

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 05/19/2026
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 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. Based on observations, interviews, and record reviews, 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 storage, preparation, and sanitation. The facility failed to ensure coffee cups and bowls were clean. The facility failed to ensure clean racks/trays of coffee cups and bowls had drying mats. The facility failed to ensure the dishwasher was in good working order. The facility failed to ensure the vent above the dishwasher was clean and without corrosion and rust. The facility failed to ensure the freezers did not have worn seals and ice accumulation inside of them. The facility failed to ensure the refrigerators did not have worn seals, bulging seals, and condensation inside of them. The facility failed to ensure the steam table wells were clean and free of rust. These failures could place residents who received meals and/or snacks from the kitchen at risk for food contamination and food-borne illness. Findings included: Observation and initial tour of the kitchen on 05/17/26 beginning at 10:45 am revealed 18 of 20 plastic coffee cups on a clean rack had white residue and/or brown stains and scratches inside them. The clean racks did not have any kind of drying mats. The dirty and clean cups were rim-side down together on the clean racks (trays), sitting in water. The low temp dishwasher machine required 4 run times to reach a minimum temperature of 120F. The vent above the dishwasher was rusted and crusted with a thick dark brown/black substance. A chest type milk refrigerator had bulging, separating seams inside of it, on the lid and a black substance around the seals on the lid. A chest type freezer had a black substance around the seals on the lid. Two standing freezers had ice build-up on the inside doors near the seal. One of them had condensation dripping on the inside. The 5 of 5 steam wells in the steamer table had thin whitish yellow scaling around the insides and a dark brown ring at the water line inside all five wells. In an interview with the DM during the initial tour of the kitchen on 05/17/26 beginning at 10:45 am, he said all of the equipment in the kitchen was in good working order. The DM said the facility needed a new dishwasher machine. He said the washer worked, but it had to be run several times to reach a minimal temperature of 120F. He said the DW was responsible for checking the dishes for cleanliness before placing them on a clean rack. He said there were no drying mats on the clean rack trays and cross contamination could occur with the clean and dirty cups draining into the same water on the trays. The DM said he had a work order for the vent to be replaced. The DM said the facility needed new freezers, such as a walk-in. He said the seals were bad on the freezers and refrigerators. He said the steam table wells were cleaned daily and every 2 months. Observations during a return visit to the kitchen on 05/19/2026 at 8:00 am revealed 6 of 10 plastic desert bowls on a clean rack had a creamy yellow substance on the insides, in addition to the same observations made on 05/17/26 beginning at 10:45 am. In an interview with the DM on 05/19/2026 at 8:05 am, he said he did not know what was going on with the dirty dishes on the clean racks. He said the DW was responsible for making sure (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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dishes were clean before being put on a clean tray. In an interview with the [NAME] on 05/19/2026 at 8:10 am, she said the steam table wells were supposed to be cleaned every night, and every 2 months with the chemicals to descale them. She said they had been rusted for years. In an interview with the RD on 05/19/2026 at 10:00 am, she said there had been no outbreaks of foodborne illnesses at the facility. She said she visited the facility at least monthly to check cleanliness, temperatures, and the quality of the food. She said when she was not at the facility, she checked trends and messages on her computer. She said she made rounds in the kitchen and spoke to residents regarding the quality of the food and checked on anyone with weight gain or loss. She