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	04/02/2025

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301 Based on interview and record review the facility failed to conduct an assessment of each resident's functional capacity for 1 (Resident # 1) of 8 residents reviewed for resident assessments. The facility failed to complete the MDS discharge assessment for Resident #1. This failure could place residents at risk of receiving care and services to meet their needs. The findings include: Record review of Resident #1's face sheet dated 04/02/25 reflected Resident #1 was a [AGE] year-old female admitted on [DATE]. Resident #1 had diagnoses of hypertension (high blood pressure), dementia (cognitive disorders characterized by progressive decline in memory, thinking, reasoning, and other mental abilities that interfere with daily life and activities), aphasia (neurological disorder that impairs the ability to comprehend or formulate language), epilepsy (neurological disorder characterized by recurrent, unprovoked seizures), myocardial infarction (commonly known as a heart attack where blood flow to the heart muscle was significantly reduces or blocked), and contracture (muscles, tendons, or ligaments become permanently shortened and tight, limiting range of motion in a joint or body part) of muscle. Record review of Resident #1's most recent MDS assessment dates on PCC revealed: No Discharge MDS was completed. Last MDS completed was Resident #1's annual MDS on 09/10/2024. Record review of Resident #1's most recent annual MDS dated [DATE] revealed: BIMS Summary Score was a 02, which indicated Resident #1's cognition was severely impaired. Record review of Resident #1's progress notes dated 10/24/2024 at 5:44 p.m. reflected, Resident will be leaving to ., report has been given to nurse ., medications and belonging have been transported with resident RP. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/25 at 11:20 am, MDS A said, anytime a resident was discharged there must be a DC MDS. She said a negative effect could be the resident still shows as active, but Resident #1 was already in another facility. She said she does not think it will affect the other facility because they provide clinical information during report, and the receiving facility can request any information they need. She was asked if this would affect billing for this facility and she said it would not. She said she oversees the short-term care residents and Resident #1 was in Long-Term care. She said MDS B oversaw LTC residents. During an interview on 4/2/25 at 11:30 am, MDS B said the DC MDS was not done. She said a DC MDS should have been done. She said not completing a DC MDS does not have a negative effect, because they send over resident records and the nurses give report. She said the receiving facility can request records. She said it does not affect billing because once Resident #1 was admitted to another facility, she automatically got dropped from the facility's billing and gets picked up by the receiving facility's billing. She said Resident #1 automatically got cancelled from the ADT at this facility on the exact discharge date . She said she does not believe the receiving facility requests the MDS. She said they must complete an entry and DC MDS on all residents. She said it was more as a record. She said she was sure there was a reason for it being required, she just could not recall why. During an interview on 4/2/25 at 1:30 pm, ADON C said he was not familiar with MDS, but he felt the facility provides the receiving facility all the information they need regarding a resident's current health and care required. He said if a DC MDS were not completed, he does not feel it would affect the resident's care. He said upon DC the floor nurse gets medications ready and goes over with family. They provide final assessment of resident prior to DC. He said they provided receiving facility resident's status, vitals, medication, any abnormalities, follow up appointments, and last BM. He said they also provided receiving facility information on any recent falls, any current therapies, and all the care the resident was receiving. During an interview on 4/2/25 at 2:00 pm DON said if MDS did not complete a DC MDS, that would not have any effect on the care a resident received from the receiving facility. She said she could not think of any negative effect in care a resident would have by not completing a DC MDS. During an interview on 4/2/25 at 2:37 pm Administrator said she knows some about MDS but not in depth. She said they should complete a DC MDS on all residents that have been discharged . She said she does not know exactly why a DC MDS was needed. She said she did not think it had a negative effect for the care Resident #1 received at the receiving facility, because she would have already been informed of it since it was a sister facility. Record review of CMS's RAI Version 3.0 Manual dated October 2025 reflected, CH2: Assessments for the RAI: RAI OBRA-required Assessment Summary (cont.) . Discharge Assessment - return not anticipated (Non-Comprehensive) . MDS Completion Date .No Later Than discharge date + 14 calendar days.

