with her level of care. Record review of the facility's Comprehensive Care Plans policy dated 10/24/22, reflected: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain the resident's highest practicable, physical, mental, and psychosocial well-being.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to review and revise the comprehensive care plan for 1 (Resident #106) of 5 residents reviewed for comprehensive care plan revisions.The facility failed to review and revise Resident #106's comprehensive person - centered care plan's oxygen interventions to reflect current order of 2 LPM.This failure could affect residents and place them at risk of not receiving appropriate interventions to meet their current needs.The findings were: Record review of Resident # 106's admission record dated 02/23/26 revealed a [AGE] year-old female with an original admission date of 02/19/24 along with a recent admission date of 01/12/26. The diagnosis for Resident #106 included: Hemiplegia (paralysis that affects only one side of your body) and Hemiparesis (one-sided muscle weakness) following cerebral infarction (occurs as a result of disrupted blood flow to the brain) affecting the left non-dominant side, Acute respiratory failure with hypoxia (low levels of oxygen in your body tissues), pneumonia, muscle wasting, and atrophy (wasting away of a part of the body).Record review of Resident #106's Quarterly MDS assessment dated [DATE] revealed resident had a BIIMS score of 00 which indicated severe cognitive impairment. The MDS assessment also revealed Resident #106 was on a respiratory treatment, oxygen therapy. Record review of Resident #106's active Order Summary Report revealed an order dated 02/07/26 for Oxygen at 2 LPM via NC every shift related to moderate persistent asthma Record review of Resident #106's Care Plan dated 01/30/26 revealed: Problem: [Resident #106] has oxygen therapy r/t respiratory failure. Date initiated: 07/28/25. Interventions: Oxygen settings: Oxygen at 5 LPM via NC every shift related to acute respiratory failure with hypoxia. Date initiated: 07/28/25 Revised on 07/30/25. In an interview on 02/23/26 at 4:10 pm, the DON stated care plans are revised quarterly or when there is a change in condition. The DON stated she and MDS were in charge of implementing and revising the care plans. The DON stated Resident #106 had changes in July that required revision but the revision in the care plan was not done. She stated the resident had recently been placed on oxygen again but failed to update the care plan. The DON stated she was not aware the care plan had not been revised stating, It was overlooked. In an interview on 02/24/26 at 3:49 pm, MDS E stated she was in charge of care plan revisions. MDS E stated she would revise care plans quarterly. If a care plan needed to be revised between quarters, then the DON would do those revisions. MDS E stated she took responsibility for Resident #106's care plan not being updated during the quarterly revision. Record review of the facility's policy: Care Plan Revisions Upon Status Change dated 10/24/22 revealed: 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change.2. Procedure for reviewing and revising the care plan when a resident experiences a status change:d. The care plan will be updated with the new or modified interventions.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on interview, observation, and record review, the facility failed to provide an ongoing activities program to support residents in their choice of activities, both facility sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 1 of 3 residents (Resident #1) reviewed for activities.The facility failed to provide Resident #1 with in-room activities.This failure could place residents at risk for boredom, depression, and diminished quality of life.Findings included:Record review of Resident #1's admission Record dated 02/23/26 revealed a [AGE] year-old-female, admitted to facility on 01/02/26 with diagnoses of Metabolic Encephalopathy (brain dysfunction causing confusion, delirium), Tracheostomy (surgically opening a hole in neck to provide alternate airway for breathing), Cognitive Communication Deficit (impairment in communication), Muscle Weakness (Generalized), Down Syndrome (genetic condition resulting in mild to moderate intellectual disability), and Mixed Receptive-Expressive Language Disorder (struggle to understand and use language).Record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS of 00 indicating his cognition was severely impaired and functional abilities also revealed resident was dependent (helper does all of the effort, resident does none to complete the activity) on sit to lying on bed, chair/bed to chair transfer, and oral hygiene.Record review of Resident#1's Comprehensive Care Plan with an initiation date of 01/02/26 reflected no goals/interventions for Activities for Resident #1. Resident has an ADL self-care performance deficit r/t impaired cognition/down syndrome and requires total x2 staff assistance for dressing, oral care, and transferring.Record review of Activities - Initial Review effective date 01/05/26 for Resident #1 revealed Instructions: Complete on admission. Use this data to design an activities program that meets the residents needs and preferences. Update the care plan upon completion. Resident #1 likes to watch cartoons and movies on tv and be close to her family. Resident is appropriate for in-room visits and would benefit from in-room visits.Record Review of Resident #1's hard copy document titled Activity Department dated February 2026 revealed no activity entries for Resident #1.Observation of Resident #1 on 02/22/26 at 10:24 a.m. in bed, alert, non-verbal, non-responsive. Television is off, no other forms of stimulation observed in room.Observation of Resident #1 on 02/23/26 at 2:13 p.m. in bed, alert, non-verbal, non-responsive. Television is off, no other forms of stimulation observed in room.In an interview on 02/23/26 at 4:40 p.m., the AD said that she had done activities with Resident #1 but had not been documenting because she had been busy with new staff. She said she would turn on the television and played movies for Resident #1. She said Resident#1's father had been spending more time with her so she had not been doing as many activities with her. AD said she hadn't added activities in Resident #1's care plan because she was not required to do that, it was MDS who was responsible for that task.In a follow-up interview on 02/24/26 at 1:20 p.m. the AD said she had received training from the previous Activity Director and also had done online classes.In an interview on 02/24/26 at 2:32 p.m. the DON said she may have benefited from stimulation activities but could not answer for certain.In an interview on 02/24/26 at 3:16 p.m. the Administrator said the AD works closely with MDS. They work together to create activities for residents. He said AD had been trained by the previous activity director. he said if a resident is not receiving any type of activities they would have lack of stimulation, involvement.Facility provided no policy for Resident Activities.