said she collaborated with the DM if there were any food preferences that needed updates. In an interview with the ADM on 05/19/2026 at 12:40 pm, he said he was aware of the vent above the dishwasher and that he was in the process of getting it replaced. He said the invoice the DM had was only a quote. He said he was unaware of the seals on the freezers and refrigerators in the kitchen. He said he was unaware the dishes needed a drying mat on the clean rack trays. He said it made sense for the dishes not to be sitting in water upside down to dry. In an interview with the DW on 05/19/2026 at 1:45 pm, she said the dishwasher person was responsible for making sure the dishes were clean. She said she wiped them out before she put them through the washer and looked at them again after the trays came out of the washer. She said if she saw any dishes that were still dirty, she would put them back through the washer. She said there were no drying mats on the clean rack trays. She said she did not know what a dry mat was. Record review of the daily and weekly cleaning schedules for the last three months revealed all cleaning had been marked done. Record review of work order # 700105 for Replacement for range cabinet under dish room. Remove and replace with new. The amount shown was \$3500.00 for materials and labor. Record review of the facility policy dated 10/01/18 titled, General Kitchen Sanitation under policy; The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All Nutrition & Foodservice employees will maintain clean, sanitary kitchen facilities in accordance with the state and US Food Codes in order to minimize the risk of infection and foodborne illness. 1. After each use, clean and sanitize all tableware, kitchenware and food-contact surfaces of equipment 3. Keep food-contact surfaces of all cooking equipment free of encrusted grease deposits and other accumulated soil. 4. Clean and sanitize all multi-use utensils and food-contact surfaces of equipment used in the preparation or storage of potentially hazardous food prior to each use. Clean and sanitize food-contact surfaces of equipment and multi-use utensils used for preparation of potentially hazardous foods on a continuous or production line basis at scheduled intervals throughout the preparation period based on food temperature, type of food and amount of food particle accumulation. 5. After cleaning and until use, store and handle all food-contact surfaces of equipment and multi-use utensils in a manner that protects the surfaces from manual contact ' splash, dust, dirt, insects and other contaminants. Record review of the facility policy dated 10/01/18 titled, Mechanical Cleaning and Sanitizing of Utensils and Portable Equipment under policy; The facility will follow the cleaning and sanitizing requirements of the state and US Food Codes for mechanical cleaning in order to ensure that all utensils and equipment are thoroughly cleaned and sanitized to minimize the risk of food hazards. 3. Rinse or scrape equipment and utensils and, when necessary, soak to remove gross food particles and soil prior to being washed. 4. Place equipment and utensils on racks, trays, or baskets, or on conveyors, so that all food-contact surfaces are exposed to the detergent wash and clean rinse water and the equipment and utensils can freely drain. References: FDA Food Code 2022 Ch. 3-305 Preventing contamination from the premises Ch. 4-1-101.11 Characteristics. Materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be: (A) Safe; (B) Durable, corrosion- resistant, and nonabsorbent; (C) Sufficient in weight and thickness to withstand repeated warewashings; (D) finished to have a smooth, easily cleanable surface; and ? Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. Ch. 4-202 Cleanability 4-202.11 Food-Contact Surfaces. (A)Multiuse FOOD-CONTACT SURFACES shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections; (3) Free of sharp internal angles, corners, and crevices; (4) Finished to have smooth welds and joints 4-5 Maintenance and Operation 4-501 Equipment 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. 