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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** 47828 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial need that were identified in the comprehensive assessment for 1 of 7 residents (Resident #87) reviewed for comprehensive person-centered care plans. The facility failed to develop a comprehensive person-centered care plan for Resident #87 to address identifiable triggers to his active diagnosis of Post Traumatic Stress Disorder (a disorder in which a person had difficulty after experienceing or witnessing a terrifying event). This failure could place residents at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs. The Findings include: Record review of Resident #87 ' s admission record, dated 04/02/25 reflected a [AGE] year-old male admitted to facility on 03/07/25 with an original admitted [DATE]. His relevant diagnoses included post-traumatic stress disorder, age-related physical debility (a state of physical or mental weakness associated with advanced age), and depression (mental health condition characterized by persistent feelings of sadness, or loss of interest in activities once enjoyed). Record review of Resident #87 ' s quarterly MDS assessment dated [DATE] reflected his BIMS score was 5, indicating his cognition was severely impaired. Further review reflected Resident #87 had an active diagnosis of post-traumatic stress disorder. Record review of Resident #87 ' s quarterly care plan dated 03/30/25 reflected no problem, goal or interventions for his diagnosis of post-traumatic stress disorder. Record review of Resident #87 ' s medical diagnosis reflected a diagnosis of post-traumatic stress disorder effective 03/07/25. In an observation on 03/30/25 at 2:20 p.m., Resident #87 was observed lying in bed awake with no signs of distress. He was not interviewable. In an interview on 04/01/25 at 2:56 p.m., MDS A said when Resident #87 was initially admitted he had a diagnosis of post-traumatic stress disorder from the VA. She said since his admission, Resident #87 had not displayed any symptoms/triggers of post-traumatic stress disorder. MDS A said Resident #87 ' s diagnosis of post-traumatic stress disorder was not considered active because he was not being treated for it. She said if a resident had a diagnosis and was not being treated it did not have to be care planned. She said if Resident #87 had received counseling or medication for post-traumatic stress disorder, she would have care planned it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/01/25 at 3:06 p.m., the SW said when a new resident was admitted to the facility, she would conduct an initial social history that covered questions pertaining to post-traumatic stress disorder among other mental conditions. She said when Resident #87 was originally admitted on [DATE], she did not identify any triggers during his initial social history assessment. She said at that time; Resident #87 was still verbal and was able to hold a conversation. She said she asked him if he had any triggers related to post-traumatic stress disorder and he answered no. The SW said she had also spoken with family member and she had requested counseling, but Resident #87 refused. She family member had not mentioned any triggers. She said at that time all she could do was to monitor any behaviors of fears which he had not demonstrated so far. The SW said Resident #87 had recently had a mental and physical decline. She said she had not been informed by any staff of any behaviors that would have prompted her identity as triggers. She said at present time the family was considering placing Resident #87 in hospice due to his rapid health decline. In an interview on 04/02/25 at 8:18 a.m, LVN F, said Resident #87 was calm with no behaviors of post-traumatic stress disorder. She said Resident #87 was bed bound. She said she had not witnessed Resident #87 being easily startled, yelling or any behaviors that was indicative of post-traumatic stress disorder. She said if she were to have witnessed any behavior, she would report it to her ADON. Record review of Resident #87's electronic medical record (progress notes and change in condition) did not show evidence of any signs/triggers of post-traumatic stress disorder since admission. In an interview on 04/02/25 at 9:15 a.m., the DON said Resident #87 had a diagnosis of post-traumatic stress disorder. She said since his admission, Resident #87 had not displayed any signs of post-traumatic stress disorder and was not being treated for it. She said she would have to ask MDS to see if his diagnosis of post-traumatic stress disorder had to be care planned. Record review of the facility ' s Comprehensive Care Plans policy Implementedd on 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 timeframes to meet a resident ' s medical, nursing, and mental and psychosocial needs that are identified in the resident ' s comprehensive assessment. 3. The comprehensive care plan will describe, at a minimum, the following: g. individualized interventions for trauma survivors, that recognizes the interrelation between trauma and symptoms, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident ' s exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory was provided such care, consistent with professional standards of practice for 1 of 7 residents (Resident #47) reviewed for respiratory care. 1. The facility failed to ensure Resident #47's oxygen was administered at 3 lpm instead of 5 lpm as ordered. 