

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 01/01/2026
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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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<p>F 0609</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 that all alleged violations involving abuse, neglect or exploitation were reported no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the State Survey Agency where state law provides for jurisdiction in long-term care facilities in accordance with State law through established procedures for 1 of 2 residents (Resident #1), reviewed for freedom from abuse, neglect, and exploitation. The facility failed to report to the State Survey Agency (HHSC) an incident that occurred on 11/27/25 in which Resident #1 was returned to the facility by a police officer. Resident #1 had been driving around town in his own vehicle and did not know his way back to the facility. This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and physical harm. Record review of Resident #1's face sheet dated 12/29/2025, revealed a [AGE] year old male admitted into the facility on [DATE] with diagnosis of Alzheimer's disease (a progressive brain disorder and the most common cause of dementia, characterized by gradual memory loss, impaired thinking, and behavioral changes that worsen over time, eventually affecting daily activities), Type 2 diabetes (a chronic condition where the body either doesn't make enough insulin or doesn't use insulin effectively leading to high blood sugar levels), unspecified protein calorie malnutrition (a nutritional deficiency from not getting enough protein and calories), and hypertension (a common condition where the force of blood against your artery walls is consistently too high, making your heart work harder and increasing the risk of heart attack, stroke, and other serious problems). Record review of Resident #1's BIMS assessment dated [DATE] revealed a score of 8 which indicated moderately impaired cognition. Record review of progress note dated 11/27/2025 time stamped 7:45 p.m., revealed Resident #1 returned to the facility from being out on pass. Resident #1 arrived via wheelchair accompanied by an officer from a local police department. Per the police officer, Resident #1 was driving his truck around and got lost. Per Resident #1, he did not know his way back to facility. Resident #1's RP was made aware of the incident and was informed the resident's truck needed to be picked up from the location where Resident #1 was picked up from by the officer. Record review of Resident #1's care plan revised on 11/27/2025, revealed Resident #1 was unable to return to facility without assistance due to forgetfulness and intermittent cognition; removed keys and kept with nurse, administer medications as ordered, monitor behavior episodes and attempt to determine underlying cause, and provide a program of activities. During an interview on 12/29/2025 at 9:24 a.m., Resident #1 did not recall the incident of driving and being returned to the facility by a police officer. During an interview on 12/29/2025 at 11:44 a.m., Resident #1's RP stated she received a call on 11/27/2025 from a police officer. The police officer said he had Resident #1. Resident #1 had been driving his truck around and was lost. Resident #1 could not remember how to return to the facility. The RP stated she provided the police officer the phone number and address to the facility. The police officer said he was going to contact the facility to verify Resident #1 was a resident at the facility and take the resident back. During an interview on 12/30/2025 at 8:50 a.m. the DON stated she did not notify the Administrator that Resident #1 was brought back to the facility by a police officer. The DON stated the Administrator was out on vacation and did not want to bother her. The DON stated that since Resident #1 was returned safe and with no injuries, she felt there was no need to notify the Administrator. During an interview on 01/01/2026 at 3:00 p.m., the Administrator stated that on 11/17/2025, she was not notified Resident #1 had been returned to the facility for being lost. The Administrator stated it was not until days later that the DON mentioned the incident. The Administrator stated she felt she did not report the incident to HHSC for the same reasons the DON did not notify her; Resident #1 had returned to the facility safely. The Administrator said that on 12/06/2025, the HRC notified her that the resident had left the building in his own vehicle. The Administrator initiated a code purple, the code used to notify staff there was a resident missing. The Administrator said that at 6:45 p.m., she received a call from a nearby nursing facility reporting they had Resident #1. The nearby facility was approximately 0.6 miles away. The Administrator said she sent three staff members to bring Resident #1 back to the facility. One of the three staff members drove Resident's truck back to the facility. The Administrator stated that Resident #1 had arrived at that other facility because he was confused as to which facility he was a resident of. The Administrator stated that Resident #1's RP had his truck picked up after the incident. The administrator stated that it was best that Resident #1 did not have a vehicle on