STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675785	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edinburg Nursing and Rehabilitation Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the residents' rights to be free from abuse, neglect, and exploitation for four residents (Resident #2, Resident #6, Resident #9, and Resident #10) out of 5 residents reviewed for abuse. 1. The facility failed to protect Resident #6 and Resident #2 from both verbally and physically harming each other on [DATE]. Resident #6 and Resident #2 had a verbal altercation which turned physical on [DATE] in which Resident #6 ended up with a small skin tear to her hand. 2. The facility failed to protect Resident #2 and Resident #6 from both verbally and physically harming each other on [DATE]. Resident #2 and Resident #6 had a verbal altercation which turned physical on [DATE] in which Resident #2 ended up with a small scratch to her left arm. 3. The facility failed to protect Resident #9 when Resident #10 hit her with an electric wheelchair on [DATE], causing her to move backward, and creating a skin tear to her left calf. These failures could place residents at risk for serious physical or psychological harm.The findings included: 1. Record review of Resident #6's face sheet, dated [DATE], revealed a [AGE] year-old-female with an admission date of [DATE]. Pertinent diagnoses included Cerebral Infarction (most common form of stroke) and Altered Mental Status (a change in cognitive function). Record review of Resident #6's Quarterly MDS Assessment, dated [DATE], revealed a BIMS score of 15, intact cognition. Record review of Resident #6's care plan, initiated [DATE], revealed Resident #6 had a potential to be physically aggressive as evidenced by striking another resident in the arm related to poor impulse control. Interventions included assessing for contributing sensory deficits, assessing Resident #6's needs, and lab work. This care plan was revised on [DATE] to include Resident #6 was involved in a physical altercation with another female resident. Record review of the provider investigation report, dated [DATE], in a narrative given by LVN-F, revealed Resident #2 and Resident #6 were involved in a physical altercation in which Resident #2 looked at Resident #6 ugly, so in response, Resident #6 made a noise to scare her away. Then, Resident #2 grabbed Resident #6 by the arms causing a small skin tear to Resident #6's hand. The Provider Investigation report revealed the Administrator confirmed the incident with both residents, however, both residents blame the other for instigating the altercation. Record review of Resident #6's progress note, dated [DATE], revealed Resident #6 was heard arguing with another resident. Upon visualization of Resident #6 and Resident #2, LVN-F saw both residents throwing their hands up in the air and on their arms. LVN-F got in the middle of the altercation and separated both residents. This incident occurred in the hallway outside of the dining room. Only a small nail imprint, 0.25 cm, on the right wrist visualized on Resident #6. A progress note dated [DATE] revealed Resident #6 was seen with her hands on another resident in a physically aggressive manner. Resident #6 stated the other resident started it. Record review or Resident #6's care plan note, dated [DATE], revealed it was discussed with Resident #6 the other resident had intellectual disabilities, and these altercations could be considered mental abuse. It was recommended for Resident #6 to try and avoid the other resident, and if Resident #6 felt she was being bothered by the other resident, to notify a staff member so they could intervene. 2. Record review of Resident #2's face sheet, dated [DATE], revealed a [AGE] year-old-female with an admission date of [DATE], and a discharge date of [DATE]. Relevant diagnoses included Senile Degeneration of the Brain (progressive deterioration of brain tissue and function), bipolar disorder (a mental health condition characterized by extreme mood swings, including emotional highs and lows), Genetic Related Intellectual Disability (a learning disability significantly influenced by genetic factors), and Severe Intellectual Disabilities (significant limitations in cognitive functioning and adaptive behavior). Record review of Resident #2's Quarterly MDS Assessment, dated [DATE], revealed a BIMS score of 09, moderately impaired cognition. Record review of Resident #2's care plan, initiated [DATE], revealed Resident #2 had a potential to be verbally aggressive (she yelled at other residents and staff). Interventions included: medication review was done by the hospice doctor; urinalysis was done; administer medications as ordered; assess Resident #2's understanding of the situation; allow time for Resident #2 to express self and feelings toward the situation. Another care plan, initiated [DATE], revealed Resident #2 had the potential to be physically aggressive. Interventions included: labs obtained, modify environment (to include adjust room temperature to comfortable level, reduce noise, dim lights, place familiar objects in room, keep door closed), started on antibiotic for urinary tract infection. This care plan was revised on [DATE] to include Resident #2 was involved in a resident-to-resident altercation with a skin tear to Resident #2's left forearm. Record review of the provider investigation report, dated [DATE], in a narrative

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident #5) of 5 residents reviewed for MDS assessment. Resident #5's MDS admission assessment dated [DATE] failed to indicate Resident #5 had a fall that resulted in major injury. This deficient practice could place residents at risk for inadequate care and services to meet their needs based on inaccurate MDS assessments. Findings included:Record review of Resident #5's admission assessment reflected an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included displaced intertrochanteric fracture of left femur (a break in the top of the thigh bone), history of falling, cognitive communication deficit (difficulty with communication), vascular dementia (problems with thought processes and memory caused by brain damage from impaired blood flow), hyperlipidemia (high cholesterol), atherosclerotic heart disease (buildup of fats and other substances in and on the artery walls of the heart causing decreased blood flow and/or clots), non-ST elevation myocardial infarction (a type of heart attack characterized by a partial artery blockage in the heart), hypertension (high blood pressure), and unspecified osteoarthritis (degenerative joint disease that results from breakdown of joint cartilage and underlying bone). Record review of Resident #5's previous hospital records dated 04/29/25 to 05/10/25 reflected an orthopedic consultation dated 05/02/25 which stated in part: History of Present Illness: [AGE] year-old female who was admitted after sustaining a ground level fall. Resident #5 was complaining of knee pain but did not require surgery during that hospital stay. Record review of the facility's provider investigation report dated 07/03/25 reflected Resident #5 had an unwitnessed fall in her room on 06/27/25 that resulted in a cut to the back of her head and complaints of left hip and leg pain. Resident #5 was transferred to the hospital and underwent surgery on 06/28/25 to repair her left hip fracture that was sustained as a result of the fall. Record review of Resident #5's admission MDS dated [DATE] and electronically signed by the MDS nurse on 07/17/25 reflected it was a reentry into the facility on [DATE] from a short-term general hospital and a BIMS score of 5 which indicated severe cognitive impairment. Section I-Active Diagnoses reflected Resident #5 had a hip fracture. Section J 1700- Fall History on Admission/Entry or Reentry reflected the MDS nurse answered, No, Resident #5 did not have a fall any time in the last month or in the last 2 to 6 months, and Resident #5 did not have any fracture related to a fall in the 6 months prior to admission/entry or reentry. Section J 2100- Recent Surgery Requiring Active SNF Care reflected Resident #5 had a major surgical procedure (repair of a fracture of the pelvis, hip, leg, knee, or ankle) during the prior inpatient hospital stay that required active care during the SNF stay. Section M 1040- Other Ulcers, Wounds, and Skin Problems reflected Resident #5 had a surgical wound that required surgical wound care. In an interview on 10/08/25 at 2:44pm, the MDS nurse stated she coded the fall with major injury on the resident's discharge MDS dated [DATE], so she did not answer yes to those questions on the reentry MDS. She stated the questions about the falls should have been answered yes instead of no. The MDS nurse stated Resident #5's falls were on the care plan even though they were not on the MDS but if falls were not triggered on the MDS for a new resident, it did not show up on the care plan as high risk. The MDS nurse stated it was the responsibility of the MDS nurses to ensure resident assessments were accurate. A policy for accuracy of MDS assessments was requested from the facility, however they did not have one and stated they referred to the RAI for whichever section is being answered. Record review of CMS's RAI Version 3.0 Manual, CH 3: MDS Items J effective 10/01/25 reflected in part: Steps for Assessment The period of review is 180 days (6 months) prior to admission, looking back from the resident's entry date (A1600). 1. Ask the resident and family or significant other about a history of falls in the month prior to admission and in the 6 months prior to admission. This would include any fall, no matter where it occurred. 2. Review inter-facility transfer information (if the resident is being admitted from another facility) for evidence of falls. 3. Review all relevant medical records received from facilities where the resident resided during the previous 6 months; also review any other medical records received for evidence of one or more falls. Coding Instructions for J1700A, Did the Resident Have a Fall Any Time in the Last Month Prior to Admission/Entry or Reentry? Code 0, no: if resident and family report no falls and transfer records and medical records do not document a fall in the month preceding the resident's entry date item (A1600). Code 1, yes: if resident or family report or transfer records or medical records document a fall in the month preceding the resident's entry date item (A1600). Coding Instructions for J1700B, Did the Resident Have a Fall Any Time in the Last 2-6 Months prior to