2. The facility failed to ensure Resident #47 ' s oxygenator humidifier was not empty. These failures could place residents at risk of developing respiratory complications, having a decreased quality of care and expose residents to hazards such as explosions which could lead to physical harm. The findings included: Record review of Resident #47 ' s admission record, dated 03/30/25 reflected a [AGE] year-old female who was admitted to facility on 02/24/25 with an original admitted [DATE]. Her relevant diagnoses included chronic respiratory failure with hypoxia (improper gas exchange), dependence on supplemental oxygen (requiring a continuous or long-term supply of extra oxygen to maintain adequate blood oxygen levels) and acute respiratory distress (a chronic condition in which fluid collects in the lungs ' air sacs, depriving organs of oxygen). Record review of Resident #47 ' s quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 14, which indicated her cognition was intact. Further review reflected an active diagnosis of being dependent on supplemental oxygen. Record review of Resident #47 ' s quarterly care plan reflected she had a problem of COPD (date initiated 01/08/24) and her interventions in part were to have her oxygen settings at 3 lpm via nasal prongs (date initiated 01/08/24). Record review of Resident #47 ' s order summary reflected an order for oxygen at 3 lmp via nasal cannula effective 02/24/25 with no end date. In an observation on 03/30/25 at 11:35 a.m., Resident #47 was lying awake in bed with nasal cannula on. Her oxygenator was set at 5 lpm and the humidifier was empty. She did not display any signs or symptoms of respiratory distress. In an interview on 03/30/25 at 11:38 a.m., Resident #47 said she was on continuous oxygen therapy because she suffered from COPD. She said she was feeling good and was not having any respiratory problems. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 03/30/25 at 11:45 a.m., LVN E was observed as she checked Resident #47 ' s oxygen setting and said the oxygenator was set at 5 lpm and the humidifier was empty. She was later observed as she checked Resident #47 ' s medical electronic record and said she had an oxygen order for 3 lpm. LVN E said her shift started at 6 am on 03/30/25 and she had already gone into Resident #47 ' s room twice, the first time to give her a nebulizer treatment and the other for medication administration. She said she failed to check her oxygen setting and humidifier. LVN E said the negative outcome for Resident #47 ' s humidifier being empty would be nasal dryness and her oxygen setting not being set as ordered could cause her to receive more oxygen to her brain. In an interview on 03/31/25 at 1:28 p.m., the DON said if a resident was on oxygen therapy, it was the nursing staff's responsibility to ensure their oxygen was set as ordered and the humidifier was not empty. She said nursing staff were continuously in-serviced on oxygen administration. The DON said the negative outcome to Resident #47 having the humidifier empty would be nasal dryness. She said there were no negative outcome to Resident #47 not having her oxygen setting as ordered because it was not higher than 10 lpm. The DON said the facility did not have a policy regarding oxygen administration.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for sanitation in that: The facility failed to ensure the juice nozzle was clean. The facility failed to ensure food in the refrigerator was not expired. These failures could place residents at risk of foodborne illnesses. The findings included: During the initial observation of the kitchen on [DATE] at 10:30 a.m., revealed the juicer ' s nozzle dispenser had red and yellow slimy substance in the middle and a white slimy substance on the outer part. The vegetable refrigerator contained an uncovered clear plastic box with a label dated ,d+[DATE] that had 12 cucumbers that had brown, white, and black spots on them. Some of the cucumbers had soft spots that made it difficult to pick up. In an interview on [DATE] at 10:35 a.m., the DM said his staff had a hard time removing the juicer nozzle but ensured it was cleaned daily. He said he did not know what the slimy substances were. He said he kept a weekly cleaning schedule which included the juice machine. He said he would check the logs daily to ensure the cleaning had been done. The DM said he had not noticed the cucumbers in the vegetable refrigerator had brown, white, and black spots or being soft to the touch. He said he would discard the cucumbers immediately. He said the clear plastic box did not have a lid. The DM was not able to say what negative outcome to the residents for having the juicer ' s nozzle with slimy substances and cucumbers that were soft to the touch with colored spots. The DM said the facility did not have a policy addressinng cleaning kitchen appliances. Record review of the kitchen ' s weekly cleaning schedule from [DATE] to [DATE] reflected the juice machine and refrigerators had been cleaned. Record review of the Food Storage policy from the Nutrition & Foodservice Policies & Procedures Manual dated 2018 reflected: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal, and US Food Codes and HACCP guidelines. 2.Refrigerators: d. date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage.