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 03/13/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to conduct a comprehensive and accurate assessment of each resident using the resident assessment instrument (RAI) specified by CMS for 1 of 3 residents (Resident #1) whose records were reviewed for assessments. Resident #1's MDS erroneously indicated her ADLs of sit to stand or chair/bed-to-chair transfer were not attempted due to medical condition or safety concerns. This failure to ensure comprehensive and accurate assessments could affect residents by placing them at risk for not receiving correct care and services.Findings include:Record review of Resident #1's admission record, dated 03/11/26, reflected a [AGE] year-old female with an admit date of 04/19/24 with diagnoses that included cerebral infarction due to embolism (blood clot or debris forms elsewhere (often the heart or neck arteries), travel to the brain and locks blood flow), osteoarthritis-left shoulder (a chronic degenerative joint disease where cartilage breaks down, causing pain, swelling, and reduced motion), and flaccid hemiplegia (a severe neurological condition characterized by limp, weak, and paralyzed muscles on one side of the body) affecting left nondominant side. Record review of Resident #1's significant change MDS assessment, dated 02/26/26 reflected a BIMS score of 6, which indicated her cognition was severely impaired. Resident #1's level of assistance for her ADL for chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair (or wheelchair) had a code of 88 which indicated not attempted due to medical condition or safety concerns, for sit to lying and lying to sitting on side of bed she was coded a 2 which indicated she required substantial/maximal assistance (helper does more than half the effort. Helper lifts or hold truck or limbs and provides more than half the effort.Record review of Resident #1's quarterly care plan, dated 02/22/26 reflected a problem: Functional performance: chair/bed-to-chair transfer: [Resident #1] requires (x2 staff) to transfer to and from a bed to a chair (or wheelchair), date initiated 04/29/24 and revised on 08/29/25. Functional performance: lying to sitting on the side of bed: lying to sitting on side of bed: [Resident #1] requires (substantial/maximal assistance) to move from lying on the back to sitting on the side of the bed and with no back support x2, date initiated 12/31/24 and revised 08/29/25. Functional performance: sit to lying [Resident #1] requires (substantial/maximal assistance required) to come to a standing and side of bed to lying flat on the bed. X2 staff, date initiated 04/29/24 and revised on 08/29/25.In an interview and observation on 03/11/26 at 4:26 p.m., MDS nurse was observed as she reviewed Resident #1's electronic medical record/MDS change in condition assessment, dated 02/26/26 and said the code 88 entered for her ADL of sit to stand and chair/bed-to-chair transfer had been entered in error. She said the correct code for Resident #1 for her ADLs of sit to stand and chair/bed-to-chair transfer should have been 01 which indicated she was dependent (helper does all the effort). She said code 88 was for residents who were bedridden and Resident #1 was not. MDS nurse said there were no negative outcomes to Resident #1 not having her MDS assessment indicate she was dependent for her ADLs of sit to stand and chair/bed-to-chair transfer because her plan of care indicated she required a mechanical lift for transfers.In an interview and observation on 03/12/26 at 2:39 p.m., the DON said Resident #1 liked to sit in her wheelchair during the day. She said Resident #1 was not bedbound. The DON was observed as she reviewed Resident #1's electronic medical record/MDS (continued on next page)

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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 interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs, for 1 (Resident #5) of 6 residents reviewed for care plans.The facility failed to ensure Resident #5's care plan reflected his diet was no added salt, pureed texture, with nectar thickened liquids consistency.This failure could place the residents at risk of not receiving appropriate care to meet their needs.Findings included:Record review of Resident #5's face sheet, dated 03/11/26, reflected a [AGE] year-old male, admitted on [DATE] with diagnoses that included: cerebral infarction (stroke), chronic heart failure, type 2 diabetes (high levels of blood sugar levels), dementia (decline in cognitive function, affecting memory, thinking, and behavior), urinary tract infection, hypertension (high blood pressure), muscle wasting and atrophy (decreased muscle mass and strength), dysphagia (trouble swallowing), and other lack of coordination. Resident #5 was discharged to the hospital on [DATE]. Record review of Resident #5's MDS assessment, dated 02/09/25, reflected Resident #5 had a BIMS score of 1, indicating severe cognitive impairment. Resident #5 required a mechanically altered and therapeutic diet. Record review of Resident #5's care plan, dated 03/11/26, reflected [Resident #5] had potential nutritional problem related to diet restrictions. Date initiated: 01/11/26. Interventions included: No added salt, mechanical soft texture, regular liquids consistency diet. Date initiated: 01/11/26. Resident #5's care plan was not updated to Resident #5's current diet of no added salt, pureed texture, with nectar thickened liquids consistency. Record review of Resident #5's order summary report, dated 03/11/26 at 2:45 PM, reflected Resident #5 had an order for a diet of no added salt, pureed texture, with nectar thickened liquids consistency with start date: 02/03/26. In an interview with MDS Nurse B, on 03/13/2026 at 9:30 AM, she said the team reviewed orders and ensured everything was care planned accordingly including the resident's diet. MDS Nurse B said Resident #5's diet was changed from mechanical soft with regular liquids to pureed texture with nectar thickened liquids on 02/03/26, but the care plan was not updated with the current diet. MDS Nurse B said Resident #5 was not affected by not having the correct diet on his care plan as the kitchen and the staff followed the diet orders, not the care plan. MDS Nurse B said Resident #5 had no negative outcome, however, it was important for the current diet to be care planned so everyone was aware of how to care for Resident #5. In an interview with ADON A, on 03/13/26 at 10:00 AM, he said care plans, including diets, were updated by the ADONs. ADON A said if the resident's diet changed from mechanical soft with regular liquids to pureed with nectar liquids, that was care planned. ADON A said Resident #5 was assigned to ADON B so he was not very familiar with him. ADON A said the meal trays were prepared following the diet orders, not the care plan. ADON A said it was important to have the resident's current diet care planned so that everyone knew how to care for the resident. In an interview with ADON B, on 03/13/26 at 10:15 AM, he said Resident #5's diet was changed from mechanical soft with regular liquids to pureed with nectar thickened liquids on 02/03/26 because it was safer for him. ADON B said the team, including the ADONs, updated the care plans as needed and the diet should have been updated on the care plan. ADON B said he reviewed Resident #5's care plan and his diet did not reflect a pureed texture with nectar thickened liquids. ADON B said Resident #5 received his diet as ordered and had no negative outcome. ADON B said the care plan should have been updated because it reflected the resident's needs. In an interview with the DON, on 03/13/26 at 11:00 AM, she said Resident #5's diet was changed from mechanical soft with regular liquids to pureed with nectar thickened liquids on 02/03/26, following a speech evaluation. The DON said when the diet was changed, the care plan should have been updated. The DON said the care plan was updated by the ADONs, MDS nurses, or herself as it was a team effort. The DON said the kitchen (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	followed the orders, not the care plan, and Resident #5 received his correct diet, so there was no negative outcome for him. The DON said it was important for the care plan to be updated because the care plan communicated to the staff what the resident needed and how to care for him. In an interview with the ADM, on 03/13/26 at 11:50 AM, he said diets and changes were care planned by the team. The ADM said he was not aware of any negative outcome for Resident #5. The ADM said it was important for care plans to be updated to current information so the staff can follow the care specific to the resident. 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 timetables to meet the resident's medical, nursing, mental and psychosocial needs.6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.