4-602 Frequency 4-602.11 Equipment Food-Contact Surfaces and Utensils. (A) Equipment food-contact surfaces and utensils shall be cleaned: (5) At any time during the operation when contamination may have occurred. EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned throughout the day at least every 4 hours. All refrigerator units are kept clean and in good working condition at all times.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain clinical records that were accurately documented for four of six residents (Resident #42, Resident #99, Resident #100, and Resident #97) reviewed for medical records. 1. The facility failed to ensure Resident #42's blood pressures were not duplicated for the month of May of 2026 by RN A and LVN B. 2. The facility failed to ensure Resident #99's blood pressures were not duplicated for the month of May of 2026 by RN A and LVN B. 3. The facility failed to ensure Resident #100's blood pressures were not duplicated for the month of May of 2026 by RN A and LVN B. 4. The facility failed to document Resident #97's physician order for a one-time dose of haloperidol injected on 04/02/2026. These failures could place residents at risk for errors in care and treatment. The findings include: Record review of Resident #42's face sheet dated 5/18/26 reflected a [AGE] year-old-female with an admission date of 04/06/26. Diagnoses included high blood pressure and stroke. Record review of Resident #42's care plan created on 04/22/26 reflected: Resident #42 had hypertension, due to lifestyle choices and stroke. Interventions included: Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (sudden drop in blood pressure when standing up often causing dizziness, lightheadedness and or fainting) and increased heart rate and effectiveness. Medications: -Losartan (blood pressure altering medication) -Metoprolol (blood pressure altering medication) The resident will remain free of complications related to hypertension through review date. Record review of Resident #42's May 2026 blood pressure log reflected: 5/17/2026 22:36 (10:36pm) 122 / 68 mmHg (RN A) 5/17/2026 15:38 (3:38pm) 122 / 68 mmHg 5/17/2026 15:26 (3:26pm) 118 / 62 mmHg (LVN B) 5/17/2026 08:44 (8:44am) 118 / 62 mmHg 5/16/2026 20:07 (8:07pm) 128 / 64 mmHg (RN A) 5/16/2026 16:40 (4:40pm) 128 / 64 mmHg 5/16/2026 15:12 (3:12pm) 120 / 62 mmHg (LVN B) 5/16/2026 07:39 (7:39am) 120 / 62 mmHg 5/15/2026 22:45 (10:45pm) 130 / 80 mmHg (RN A) 5/15/2026 19:05 (7:05pm) 130 / 80 mmHg 5/15/2026 13:57 (1:57pm) 120 / 70 mmHg (LVN B) 5/15/2026 07:09 (7:09am) 120 / 70 mmHg 5/14/2026 19:31 (7:31pm) 120 / 60 mmHg (RN A) 5/14/2026 18:02 (6:02pm) 120 / 60 mmHg 5/14/2026 14:36 (2:36pm) 110 / 62 mmHg (LVN B) 5/14/2026 08:10 (8:10am) 110 / 62 mmHg 5/11/2026 11:07 (11:07am) 120 / 68 mmHg (LVN B) 5/11/2026 07:12 (7:12am) 120 / 68 mmHg 5/10/2026 11:20 (11:20am) 124 / 68 mmHg (LVN B) 5/10/2026 07:43 (7:43am) 124 / 68 mmHg 5/9/2026 14:18 (2:18pm) 128 / 73 mmHg (LVN B) 5/9/2026 07:18 (7:18am) 128 / 73 mmHg 5/8/2026 14:16 (2:16pm) 112 / 64 mmHg (LVN B) 5/8/2026 08:28 (8:28am) 112 / 64 mmHg 5/4/2026 13:03 (1:03pm) 122 / 64 mmHg (LVN B) 5/4/2026 07:33 (7:33am) 122 / 64 mmHg 5/3/2026 13:42 (1:42pm) 118 / 64 mmHg (LVN B) 5/3/2026 07:13 (7:13am) 118 / 64 mmHg 5/2/2026 13:21 (1:21pm) 112 / 62 mmHg (LVN B) 5/2/2026 08:10 (8:10am) 112 / 62 mmHg 2. Record review of Resident #99's face sheet dated 05/18/26 reflected a [AGE] year-old-female with an original admission date of 05/12/26. Diagnoses included high blood pressure, heart disease, and old myocardial infarction (heart attack). Record review of Resident #99's care plan initiated on 05/17/26 reflected: Resident #99 had coronary artery disease (narrowing or blockage of the coronary arteries due to plaque buildup) r/t Atherosclerosis (buildup of plaque in the arteries), hypercholesterolemia (elevated levels of cholesterol), high blood pressure, due to lifestyle choices and myocardial infarction. Interventions included: Avoid taking the blood pressure reading after physical activity or emotion distress. Give anti-hypertensive (high blood pressure) medications as ordered. Monitor for side effects such as orthostatic hypotension and (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	increased heart rate and effectiveness. Medications: - Losartan -Hydralazine (blood pressure altering medication) -Clonidine (blood pressure altering medication) Record review of Resident #99's May 2026 blood pressure log reflected: 5/17/2026 22:34 (10:34pm) 187 / 100 