STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675617	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Pass Nursing and Rehabilitation	2550 Zacatecas Dr Eagle Pass, TX 78852

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to post the nurse staffing data on a daily basis at the beginning of each shift for 1 of 1 facilities reviewed for nursing services. The daily staff posting was not updated on 5/18/25. This failure could result in residents and visitors not knowing how many staff were providing services to the residents. The findings were: In an observation on 5/18/25 at 10:15 a.m., the daily staff posting was on a dry erase board made specifically for the daily staff posting on the wall behind the left side of the nursing station in public view. The daily staff posting was dated 5/18/25. The daily staff posting had the number 0 for Medication Aide (MA). In an observation and interview on 5/18/25 at 10:17 a.m., MA F was on A-hall with a medication cart and stated she was working that morning. In an observation and interview on 5/18/25 at 10:20 a.m., RN G was observed holding the daily schedule book and was erasing the specific staffing numbers and writing in new numbers in the data areas for staffing. RN G stated someone from the office or a charge nurse was responsible for changing the daily staff posting. In an interview on 5/18/25 at 10:34 a.m., the DON stated it was the charge nurse who was responsible for posting the daily staffing on the weekends. The DON stated possible consequences of the daily staff posting not being updated with the correct information could be something might happen with RN coverage. In an interview on 5/21/25 11:43 a.m., the Administrator stated it was important for the daily staff posting to be accurate and updated daily so people would know how many staff are caring for the residents. In an interview on 5/21/25 at 1:22 p.m., the Administrator stated there was no policy for the daily staff posting.

