

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675785	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Edinburg Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5215 S Sugar Rd Edinburg, TX 78539	

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for one of three residents (Resident #1) reviewed for medication errors. The facility failed to ensure Resident #1's blood pressure/pulse altering medications (Midodrine) was not given outside of the scheduled time parameters for the month of November 2025 per the physician's orders. This failure could place residents at an increased risk for complications such as decreased blood pressure, decreased pulse, exacerbation of symptoms and disease process, and potential hospitalization. The findings include: Record review of Resident #1's face sheet dated 11/18/25 reflected an [AGE] year-old-female with an original admission date of 12/06/23. Resident #1 had diagnoses which included Type 2 diabetes (insufficient insulin production in the body), Dementia (the loss of cognitive functioning that interferes with daily life and activities), high blood pressure, coronary artery disease (narrowing or blockage of your coronary arteries) and acute kidney failure. Record review of Resident #1's care plan with an initial date of 01/15/24, and a revision on 07/18/25 reflected: Resident #1 has coronary artery disease r/t lifestyle choices and high blood pressure. Interventions included: Administer hypotension medications as ordered by MD. Monitor for side effects and effectiveness. Record review of Resident #1's physician orders dated 09/04/25 reflected: Midodrine Tablet 10 MG Give 1 tablet by mouth three times a day for Hypotension. Hold if SPB 130 or above. No doses should be given after evening meal or within 4 hours of bedtime. Record review of Resident #1's annual MDS dated [DATE] reflected a BIMS score of 5 which indicated (severe cognitive impairment). Record review of Resident #1's blood pressure log reflected Midodrine was given on the following dates and times: the blood pressures reflected Resident #1's reading prior to medication administration. Dinner was noted to be served beginning at 5:00pm. 11/02/25 at 9:09pm 11/05/25 at 8:43pm 11/06/25 at 8:40pm 11/07/25 at 8:50pm 11/08/25 at 9:21pm 11/12/25 at 8:29pm 11/13/25 at 8:57pm 11/14/25 at 8:33pm 11/17/25 at 8:31pm Attempted interview on 11/18/25 at 11:36am, Resident #1 was non-interviewable. In an interview on 11/18/25 at 12:14pm, MA A stated dinner was served around 5:00pm. MA A stated Resident #1's Midodrine could be given an hour before or after 5:00pm. MA A stated if the orders stated do not give after the evening meal, then it should not be administered after 6:00pm since the medication was scheduled for 5:00pm. MA A stated if the medication was not given as prescribed, Resident #1's blood pressure could drop or become too high. MA A stated sometimes when logging blood pressures, the system did not allow MA's to input the blood pressure reading and the nurse must be informed so the blood pressure could be documented. MA A stated it was important to document accurate times and blood pressure readings to see if there was a pattern and if medication needed to be adjusted. MA A stated she did not know why Resident #1's Midodrine medication was given outside of prescribed parameters. In an interview on 11/18/2025 at 12:54pm, the DON stated dinner was served between 5:00pm and 5:45pm. The DON stated the medication Midodrine was scheduled for 5:00pm and could be given an hour before or an hour after. The DON stated the medication should not have been given after 6:00pm per physician orders. The DON stated she did not know if staff were signing out the medication late or if it was being given at the time documented. The DON stated it was important to accurately document the times of medication administration so Resident #1's blood pressure could be tracked and trended and to see if medication needed to be held. The DON stated all MA's and nurses should be following the physician orders. The DON stated if the medication was not given as prescribed, Resident #1 could become hypotensive (low blood pressure) or hypertensive (high blood pressure). The DON stated audits were conducted daily and monthly, but the system did not alert them if the medication was given late. The DON stated staff were checked off on administering medication randomly and annually to make sure they knew the Rights of Administration. Record review of the facility's Medication Administration policy dated 10/24/22 reflected: Policy Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy of Explanation and Compliance Guidelines: 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. Record review of the facility's Documentation in Medical Record policy dated 10/24/22 reflected: Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of</p>		

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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>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** Based on interviews and record review, the facility failed to, in accordance with accepted professional standards and practices, maintain clinical medical records on each resident that were complete and accurately documented for one of three residents (Resident #1) reviewed for medical records. The facility failed to ensure Resident #1's vital signs were documented in the MAR from 10/01/25 to 10/24/25. This failure could place residents at risk for errors in care and treatment. The findings include: Record review of Resident #1's face sheet dated 11/18/25 reflected an [AGE] year-old-female with an original admission date of 12/06/23. Resident #1 had diagnoses which included Type 2 diabetes (insufficient insulin production in the body), Dementia (the loss of cognitive functioning that interferes with daily life and activities), high blood pressure, coronary artery disease (narrowing or blockage of your coronary arteries) and acute kidney failure. Record review of Resident #1's care plan with an initial date of 01/15/24 and a revision on 07/18/25 reflected: Resident #1 has coronary artery disease r/t lifestyle choices and high blood pressure. Interventions included: Administer hypotension (low blood pressure) medications as ordered by MD. Monitor for side effects and effectiveness. Record review of Resident #1's physician orders dated 09/04/25 reflected: Midodrine Tablet 10 MG Give 1 tablet by mouth three times a day for high blood pressure. Hold if SPB 130 or above. No doses should be given after evening meal or within 4 hours of bedtime. Record review of Resident #1's annual MDS, dated [DATE], reflected a BIMS score of 5 which indicated (severe cognitive impairment). Record review of Resident #1's MAR reflected vital signs were not documented from 10/01/25 to 10/24/25. In an interview on 11/18/25 at 12:14pm, MA A stated sometimes when logging blood pressures, the system did not allow MA's to input the blood pressure readings and the nurse must be informed so the blood pressure could be documented. MA A stated it was important to document accurate times and blood pressure readings to see if there was a pattern and if medication needed to be adjusted. In an interview on 11/18/2025 at 12:54pm the DON stated it was important to accurately document vitals were taken so Resident #1's blood pressure could be tracked and trended and to see if medication needed to be held. The DON stated all MA's and Nurses should be following physician orders and documenting vital signs when they were taken to ensure accuracy. The DON stated staff were checked off on administering medication randomly and annually to make sure they knew the Rights of Administration. Record review of facility's Documentation in Medical Record policy, dated 10/24/22, reflected: Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Policy Explanation and Compliance Guidelines: 3. Principles of documentation include, but are not limited to: a. Documentation shall be factual, objective, and resident centered. i. False information shall not be documented. b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. c. Documentation shall be timely and in chronological order. e. Record date and time of entry. 4. When documentation occurs after the fact, outside acceptable time limits, the entry shall be clearly indicated as late entry.</p>		