mmHg (RN A) 5/17/2026 15:26 (3:26pm) 187 / 100 mmHg (RN A) 5/17/2026 11:53 (11:53am) 187 / 100 mmHg (LVN B)5/17/2026 08:34 (8:34am) 187 / 100 mmHg (LVN B)5/16/2026 20:01 (8:01pm) 164 / 73 mmHg (RN A) 5/16/2026 16:02 (4:02pm) 164 / 73 mmHg (RN A) 5/16/2026 09:41 (9:41am) 180 / 94 mmHg (LVN B)5/16/2026 08:12 (8:41am) 180 / 94 mmHg (LVN B)5/15/2026 22:33 (10:33pm) 188 / 100 mmHg (RN A) 5/15/2026 16:13 (4:13pm) 188 / 100 mmHg (RN A) 5/15/2026 13:42 (1:42pm) 188 / 100 mmHg (LVN B)5/15/2026 08:13 (8:13am) 188 / 100 mmHg (LVN B)5/14/2026 19:28 (7:28pm) 189 / 100 mmHg (RN A) 5/14/2026 18:40 (6:40pm) 189 / 100 mmHg (RN A) 5/14/2026 14:29 (2:29pm) 189 / 100 mmHg (LVN B) 3. Record review of Resident #100's face sheet dated 05/18/26 reflected a [AGE] year-old-femalewith an original admission date of 05/11/26. Diagnosis included high blood pressure. Record review of Resident #100's care plan initiated on 05/17/26 reflected: Resident #100 had high blood pressure r/t heart problems. Interventions included: Avoid taking the blood pressure reading after physical activity or emotion distress. Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate and effectiveness. Medications: -Lisinopril -Metoprolol. Monitor/document/report PRN any signs and symptoms of malignant hypertension: Headache, visual problems, confusion, disorientation, lethargy (significant decrease in energy, mental capacity and alertness), nausea and vomiting, irritability, seizure activity, difficulty breathing. Record review of Resident #100's May 2026 blood pressure log reflected: 5/17/2026 22:37 (10:37pm) 122 / 66 mmHg (RN A) 5/17/2026 20:49 (8:49pm) 122 / 66 mmHg 5/17/2026 15:24 (3:24pm) 128 / 68 mmHg (LVN B)5/17/2026 13:26 (1:26pm) 128 / 68 mmHg 5/16/2026 15:04 (3:04pm) 120 / 70 mmHg (LVN B)5/16/2026 08:28 (8:28am) 120 / 70 mmHg 5/15/2026 22:46 (10:46pm) 110 / 66 mmHg (RN A) 5/15/2026 20:46 (8:46pm) 110 / 66 mmHg 5/15/2026 14:06 (2:06pm) 108 / 68 mmHg (LVN B)5/15/2026 08:40 (8:40am) 108 / 68 mmHg 5/14/2026 19:06 (7:06pm) 118 / 62 mmHg (RN A) 5/14/2026 14:37 (2:37pm) 118 / 62 mmHg (LVN B)5/14/2026 08:13 (8:13am) 118 / 62 mmHg In a phone interview on 05/18/26 at 2:42 pm, RN A who worked the evening shifts and had been employed at the facility for approximately four weeks, stated that the PCC (cloud-based healthcare software platform designed to streamline long-term and post-acute care management) system included a recall feature that displays previously entered vital signs when new vitals were documented. RN A stated staff may review prior vital signs before documenting and entering updated values. RN A further stated that if the vital signs were the same or very close, he would enter the previously documented value, particularly if the difference was not considered significant and only varied by one number. RN A stated that accurate blood pressure documentation was important since blood pressures can fluctuate throughout the day. RN A explained that elevated blood pressures could lead to cardiac complications, while low blood pressure could result in a resident being difficult to arouse. RN A stated it would be unlikely for a resident's blood pressure to remain the same throughout the entire day. In a phone interview on 05/18/26 at 2:47pm, LVN B, employed at the facility for approximately seven years, stated she was unsure whether the PCC system contained a recall feature. LVN B stated she would personally document the blood pressure values she obtained at that time. LVN B stated that during the evening shift, if a resident had a blood pressure reading monitoring ordered twice a day, or three times a day, staff were expected to obtain and document a current blood pressure reading for those ordered times. LVN B stated if a resident had an order to obtain vital signs every shift, she would reuse the previous blood pressure reading she took earlier that day since the order was only once per shift. LVN B also stated that when administering blood pressure altering (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications, she would document the resident's actual blood pressure reading. LVN B further stated there could be potential complications if a staff member documented blood pressure readings that were not personally obtained at that time. LVN B stated she was unsure how duplicate blood