| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675785 | A. Building<br>B. Wing | 05/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Edinburg Nursing and Rehabilitation Center | 5215 S Sugar Rd<br>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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have the interdisciplinary team review and revise the comprehensive care plan after the completion of the quarterly review assessments for 1 (Resident #1) of 5 residents reviewed for care plan revision.The facility failed to complete a quarterly care plan for Resident #1.This failure could place the residents at risk of care and needs not being met.Findings included:Record review of Resident #1's admission record, dated 5/13/2026, reflected a [AGE] year-old male admitted [DATE]. Resident #1's diagnoses included quadriplegia (a form of paralysis, resulting in the loss of movement and feeling to both arms and legs and torso), dysuria (pain when urinating), neuromuscular dysfunction of bladder (damage to the brain, spinal cord, or nerves disrupts the signals needed to store or empty urine properly), urinary catheterization (insertion of a hollow tube and into the bladder to drain urine), and hypertension (high blood pressure).Record review of Resident #1's MDS assessment, dated 3/17/2026, reflected a BIMS score of 15 which indicated cognitively intactRecord review of Resident #1's care plan, on 5/14/2026, reflected the last quarterly care plan was made on 8/26/2025.During an interview on 5/14/2026 at 4:51 p.m., the MDS Coordinator said the last care plan for Resident #1 was done on 8/26/2025. She said the care plans were updated every three months (quarterly). She said Resident #1's care plan was not updated because it was overlooked and there were no changes to his care plan. She said the last assessment (MDS) was done on 3/27/2026 and his care plan would have been due at the beginning of April 2026. She said the MDS coordinators were responsible for updating the care plans quarterly and the ADONs were responsible for any acute (sudden or short-term) changes to the care plans. She said Resident #1 was not negatively affected from not having an updated care plan because the assessments were being completed in a timely manner. She said the MDS coordinators received training from the facility's corporate office on MDS assessments and care planning. The MDS coordinator said the last training was done in April 2026.During an interview on 5/14/2026 at 5:17 p.m., the DON said the care plans were updated quarterly and as needed. She said the MDS coordinators were responsible for updating the quarterly care plans and the ADONs and DON were responsible for updating the acute care plans. She said she was not sure why the care plan was not updated and said it might have been overlooked. She said the Administrator and the DON were responsible for ensuring the care plans were updated in a timely manner. She said the facility's regional MDS coordinator was also responsible for ensuring the care plans were updated in a timely manner. She said the MDS coordinators attended quarterly in-services regarding care plans and MDS assessments. She said there was no negative effect for Resident #1 by not having an updated care plan.Record review of the facility's policy titled, Comprehensive Care Plans, dated 10/24/2022, reflected Policy Explanation and Compliance Guidelines: .2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment.5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 2 of 5 residents (Resident #1 and Resident #2) reviewed for medical records. 1. The facility failed to ensure LVN A documented accurate medication administration records for Resident #1 after medications and treatments were administered. 2. The facility failed to ensure LVN B documented accurate physician orders for Resident #2 after receiving telephone orders. This failure could place residents at risk for errors in care and treatment.Findings included: 1. Record review of Resident #1's admission record, dated 5/13/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. Resident #1's diagnoses included quadriplegia (a form of paralysis, resulting in the loss of movement and feeling to both arms and legs and torso), dysuria (pain when urinating), neuromuscular dysfunction of bladder (damage to the brain, spinal cord, or nerves disrupts the signals needed to store or empty urine properly), urinary catheterization (insertion of a hollow tube and into the bladder to drain urine), and hypertension (high blood pressure). Record review of Resident #1's annual MDS assessment, dated 3/17/2026, reflected a BIMS score of 15 which indicated cognitively intact. Record review of Resident #1's medication administration record, dated 5/13/2026, indicated no nurse's signature was entered for medications and treatments administered on 5/7/2026 at 7:00 p.m., 5/8/2026 at 9:00 a.m., and 5/8/26 at 7:00 p.m. During an interview on 5/12/2026 at 1:56 p.m., Resident #1 said a few nights ago the nurse administered his medications and treatments, but he felt the nurse took too long. He said he takes medications