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs for 3 of 5 residents (Resident #6, Resident #2, and Resident #5) reviewed for care plans. The facility failed to develop care plans for Resident #6 and Resident #2 to include previous verbal altercations in the months leading up to when the physical altercations began between Resident #6 and Resident #2. The facility failed to include wound care for Resident #5's care plan for her surgical wound. These failures could place residents at risk of not receiving person-centered care and/or services to meet their physical and/or psychosocial needs. Findings included: 1. Record review of Resident #6's face sheet, dated 10/08/2025, revealed a [AGE] year-old-female with an admission date of 01/15/2023. Pertinent diagnoses included Cerebral Infarction (most common form of stroke) and Altered Mental Status (a change in cognitive function). Record review of Resident #6's Quarterly MDS Assessment, dated 04/17/2025, revealed a BIMS score of 15, intact cognition. Record review of Resident #6's care plan, initiated 06/02/2025, revealed Resident #6 had a potential to be physically aggressive as evidenced by striking another resident in the arm related to poor impulse control. Interventions included assessing for contributing sensory deficits, assessing Resident #6's needs, and lab work. This care plan was revised on 06/11/2025 to include Resident #6 was involved in a physical altercation with another female resident. There was no care plan which addressed Resident #6's verbal altercations with Resident #2 which began in April 2025 (according to interviews and incident and accident reports). Record review of Resident #6's progress note, dated 04/06/2025, revealed resident to resident verbal altercation. Both residents became increasingly verbally aggressive. Residents were separated and no physical altercation occurred. Record review of the provider investigation report, dated 06/02/2025, in a narrative given by LVN-F, revealed Resident #2 and Resident #6 were involved in a physical altercation in which Resident #2 looked at Resident #6 ugly, so in response, Resident #6 made a noise to scare her away. Then, Resident #2 grabbed Resident #6 by the arms causing a small skin tear to Resident #6's hand. The Provider Investigation report revealed the Administrator confirmed the incident with both residents, however, both residents blame the other for instigating the altercation. Record review of Resident #6's progress note, dated 04/06/2025, revealed resident to resident verbal altercation. Both residents became increasingly verbally aggressive. Residents were separated and no physical altercation occurred. Record review of Resident #6's progress note, dated 06/02/2025, revealed Resident #6 was heard arguing with another resident. Upon visualization of Resident #6 and Resident #2, LVN-F saw both residents throwing their hands up in the air and on their arms. LVN-F got in the middle of the altercation and separated both residents. This incident occurred in the hallway outside of the dining room. Only a small nail imprint, 0.25 cm, on the right wrist visualized on Resident #6. A progress note dated 06/11/2025 revealed Resident #6 was seen with her hands on another resident in a physically aggressive manner. Resident #6 stated the other resident started it. Record review or Resident #6's care plan note, dated 06/12/2025, revealed it was discussed with Resident #6 the other resident had intellectual disabilities, and these altercations could be considered mental abuse. It was recommended for Resident #6 to try and avoid the other resident, and if Resident #6 felt she was being bothered by the other resident, to notify a staff member so they could intervene. 2. Record review of Resident #2's face sheet, dated 10/07/2025, revealed a [AGE] year-old-female with an admission date of 02/09/2025, and a discharge date of 06/19/2025. Relevant diagnoses included Senile Degeneration of the Brain (progressive deterioration of brain tissue and function), bipolar disorder (a mental health condition characterized by extreme mood swings, including emotional highs and lows), Genetic Related Intellectual Disability (a learning disability significantly influenced by genetic factors), and Severe Intellectual Disabilities (significant limitations in cognitive functioning and adaptive behavior). Record review of Resident #2's Quarterly MDS Assessment, dated 05/17/2025, revealed a BIMS score of 09, moderately impaired cognition. Record review of Resident #2's care plan, initiated 05/19/2025, revealed Resident #2 had a potential to be verbally aggressive (she yelled at other residents and staff). Interventions included: medication review was done by the hospice doctor; urinalysis was done; administer medications as ordered; assess Resident #2's understanding of the situation; allow time for Resident #2 to express self and feelings toward the situation. Another care plan, initiated 06/02/2025, revealed Resident #2 had the potential to be physically aggressive. Interventions