pressure documentation could occur, specifically referencing her duplicated documentation of blood pressures. LVN B stated she was not certain what the facility's policy regarding reusing previously documented blood pressures stated. She explained that nurses were expected to obtain and document blood pressure readings at the time assessments were completed and she had never been informed that blood pressure documentation was required to reflect a reading obtained at that exact documented time. In an interview on 05/19/26 at 10:01am, the DON stated that the recall button was removed from the PCC system. The DON stated it was not very likely that a resident's blood pressure could remain the same throughout the day. The DON stated staff were aware that when a blood pressure was documented, it should reflect the actual reading at that time. The DON stated the system does alert staff when a blood pressure is out of parameters and for Resident #99, they were made aware by LVN B sometime last week, that her blood pressure was out of parameters, but the system does not notify staff if blood pressures were being duplicated. The DON stated if a resident's blood pressure reading was duplicated throughout the day, the facility would not be able to track and trend any possible concerns and the resident could have a low or high blood pressure and staff would be unaware. The DON stated an in-service on blood pressure and documentation was conducted on 05/18/26. 4. Record review of Resident #97's face sheet, dated 05/18/2026, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: Cerebral edema (swelling of the brain), chronic obstructive pulmonary disease with sudden exacerbation (a sudden worsening of chronic obstructive pulmonary disease symptoms, such as increased shortness of breath, chest tightness, and a change in mucus), respiratory failure (occurs when the lungs cannot get enough oxygen into the blood or fail to remove enough carbon dioxide the blood), and heart disease (a general term that refers to several types of conditions affecting the heart's structure and function). Record review of Resident #97's quarterly MDS assessment, dated 02/12/2026, revealed Resident #97 had a BIMS assessment score of 12, indicating she had moderate cognitive impairment. Record review of Resident #97's Change of Condition Progress Note written by LVN C, dated 04/02/2026 at 10:08 a.m., revealed The change in condition, symptoms, or signs to report: agitation/increased anxiety/ increased confusion; Long-Term Care Primary Diagnosis: copd Allergies: Zantac Vitals : Blood Pressure: 110/62 Sitting 04/03/2026 Pulse:70 Regular 04/02/2026 Respiration: 18 04/02/2026 Temp: 97.6 04/02/2026 Weight: NA 04/02/2026 O2: 96 04/02/2026 O2 L/M; Mentals Status : Mental Status Change: Increased confusion; Notifications : Name of Family/Health Care Agent Notified: [NP D]. Record review of Resident #97's April 2026 MAR revealed on 04/02/2026 at 11:33 a.m., LVN C injected Haloperidol Lactate Injection Solution 5 MG/ML (Haloperidol Lactate) Inject 1 ml intramuscularly one time only for mood disorder; agitation until 04/02/2026 12:59 p.m. Record review of Resident #97's Progress Note dated 04/02/2026 at 01:10 p.m., written by LVN C revealed, sn and resident on a tele visit with [NP E palliative care] as per her she would consult with medical doctor and get back to us if any changes would be made to resident's medication regimen. [sic]Record review of Resident #97's Doctor - MD Progress Note written by NP D on 04/02/2026 at 01:14 p.m., revealed Face to face consult done with resident and [NP E palliative care] due to patient's progressive decline, SOB and worsening anxiety. Record review of Resident #97's NP D's order dated 04/02/2026 revealed Haloperidol Lactate Injection Solution 5 MG/ML (Haloperidol Lactate) Inject 1 ml intramuscularly one time only for mood disorder; agitation until 04/02/2026 12:59 p.m. Record review of Resident #97's consent form dated 04/02/2026 revealed (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #97 signed the consent form for the injection of haloperidol 1 ml intramuscularly one time only for mood disorder; agitation. During an interview on 05/19/2026 at 10:47 a.m., the DON stated the NP or doctor would write their notes in the Progress Notes when they visited a