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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 a resident who needed respiratory care was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 3 (Resident #106) residents reviewed for respiratory care.The facility failed to ensure Resident #106's oxygen was being administered on 02/22/26 as ordered by the physician.This deficient practice 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 # 106's admission record dated 02/23/26 revealed a [AGE] year-old female with an original admission date of 02/19/24 along with a recent admission date of 01/12/26. The diagnosis for Resident #106 included: Hemiplegia (paralysis that affects only one side of your body) and Hemiparesis (one-sided muscle weakness) following cerebral infarction (occurs as a result of disrupted blood flow to the brain) affecting the left non-dominant side, Acute respiratory failure with hypoxia (low levels of oxygen in your body tissues), pneumonia, muscle wasting, and atrophy (wasting away of a part of the body).Record review of Resident #106's Quarterly BIMS assessment dated [DATE] revealed resident had a score of 00 which indicated severe cognitive impairment.Record review of Resident #106's Quarterly MDS dated [DATE] revealed Resident #106 had functional limitation in range of motion with impairment to both upper extremities. The MDS also revealed Resident #106's speech pattern was identified as no speech. The MDS assessment also revealed Resident #106 had an active diagnosis of respiratory failure therefore was on respiratory treatment: oxygen therapy. Record review of Resident #106's Care Plan dated 01/30/26 revealed: Problem: [Resident #106] has oxygen therapy r/t respiratory failure. Interventions: Oxygen at every shift related to acute respiratory failure with hypoxia.Record review of Resident #106's active Order Summary Report revealed an order dated 02/07/26 for Oxygen at 2 LPM via NC every shift related to moderate persistent asthma.During an observation of Resident #106 on 02/22/26 at 3:50 pm revealed the nasal cannula (a lightweight, flexible tube with two prongs inserted into the nostrils to deliver supplemental oxygen) was on resident's left cheek, therefore not properly placed into the nostrils. The oxygen concentrator machine (a medical device that filters ambient air to deliver oxygen) was on at the level of 2 LPM. Resident #106 was in bed, with the head of the bed slightly elevated. No signs of respiratory distress were noted.During an observation and interview on 02/22/26 at 3:51 pm LVN L observed that Resident 106's nasal cannula was not placed into her nostrils. LVN L checked Resident 106's oxygen saturation (measures the percentage of oxygen in the blood) level and it was at 94%. LVN then placed the nasal cannula into the resident's nostrils, and the oxygen saturation level quickly rose to 96%. LVN L stated she had to adjust the nasal cannula because the resident is unable to move her arms due to contractures (shortening of muscles, tendons, skin, and nearby soft tissues that cause the joints to shorten and become very stiff, preventing normal movement). LVN L stated she entered Resident 106's room at the start of her shift which was 2:00 pm but had not gone in again to check on resident. LVN L stated that the negative outcome for Resident #106 not having the nasal cannula in place was that resident could have desatted (medical term for a patient's blood oxygen saturation level dropping below normal) or she could have had shortness of breath.In an interview on 02/22/26 at 4:02 pm CNA M stated she was the CNA for Resident #106's hall. CNA M stated she was instructed to look into every room as she walked down the hallway. CNA M stated that if a resident has the nasal cannula out of place, she was able to correctly place it into a resident's nostrils. CNA M stated she then informs the nurse in case the resident needed to be assessed. CNA M stated that she had not entered Resident 106's room yet since her arrival in the hall, which was around 2:00 pm. CNA M stated she had passed by Resident #106's room several times but did not notice the nasal cannula was out of place. She stated that she is also instructed to check in more often on residents that have oxygen.In (continued on next page)

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Harlingen Nursing and Rehabilitation Center	3810 Hale St Harlingen, TX 78550

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 02/23/26 at 4:10 pm the DON stated Resident #106 was on continuous oxygen due to a recent order on 02/07/26. DON stated that nurses and CNAs were to round on residents every 2 hours and as needed. The rounding might be sooner if residents required treatment. DON stated that oxygen was considered a treatment and therefore should have been checked more frequently. DON stated she instructed the CNAs to look into the resident's rooms while walking through the halls. The DON stated a negative outcome for Resident #106 not having the nasal cannula placed properly was that the resident could have gone into respiratory distress or shortness of breath.In an interview on 02/23/26 at 4:20 pm, the DON stated the facility did not have a policy on oxygen.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observations, interviews, and record reviews the facility failed to ensure no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident agrees to this meal span for residents eating meals in their rooms, for 2 (Resident #4 and Resident #69) of 8 residents reviewed for food and nutrition services. 1.The facility failed to ensure that no more than 14 hours lapsed between a substantial evening meal and breakfast the following day and provide a nourishing snack to Resident #84 who ate in her room. 2. The facility failed to ensure that no more than 14 hours lapsed between a substantial evening meal and breakfast the following day and provide a nourishing snack to Resident #69 who ate in her room. These failures could affect all residents who received meals served from the facility's only kitchen by placing residents at risk for unplanned weight loss, and side effects from medication given without food, and diminished quality of lifeFindings included: 1.Record review of Resident #84's admission record dated 02/22/26, reflected a [AGE] year-old female with an admit date of 05/20/23 and an initial admission date of 05/27/23. Her relevant diagnoses included type 2 diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels), legal blindness (severe visual impairment or low vision), adult failure to thrive (syndrome characterized by intended weight loss, poor appetite, malnutrition, inactivity, and functional decline), and dysphagia (difficulty swallowing, causing food or liquid to get stuck in the throat or chest). Record review of Resident #84's quarterly MDS assessment dated [DATE], reflected a BIMS score of 10, which indicated her cognition was moderately impaired. Her functional abilities for eating had been scored a 1, which indicated she was dependent helper does all of the effort. Record review of Resident #84's quarterly care plan date02/24/26/26, reflected a focus of [Resident #84] has an ADL self-care performance deficit r/t failure to thrive, muscle atrophy and wasting. Her interventions in part included functional performance: Eating: The resident dependent for eating. Record review of Resident #84's Nutrition-Snacks history reflected she had not received a snack the evening of 02/21/26. Record review of Resident #84's order summary dated reflected the following medications for her diagnosis of type 2 diabetes: Lantus Subcutaneous Solution 100 unit/ml (insulin Glargine) inject 20 units subcutaneously one time a day for DM related to Type 2 diabetes mellitus with hyperglycemia, effective 01/08/26. Farxiga Oral Tablet 10 mg (Dapagliflozin Propanediol) Give 1 tablet by mouth one time a day related to Type 2 diabetes mellitus with hyperglycemia. Record review of Resident #84's February 2026 eMAR reflected that she had been administered Farxiga Oral Tablet 10 mg, 1 tablet on 02/22/26 at 6:00 a.m. and her blood sugar was 99. Record review of Resident #84's February 2026 eMAR reflected that she had been administered Lantus subcutaneous solution 100 unit/ml, 20 units on 02/22/26 at 6:43 a.m. During an observation on 02/22/26 at 9:47 a.m., this surveyor observed as CNA A as she delivered Resident #84 her breakfast tray and started feeding her. In an interview on 02/22/26 at 10:11 a.m., Resident #84 said she had received her breakfast later than usual that day. She said by the time her breakfast was served it was still warm, she had no concerns with the temperature, and the food was still palatable. In an interview on 02/22/26 at 10:14 a.m., CNA A said the kitchen staff had delivered the food cart to hall (hall 300) at about 7:45 a.m. She said there were usually three CNAs assigned to that hall, but that day one CNA was called to cover another hall. She said of the two CNAs left, one was assigned to go assist with residents in the dining hall, so she was left alone to cover the hall. She said there were 6 residents who stayed in their rooms that required assistance with their meals. CNA A stated the reason she fell behind in assisting Resident #89 with her breakfast was because she was left alone to feed all six residents. CNA A said when three CNAs were in the hall, one would help out in the (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dining room during meals and the two left feed the resident stayed in their rooms and required assistance. CNA A said management normally would not pull CNAs from her hall and residents who stayed in their room and required assistance with their meals received their breakfast by 8:30 a.m.2. Record review of Resident #69's admission record dated 02/22/26, reflected an [AGE] year-old female with an admit date of 04/09/21. Her relevant diagnoses included heart failure (a chronic serious condition where the heart cannot pump enough blood and oxygen to meet the body's needs, often causing fluid backup in the lungs and legs), dysphagia (difficulty swallowing, causing food or liquid to get stuck in the throat or chest), and bipolar disorder (a chronic mental health condition causing extreme intense mood swings). Record review of Resident #69's annual MDS assessment dated [DATE], reflected a BIMS score of 14, which indicated her cognition was intact. Her functional abilities for eating had been scored a 2, which indicated helper does more than half the effort.Record review of Resident #69's comprehensive care plan dated 02/24/26, reflected a problem of [Resident #69] has an ADL self-performance deficit r/t limited mobility, date initiated 07/11/22 and revised on 02/24/26. Her interventions in part included Functional performance: Eating: The resident requires sub/max for eating, date initiated/revised 02/24/26.Record review of Resident #69's Nutrition-Snack history reflected she had not received an evening snack on 02/21/26.During an observation on 02/22/26 at 9:43 a.m., Resident #69 was observed in a sitting position in her bed. Resident #69 was heard making a request for her food to CNA B. Resident #69 asked this surveyor to leave her room.In an observation on 02/22/26 at 9:45 a.m., CNA B delivered Resident #69's breakfast tray and assisted her with her breakfast meal. In an interview and observation on 02/22/26 at 10:20 a.m., CNA B said there were usually three CNAs assigned to hall 300, but that day one CNA was called to cover another hall. She said of the two CNAs left in the hall, she had been assigned to go assist with residents with their breakfast in the dining hall and only one stayed in the hall. She said she returned to hall 300 at about 9:40 a.m. and had immediately assisted CNA A in assisting residents with their breakfast. She said by that time she returned to her hall only Resident #69's tray was left in the food cart and immediately delivered it to her room and assisted her with her breakfast. She said Resident #69 was able to verbalize her needs and if her food was cold or not palatable, she would voice her concerns. She said Resident #69 had not voiced any concerns regarding her breakfast. In an interview on 02/23/26 at 11:15 a.m., the DM said the facility's protocol was for a dietary aide to deliver the food carts to the halls for residents that preferred to eat in their rooms. He said the dietary aide would leave the food cart in its corresponding hall for the CNAs to deliver to the residents. He said the morning of 02/22/26, a dietary aide delivered the breakfast food cart to hall 300 no later than 7:45 a.m. The DM said on 02/21/26, the dinner food cart had been delivered to hall 300 at 5:45 p.m. He said the facility offered evening snacks for residents who wanted one or were scheduled to receive one. In an interview on 02/23/26 at 11:31 a.m., the Dietician said meals should have been served with no more than 14 hours between the evening meal and breakfast the following day. He was observed as he reviewed Resident #84 and Resident #69's electronic medical record. He said Resident #84 had a diagnosis of diabetes and had 2 scheduled medications (orally and an injection) daily at 6:00 a.m. He said Resident #84's had been administered her scheduled diabetes medications on 02/22/26 at 6:00 a.m., and her sugar level at the time was 99 which was normal. The Dietician said Resident #84 did not have an order for an evening snack. He said Resident #84's snack history showed she had not received an evening snack on 02/21/26. The dietician said Resident #69 did not have a diagnosis of diabetes and did not have an order for an evening snack. He said Resident #69's snack history did not show she received an evening snack on 02/21/26. The Dietician said there were several negative outcomes to Resident #89 who had more than 14 hours between the evening meal and breakfast the following day and that would be the possibility of her sugar level dropping especially since she had been administered her diabetes medications at 6:00 a.m. He said another negative outcome for both Resident #84 and Resident #69 would be the food temperature, the fact that both residents expected their meal(s) by a certain time and the food's palatability. In an interview on 02/23/26 at 11:45 a.m., (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DON said the morning of 02/22/26, 3 CNAs had been scheduled to hall 300. She said 1 CNA from hall 100 called in sick and she had to reassign 1 CNA from hall 300 to hall 100. She said that was an isolated case. The DON said a negative outcome for Resident #84 and Resident #69 having to wait over 14 hours between their evening meal and breakfast the following day could be the possibility of Resident #84's sugar level dropping because she had not had anything to eat for that long and a negative outcome for Resident #69 could be that she was going to be hungry. Record review of the facility's Meal Times policy dated 10/02018, reflected:Policy: The facility provides three meals daily at regular times which are comparable to meal times in the community setting. Meals are served at the specified times except in emergency situations. Procedures: 1. Meals will be served according to the state and federal regulations, with no more than fourteen hours between the evening meal and breakfast the following day.

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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 observation, interviews, and record reviews, the facility failed to maintain medical records on each resident that are complete; accurately documented; readily accessible; and systematically organized for 1 (Resident #70) of 5 residents.LVN J documented changing of Resident #70's oxygen tubing on 2/15/2026, however, she did not carry out the order due to lack of tubing.The failure could place residents at risk for errors by staff when reading information in the clinical record that was inaccurate or incomplete.The Findings included:Record review of Resident #70's admission Record, indicated an admission date of 12/30/2025, an [AGE] year-old female with a Principle Diagnosis of Hypertensive Urgency (high blood pressure), and a diagnosis of Chronic Obstructive Pulmonary Disease (progressive, long-term lung disease that makes it hard to breathe by damaging and narrowing the airways).Record review of Resident #70's MDS Assessment, dated 1/1/2026 and signed as completed on 1/12/2026 by the RN Assessment Coordinator, reflected assessment observation end date of 1/1/2026. Resident #70 had a BIMS score of 11 which indicated moderate cognitive impairment.Record review of resident #70's Order Summary dated 2/22/2026, indicated an order to Change O2 tubing Q week on Sunday and PRN every night shift every Sunday for change tubing. Order Date:12/30/2025.Record review of resident #70's Medication Administration Record for the month of February 1, 2026-February 28, 2026 indicated Change O2 tubing Q week on Sunday and PRN every night shift every Sunday for change tubing was initialed on 2/15/2026 by LVN J.In an observation on 2/22/2026 at 9:20 AM, Resident #70's O2 tubing was labeled 2/9/26.In an interview on 2/22/2026 at 9:25 AM with Resident #70, she said she did not recall the date the tubing was changed out by the nurse. She said the nurses had been in her room earlier to check the O2 concentrator because it was making a loud noise and the problem was resolved.In an interview on 2/23/2026 at 2:54 PM with the ADON, she said daily rounds were conducted by Resident Ambassadors that checked O2 tubing and equipment. She said she saw the tubing was due to be changed and did not know how the tubing was overlooked. She said that there should have been documentation on the MAR when the tubing was changed. She said if the tubing was not changed there may not be effective oxygenation to the resident. She said medication administration in-services were done yearly which included oxygen and oxygen supplies.In an interview on 2/23/2026 at 3:04 PM with LVN K, he said that he had checked the O2 setting but did not notice the date on the tubing. He said the night nurses were the ones that changed the O2 tubings. He said the tubing gets dirty and were scheduled to be changed every week and as needed. He said the oxygen tubing could collect water and form condensation which would affect the resident by having possible aspiration. He said weekly reminders were given to change out the tubing for oxygen and nebulizers.In an interview on 2/24/2026 at 4:27 PM with LVN J, she said she had signed the MAR by mistake on 2/15/2026. She said she had been changing out the oxygen tubing for other residents and when she got to Resident #70, she ran out of the tubing wrap and did not change the tubing on 2/15/2026. She said once an order was carried, the MAR was supposed to be signed.Record review of the facility's policy titled: Medication Administration with s Date Implemented: 10/24/22 indicated .17. Sign MAR after administered . 20. Correct any discrepancies and report to nurse manager.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Number of residents sampled: Number of residents cited: Based on observation and interview, the facility failed to post in a place readily accessible to residents, family members, and legal representatives of residents, the results of the most recent survey and post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public for 1 of 1 facility in that: The facility failed to post the most recent surveys in a place viewable and readily accessible to residents, family members, and legal representatives of residents.This failure could place residents at risk of not being able to fully exercise their rights and at risk of not being aware of the facility's past deficiencies.The findings were:In an observation on 02/23/26 at 3:00 p.m. of the facility's front door area, near the receptionist desk revealed there was a survey binder on top of a desk that was set towards a back corner wall. The binder was covered by 2 other binders and it did not have visible lettering stating that it was a Survey binder. It contained the last survey.In a confidential interview on 02/23/26 at 2:17 p.m. 6 residents stated they did not know where or how to access survey results in the facility and they would like to know what previous survey and investigation results were. The residents stated they had never seen a binder labeled with that information anywhere in the facility.In an observation and interview on 02/23/26 at 3:06 p.m. the Administrator stated the survey binder had always been located in the front area by the receptionist desk. He said residents were aware of its location. He said he was responsible for updating the binder.The facility did not provide a policy for survey results.