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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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to maintain clinical records in accordance with accepted professional standards and practices complete and accurately documented medical records for 1 (Resident #7) of 10 residents whose records were reviewed. Clinical medical staff failed to ensure that Resident #7 suprapubic catheter output log was accurately documented as order by her physician. This failure could place residents of having incomplete and inaccurate records which could impact their treatment and health when receiving suprapubic catheter care. The findings include: Record review of Resident #7's face sheet revealed a [AGE] year-old-female initially admitted on [DATE] with diagnoses of Neuromuscular dysfunction of bladder (the nerves that carry messages back and forth between the bladder and the spinal cord and brain don't work the way they should.), chronic combined systolic and diastolic congestive heart failure (Systolic heart failure, heart isn't contracting well during heartbeats. While diastolic heart failure, by contrast, is when heart can't relax normally between beats), Type 2 diabetes mellitus without complications (body does not use insulin properly with, but it has not resulted in further health problems, such as nerve damage or stroke). Record review of Resident #7's MDS readmit date d 05/19/25 revealed BIMS score 11 indicated moderate cognitive impairment and requires prompt care plan modification. Functional abilities revealed Resident #7 needed substantial maximal assistance with activities of daily living. The MDS revealed Resident #7 has and suprapubic catheter and colostomy bag due to bowel and urine incontinence. Record review of Resident#7's care plan dated 04/04/25 revealed Resident #7 had a suprapubic Catheter related to Neuromuscular dysfunction of bladder. Interventions included administer medication Oxybutynin Chloride as ordered by MD. Monitor for effectiveness and side effects initiated 04/04/2025. Change catheter monthly 20 French catheter(a catheter sized using the French scale) 30ml foley initiated 04/04/25. Check the foley catheter and document urine output every shift. Use leg strap to secure foley in place initiated 05/07/2025. Check tubing for kinks each shift date initiated 04/04/2025. Record review of Resident #7's physician orders dated 04/26/25 indicated Check Foley catheter and document output every shift. The physician orders indicated suprapubic cath. Care every shift and as needed. The physician orders indicated monitor that collection bag is off the floor and hung below bladder level. The physician orders indicated Check suprapubic catheter every shift. Record Review of Resident #7's MAR for the month of May 2025 indicated no documentation of urine output for 4 days, May 1st through 4th, while Resident #7 stayed in the facility. In an interview and observation on 10/07/25 at 3:36 of Resident #7 she stated she has a huge hernia in her lower abdominal area which presses down on her bladder make it difficult to urinate, so she now has a suprapubic catheter to help her void her bladder. She stated that the catheter needed to be changed often but at times it can last for a couple of weeks. Resident #7 stated she still leaks at times from her urethra, so she had a pad to collect any leaked urine. Resident #7 stated her urine output was different everyday but usually voids frequently and a lot. The resident stated that when there was not a lot of output, she knows the catheter is blocked or migrated and needs to be changed. In an interview on 10/08/25 4:35PM with ADON B he stated all staff was responsible for documenting the output of urine if the bag is emptied by he or she. ADON B stated if the hospice nurse empties the urine bag the amount of urine was to be reported to a CNA or nurse. The ADON stated the amount of urine voided is to be documented both in the progress notes and MAR. ADON B could not explain why the amount were not documented on the days in question. In an interview 10/09/25 at 4:40 PM with the DON she stated no documentation could be found in either progress notes or MAR for the urine output for Resident#7. The DON could not explain why no documentation was not done for the 4 days in question. The DON stated not having accurate documentation of urine output could put the resident at risk for the bladder to rupture or urosepsis. The DON stated the facility did not have its own policy and procedure but followed the Lippincott Manual of Nursing Practice 11th Edition for procedure and treatment of residents with catheters and suprapubic catheters. In an interview on 10/0925 at 6:18pm CNA J stated she could not say why the amounts of urine voided was not documented. CNA J stated she could not remember that far back to explain why the amounts were not documented. CNA J stated she takes care of Resident #7 frequently and knows Resident #7 has large amounts of urine output about 700ml to 1000ml in her bag. CNA stated she knew to report to the nurse if Resident #7 amounts of urine during were smaller or different in color and clearness. Record of an In-Service dated 05/05/25 revealed an in-service was completed with the objective of: Suprapubic catheter change and personal protective equipment. The training