resident or wrote an order. The DON stated the nurse who took the order was supposed to remind the NP or doctor to document on a Progress Note when they visited a resident and/or wrote an order. The DON stated if the NP or doctor would not write a Progress Note showing they wrote an order for a one time dose of a medication (haloperidol), they (the facility) would not be able to track the medication or who ordered it. The DON stated for any new order of an antipsychotic even a one-time dose, the order would be on the 24-hour report. The DON stated she reviewed the 24-hour report daily. During an interview on 05/19/2026 at 10:56 a.m., LVN C stated when she was given an order by an NP or doctor whether verbally or on the telephone, she would carry out the order. She said she would notify the family. She said she would get consent from the family and have them sign a consent form for the antipsychotic. LVN C stated the NP, or the doctor would write their note for the visit and order and it went into the electronic medical record's Progress Notes. LVN C stated she would not check to ensure the NP or doctor had written their notes in the Progress Notes. LVN C stated after she received the signed consent for an antipsychotic, she would put the order in and administered the antipsychotic. LVN C stated she would not write an order if one were not given. She said she did not remember who gave the order for haloperidol one time dose for Resident #97, but if she had put NP D's name on the order, NP D would have given the order. LVN C stated she did not know why she did not document the order in her notes. During an interview on 05/19/2026 at 12:46 p.m., NP D stated the day (04/02/26) the facility did a face-to-face with NP E palliative care concerning the decline of Resident #97, she said she thought they had increased two medications. NP D stated it was her practice to document an order for an antipsychotic but could not remember if she ordered Haldol for Resident #97 on 04/02/26 and she had forgotten to document if she had. NP D stated all she remembered was how Resident #97 was that day (04/02/2026). NP D stated Resident #97 had been very agitated. NP D stated she had been there for the face-to-face with the [LVN C] and NP E palliative care. NP D stated her name was on the consent for the haloperidol for Resident #97. NP D stated, So it probably was me who ordered the one-time dose of Haldol for [Resident #97]. She said Resident #97 was very agitated that day and she (NP D) had been concerned about exacerbating her respiratory issues. NP D stated she was supposed to document (in the electronic medical record) when an order was given. NP D stated anything could happen or nothing could happen when documentation was not completed and conclusions could be jumped into. Record review of the facility's Documentation in Medical Record policy dated 10/24/22 reflected: Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. 3. Principles of documentation include, but are not limited to: a. Documentation shall be factual, objective, and resident centered. i. False information shall not be documented ii. Record descriptive and objective information based on first-hand knowledge of the assessment, observation, or service provided. b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. Record review of the facility's policy Physician Visits and Physician Delegation dated 10/24/2022, revealed, Policy: It is the policy of this facility to ensure the physician takes an active role in supervising the care of residents. Policy Explanation and Compliance Guidelines: 1. The Licensed Nurse should: f. Remind the physician to date and sign all orders and write a progress note. g. When possible, review the medical record for completeness, prior to the physician leaving the facility. h. Write a note to (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 05/19/2026
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.			
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflect the date and time of the physician visit, and indication as to whether new orders were written or no new orders were received and any special discussions between the resident and/or family and physician during the visit. 1. The physician should: d. Date, write and sign a progress note for each visit.		