and treatments at 7:00 p.m. everyday. Resident #1 said he liked to have his medications and treatments at specific times because the CNAs repositioned him in bed afterwards. During an interview on 5/13/2026 at 3:03 p.m., LVN A said she had given medications and treatments to Resident # 1 on 5/7/26 and 5/8/26 during the second shift and 5/8/26, during the day shift, but did not sign off on the MAR. She said it was overlooked. LVN A said she ensured the MARs were signed off but Resident #1 resided in a different hall and it was missed. She said if the MAR was not signed off, there would be a possibility of overmedicating the resident. She said the last in-service on medication administration and documentation she had was less than six months ago. During an interview on 5/14/2026 at 11:08 a.m., the DON said she reviewed MARs every morning to ensure staff were signing appropriately. She said she was not sure if she missed checking on Friday (5/8/26) for Thursday (5/7/26) and Monday (5/11/26) for Friday (5/8/26). She said she provided reminders/training on documentation to the staff three to four weeks ago. The DON said a negative outcome of not signing the MAR was that the resident could have received a double dose of medication. She said she did not receive concerns from the resident about not received his medications and treatments. Record review of the facility's policy titled, Medication Administration, dated 10/24/22, reflected Policy Explanation and Compliance Guidelines: .17. Sign MAR after administered. Record review of the facility's policy titled, Documentation in Medical Record, dated 10/24/22, reflected Policy Explanation and Compliance Guidelines: .2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. 2. Record review of Resident #2's admission record, dated 5/14/2026, reflected a [AGE] year-old male admitted [DATE]. Resident #1's diagnoses included left side hemiplegia/hemiparesis (conditions involving weakness or paralysis on one side of the body caused by brain or spinal cord injury), benign prostatic hyperplasia (enlargement of the prostate gland), neuromuscular dysfunction of bladder (damage to the brain, spinal cord, or nerves disrupts the signals needed to store or empty urine properly), diabetes mellitus (chronic condition where blood sugar levels are too high because the body either does not produce enough insulin or cannot effectively use the insulin it makes), and hypertension (high blood pressure). Record review of<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #2's quarterly MDS assessment, dated 4/15/2026, reflected a BIMS score of 07 which indicated severe cognitive impairment. Record review of Resident #2's nursing progress notes, dated 5/11/2026, indicated a telephone order, obtained by LVN B, for antibiotics and to place the resident on contact precaution due to ESBL (urinary tract infection caused by bacteria that are resistant to common antibiotics) in the urine. Record review of Resident #2's physician order summary, dated 5/12/2026, did not include an order for contact precautions. In an observation on 5/12/2026 at 2:29 p.m., a contact precautions sign was posted on Resident #2's door which included PPE supplies. During an interview on 5/14/2026 at 10:58 a.m., the DON said the nurse received the order for isolation precautions due to positive ESBL in the urine of Resident #2. She said it was the nurse's responsibility to enter the order into the EMR. She said there was a change of condition noted by the nurse which was then reviewed by the infection preventionist. She said she and the ADON were responsible for ensuring all orders were placed in the EMR. She said a negative outcome from not having the order in the EMR was that there could be miscommunication between the nurses. She said PPE and a sign was on the door indicating contact precautions for Resident #2. During an interview on 5/14/2026 at 11:26 a.m., LVN B said she received an order from the physician to start antibiotics and to place the resident under contact precautions due to ESBL in the urine. She said she documented a change of condition and completed an infection control form. She said the telephone order she received was supposed to be added to the order summary section in the EMR. She said she missed adding the order in the order summary section of the EMR because she had other paperwork she had filled out. LVN B said that upon receiving the telephone order by the physician, Resident #2 and his RP were notified of moving to a different room and of the orders received regarding the infection. She said the PPE and contact precautions sign were added to the resident's door. LVN B said not having an order included in the EMR for contact precautions did not affect Resident #2 because there was a sign posted on his door indicating he was under contact precautions. She said she had received a reminder/training on documentation one week ago. Record review of the facility's policy titled, Documentation in Medical Record, dated 10/24/22, reflected Policy Explanation and Compliance Guidelines: .2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. |