premises because Resident #1 could hurt himself or others while driving. Resident #1 could become confused and</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure adequate supervision and assistance devices to prevent accidents for 1 of 4 resident (Resident #1) reviewed for accidents and supervision who had a vehicle on the facility premises. The facility failed to evaluate R#1s safety awareness and risks for elopement after multiple incidents of R#1 leaving the facility without staff awareness or supervision. On 10/27/2025 R#1 left the facility and returned driving a vehicle he had purchased in another city. On 11/27/2025, R#1 left the facility and was returned by police due to driving around lost. On 12/06/2025, R#1 left the facility without being signed out on pass and was found at a nearby facility. The noncompliance was identified as PNC. The Immediate Jeopardy was identified on 12/06/2025 and ended on 12/06/2025. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of sustaining accidents, injuries, and/or death. Findings include: Record review of Resident #1's face sheet dated 12/29/2025, revealed a [AGE] year old male admitted into the facility on [DATE] with diagnosis of Alzheimer's disease (a progressive brain disorder and the most common cause of dementia, characterized by gradual memory loss, impaired thinking, and behavioral changes that worsen over time, eventually affecting daily activities), Type 2 diabetes (a chronic condition where the body either doesn't make enough insulin or doesn't use insulin effectively leading to high blood sugar levels), unspecified protein calorie malnutrition (a nutritional deficiency from not getting enough protein and calories), and hypertension (a common condition where the force of blood against your artery walls is consistently too high, making your heart work harder and increasing the risk of heart attack, stroke, and other serious problems). Record review of Resident #1's BIMS assessment dated [DATE] revealed a score of 8 which indicated moderately impaired cognition. Record review of Resident #1's baseline care plan dated 09/13/2024 revealed the resident had impaired cognitive function or impaired thought process related to Alzheimer's; included cue, reorient, and supervise as needed. The same care plan also revealed, The resident is (dependent on staff) for meeting emotional, intellectual, physical, and social needs related to cognitive deficits; The resident needs assistance with ADLs as required. Record review of Resident #1's Release of Responsibility for Leave of Absence log revealed, Resident #1's Relative V had signed Resident #1 out on 10/26/25 with anticipated date of return as PM. There was no sign-in date, time, or facility representative initials to confirm Resident #1 had returned. Record review of LVN A's progress note dated 10/27/2025 time stamped 9:00 a.m. revealed Received call from [family member] to resident stating resident was stranded in City W, SN informed him resident had signed out for out on pass and taken medication with him. SN informed to let us know if any changes with resident. City W is approximately 233 miles away from the facility. Record review of Resident #1's care plan initiated on 09/05/2024 did not reveal any new interventions regarding the 10/27/2025 incident. Record review of Resident #1's Release of Responsibility for Leave of Absence log revealed, Resident #1's Relative V had signed Resident #1 out on 11/27/2025 with anticipated date of return as PM. There was no Sign-in date, time, or facility representative initials to confirm Resident #1 had returned. Record review of LVN B's progress note dated 11/27/2025 time stamped 7:45 p.m., revealed Resident back at facility from out on pass, arrived via wheelchair accompanied by City X Police Department. Per Officer, resident was driving in his GMC truck around City X and got lost. Per resident, he did not know his way back to facility. RP made aware. Informed RP that resident's truck was left at City X. Resident's car keys and driver's license kept under lock and key in 300-Hall Nurse cart. DON and ADON made aware of situation. City X is approximately 5 miles from the facility. Record review of Resident #1's care plan revised on 11/27/2025, revealed Resident #1 was unable to return to facility without assistance due to forgetfulness and intermittent cognition; removed keys and kept with nurse, administer medications as ordered, monitor behavior episodes and attempt to determine underlining cause, and provide a program of activities. Record review of Resident #1's Release of Responsibility for Leave of Absence log revealed, Resident #1's Relative V had signed Resident #1 out on 12/06/2025. Resident #1 was signed back in by his brother on 12/06/2025 at 11:00 a.m. There were no facility representative initials on the form to confirm Resident #1 had returned. Record review of LVN C's progress noted dated 12/06/2025 time stamped 1:41 p.m. revealed: Facility receptionist saw patient leaving facility & HRC questioned if patient had signed out to go out on pass. I checked the sign out book and noted that the patient did not sign out. I then notified Administrator, DON and ADONs that patient was seen leaving the facility in a vehicle. I attempted to call patient on his cell phone multi times, but he did not answer. I also</p>		