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 05/19/2026
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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview and record review the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption for 1 (Resident #34) of 3 resident refrigerators reviewed for refrigerator sanitation. The facility failed to ensure Resident #34's personal refrigerator was maintained. Resident #34's personal refrigerator had 4 small individual cups of pudding, 5 small individual pies and a slice of bologna that all had best by dates that were expired. There was not a temperature thermometer inside her refrigerator. This failure could place residents who store food items in resident refrigerators, at risk of cross-contamination and food-borne illnesses if consumed. Findings included: Record review of Resident #34's admission Record dated 05/19/26 reflected a [AGE] year-old female, admitted on [DATE], diagnoses included, Type 2 Diabetes Mellitus without Complications (body does not use insulin properly and leads to high blood sugar), Essential (Primary) Hypertension (high blood pressure), and Hypothyroidism Unspecified (insufficient hormones are produced causing body to slow down). Record review of Resident #34's Annual MDS assessment dated [DATE] reflected a BIMS score of 11 indicating moderate cognitive impairment. Section GG, - Functional Abilities and Goals, indicated Resident #34 used a manual wheelchair and required partial/moderate assistance when eating. During observation and interview on 05/17/26 at 3:31 p.m., Resident #34 was observed in her room sitting upright on her bed and was alert. Resident #34 gave consent to observe her personal refrigerator. Inside the refrigerator there were 4 individual pudding cups, 5 small individual pies and a slice of bologna. All the items found had an expired date. Also observed was no thermometer inside, and no refrigerator temperature log on or near the refrigerator. Resident #34 said she did not know the items were expired. She said she sometimes allowed staff to check the refrigerator, but no one had told her there was expired food in it. During an interview on 05/18/26 at 10:17 a.m., Supervisor E said she was responsible for checking Resident #34's personal refrigerator. She said she had not been able to check it because Resident #34 had not allowed her to. Supervisor E said she did not know there was not a thermometer in Resident #34's refrigerator. She said nurses on duty checked the refrigerator temperature. Supervisor E said she did not know if anything could have happened to Resident #34 if she had eaten expired food. She said she had thought whoever gave her food from the refrigerator would have probably checked the dates before giving it to her. During an interview on 05/19/26 at 10:38 a.m., the DON said a staff member was assigned to each resident's room. They were responsible for making sure the residents were comfortable, call lights were within reach, the rooms cleaned and if there was a refrigerator in the room, they were to check it to make sure that it was clean and no food had expired. She said rooms were checked every morning. The DON said that Resident #34 had refused to let staff check her refrigerator. She said sometimes she had let them check it but it had not been very often. The DON said there should have been a temperature thermometer in Resident #34's refrigerator. She said she did not know why there had not been one in there. The DON said had Resident #34 eaten the expired food that was found in her refrigerator she could have gotten sick, gotten nausea or vomiting. During an interview on 05/19/26 at 3:23 p.m., LVN F said he only checked the temperature in Resident #34's (continued on next page)		

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 05/19/2026
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.			
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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room on 05/17/26. He said he did not check for expired food or if there was a thermometer in there. LVN F said he checked for the temperature with a temperature gun and logged it on the Temperature Log binder located in the nurse's station. Record review of the facility's policy titled Resident Refrigerators dated 07/03/23 revealed; Policy; This facility does not provide a refrigerator in a resident's room. However, it is the policy of this facility to ensure safe and sanitary use of any resident-owned refrigerators. Policy Explanation and Compliance Guidelines: Dormitory-sized refrigerators are allowed in resident's room under the following conditions: 1 e. The resident complies with the facility's policy for use of the refrigerator. 2. Staff shall record refrigerator temperatures weekly on a temperature log attached to the refrigerator. a. A thermometer shall remain in the refrigerator. 3. Staff shall clean the refrigerator weekly and discard any foods that are out of compliance. 4. Residents and staff shall comply with safe food handling and storage principles: c. Foods with use-by dates shall be discarded accordingly.		