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observed for kitchen sanitation. 1. The facility failed to ensure a tray of prepared and poured glasses of thicken beverages were dated. 2. The facility failed to ensure opened jar of jalapenos dated 05/05/2025 were refrigerated. 3. The facility failed to ensure a large opened plastic container of vanilla cream icing with lid open to air and partially used was sealed properly. 4. The facility failed to ensure half used bottle of salad dressing was refrigerated. 5. The facility failed to ensure a beverage container in the dining room with water was dated with prepared date. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: During observation and interview on 05/18/2025 at 10:17 a.m. the initial tour of the kitchen revealed in the walk-in refrigerator a tray with beverages poured approximately 6 glasses with thickened liquids, 1 sipping cup and one nosey cup (cup with the area cut out for the nose), not dated. The DM stated they must have been poured for lunch, but they should have been dated. The pantry revealed a jar of jalapenos dated 05/05/2025 with 2 small slits in the lid, having been opened with refrigerate after opening on the label. The DM stated 05/05/2025 was the received date however, they should have been refrigerated. The DM was observed removing the jar of jalapenos from the pantry and tossed in the trash. A large tub of vanilla cream icing was observed on the bottom shelf of the pantry with the lid open and having been partially used dated 03/12/2025 expiration date 09/17/2025 and a half-used bottle of salad dressing was also on the bottom shelf of the pantry dated 04/29/2205 label with refrigerate when opened instructions. The DM stated the vanilla cream icing should have had the lid secured and salad dressing should have been refrigerated, but she did not know it was opened. The DM removed the salad dressing from the pantry and tossed it in the trash. The DM stated by items not having been sealed properly or refrigerated after opening it the items could go bad and it could cause a resident to get sick if it was served and could cause diarrhea. In the dining room on the counter was a beverage container of water on the counter with no date as to when prepared. The DM stated the beverage container was probably put out that morning and it should have been dated. During an interview on 05/21/2025 at 11:45 a.m. the Administrator stated things could go bad if they were not dated or stored at the correct temperatures. The Administrator further stated this could cause resident to get sick if the items were bad. The administrator stated the kitchen staff were responsible for the proper storage of items. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of in-service training dated 03/21/2204 revealed, staff had been in serviced regarding Labeling, Dating and Food Storage Refrigerator. Record review in service training dated 09/02/2204 revealed, staff had been in serviced regarding Labeling and Dating. Review of facility's policy, Storage Refrigerators, dated 2012, read All Storage Refrigerators shall be maintained clean and have a proper temperature for food storage and to ensure a proper environment and temperature for food storage. Procedure: #5. Food must be covered when stored, with a date label identifying what is in the container. Review of facility's policy, Food storage and Supplies, dated 2012, read, All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and .Procedure: #4. Open packages of food are stored in closed containers with covers or in sealed bags, and dated as to when opened. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-305.11, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposited to splash, dust, or other contamination.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observations, interviews, and record review the facility failed to provide a minimum of 80 square feet per resident in 46 of 46 resident rooms (A1 through A11, B12 through B23, C24 through C33, D34 through D40, E41 through E46.) reviewed for minimum for square footage per resident. Resident rooms A1 through A11, B12 through B23, C24 through C33, D34 through D40, E41 through E46 did not have a minimum of 80 square feet per resident. This deficient practice could affect residents residing in rooms could result in inadequate space to provide care and resident dissatisfaction with the environment. The findings were: Observation of resident rooms in C hall, D hall and E hall on 05/18/2025 from 10:30 AM to 3:30 PM revealed resident room had two beds, one by the door and the other by the window. Resident beds closet to the door were at the edge of the doorframe with privacy curtains open and resting on the edge of beds. Privacy curtains were in the doorway. Interview with the the Administrator on 05/18/2025 at 3:45 PM revealed all the resident rooms are certified for two residents. The Administrator stated the facility did not have a room size waiver and she did not know the size of the resident rooms. Interview with the Administrator and Maintenance on 05/19/2025 at 2:15 pm revealed the rooms were less than 160 square feet meaning there was less than 80 square feet per resident in each room. The Administrator stated she and Maintenance measured each room to find that they did not have the required square feet for the residents. Record review of resident room measurements provided by the facility administrator revealed: Resident rooms A1 to A11 measured 159.83 square feet. Dividing the 159.83 square feet of usable floor space by 2 resulted in 79.91 square feet of floor space per resident in this room. Resident rooms B12, B15 to B23 measured 158.66 square feet. Dividing the 158.66 square feet of usable floor space by 2 resulted in 79.33 square feet of floor space per resident in this room. Resident room B13 to B14 measured 159.83. Dividing the 159.83 square feet of usable floor space by 2 resulted in 79.83 square feet of floor space per resident in this room. Rooms C24 to C33 measured 158.80 square feet. Dividing the 158.80 square feet of usable floor space by 2 resulted in 79.4 square feet of floor space per resident in this room. Rooms D34 to D40 measured 159.83 square feet. Dividing the 159.83 square feet of usable floor space by 2 resulted in 79.915 square feet of floor space per resident in this room. Rooms E41 to E46 measured 159.83 square feet. Dividing the 159.83 square feet of usable floor space by 2 resulted in 79.915 square feet of floor space per resident in this room. (continued on next page)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Form 3740, Bed Classifications, provided by the Administrator on 05/21/2025 revealed that all resident rooms were double occupancy.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on interview and record review, the facility failed to provide mandatory effective training on rights of the resident training for 1 of 28 employees (CNA C) reviewed for training. The facility failed to ensure rights of the resident training was provided to CNA C annually. This failure could affect residents and place them at risk of being uninformed due to lack of staff training. The findings were: Record review of the personnel records for CNA C revealed a hire date of 08/09/2023. Review of a training in-services for CNA C from 05/18/2024 to 05/21/2025, provided by the HR revealed no evidence of resident rights training being provided annually. Interview with the HR on 05/21/2025 at 11:00 AM, revealed the facility used Relias (computer-based training program) for employee's annual trainings. The HR stated employees received emails informing them they had annual trainings due. The HR stated that department heads also received emails when their employees had an annual training due. The HR stated department heads and HR were responsible to ensure staff completed their annual trainings timely. The HR stated it was important that staff had their annual trainings to ensure staff are up to date on policy/procedure for quality care of the residents. Interview with the DON on 05/21/2025 at 1:45 PM, revealed she had only been DON for a short time. The DON stated staff were trained annually via Relias and notified via email when a training is due. The DON stated it was the responsibility of the department heads to ensure their staff completed their annual trainings. The DON stated it was important to train staff annually to ensure resident receive care that meets their needs. Interview with the Administrator 05/21/2025 at 1:52 PM revealed the facility used Relias for employee's annual trainings. The Administrator stated staff and their supervisor were notified via email that they had a new training assigned in Relias. The Administrator stated, via the employee handbook, it was the responsibility of the employees to ensure their annual trainings were completed once assigned. The Administrator stated it was important to train staff annually to ensure residents received good care. Record review of the facility's employee handbook, section named HR-Personnel Handbook 2019, dated 09/20/2019, revealed EMPLOYEE EDUCATION PROGRAM All employees, regardless of status or classification, are required to complete mandatory training as defined by Federal, State and company policies. This facility provides multiple avenues of training that include an online learning management system, external CEU training, reimbursement for program or licensure training and more. For additional information about education opportunities, please contact the Benefits office. (continued on next page)

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy addressing required annual training including resident rights training was requested from HR on 05/21/2025 at 11:00 AM but was not provided prior to exit. A policy addressing required annual training including resident rights training was requested from the DON on 05/21/2025 at 01:45 PM but was not provided prior to exit. A policy addressing required annual training including resident rights training was requested from the Administrator on 05/21/2025 at 1:52 PM but was not provided prior to exit.