STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675933	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treasure Hills Healthcare and Rehabilitation Cente	2204 Pease St Harlingen, TX 78550

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 - Some	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675933	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treasure Hills Healthcare and Rehabilitation Cente	2204 Pease St Harlingen, TX 78550

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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure all alleged violations including abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not 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 administrator of the facility and to other officials (which included to the State Survey Agency) in accordance with State law through established procedures for 2 of 4 residents (Resident #2, #3) reviewed for reporting alleged allegation of abuse. 1.The facility failed to report, within 2 hours, when Resident #2 and Resident #3 had a resident-to-resident altercation on 02/24/25. 2. The facility failed to report, within 24 hours, when there was a flash fire in the kitchen on 04/08/25. These failures could place residents at risk for undetected abuse, neglect and/or decline in feelings of safety and well-being.The findings included: 1. Record review of Resident # 2's admission sheet, dated 08/18/25, revealed the resident was a [AGE] year-old female with an admission date of 01/24/25 with diagnoses that included: unspecified dementia (a group of thinking an social symptoms that interferes with daily functioning), muscle weakness, anxiety disorder (feeling worry or fear that are strong enough to interfere with one's daily activities), and cognitive communication deficit (difficulty paying attention to a conversation, staying on topic, remembering information, responding accurately, understanding jokes or metaphors, or following directions). Record review of Resident #2's quarterly MDS assessment, dated 08/02/25, revealed Resident #2 had a BIMS score of 07, indicating her cognition was severely impaired. Record review of Resident 2's quarterly care plan, dated of 08/12/25 reflected [Resident #1] has potential for a psychosocial well-being problem r/t another resident making contact to her throat and chest area (date initiated/revised 02/25/25). Her interventions in part included when conflict arises, remove residents to a calm safe environment and allow to vent/share feelings, needs assistance/supervision/support with identification of potential solutions to present problems. Record review of Resident #2's x-ray results dated 02/25/25 reflected: Chest x-ray 1 view, Impression: no acute cardiopulmonary process (no acute problems with heart or lungs). Spine cervical x-ray 2-3 views, impression: no acute osseous process (no bone abnormalities). Record review of Resident #2's Risk Management report with an effective date and time of 02/24/25 at 7:45 p.m., reflected This shift other resident made hand contact to resident's throat and upper chest area. [RP] was present at the time of this occurring. At this time pain medication offered and taken. Assessment done to site. No redness, no discolorations noted. Area flat. Call placed to [Dr] but no call back. At this time [Medical Director] was informed. Gave order for x-rays. [RP] was made aware of order pending to be done. Level of pain: 5, immediate action taken check x-ray and skin assessment, injuries reported post incident: no injuries observed post incident. In an attempted interview with Resident #2 on 08/19/25 at 3:00 p. m., Resident #2 was not interviewable. In an attempted telephone interview on 08/19/25 at 3:15 p.m., Resident #2's RP did not answer, voice message left. Record review of Resident #3's admission record dated 08/21/25 reflected an admit date of 04/28/2, an original admission date of 11/06/20, and a discharge date of 05/14/25. His relevant diagnosis included Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), dementia (a group of thinking and social symptoms that interferes with daily functioning), and cognitive communication deficit (difficulty paying attention to a conversation, staying on topic, remembering information, responding accurately, understanding jokes or metaphors, or following directions). Record review on Resident #3's significant change MDS dated , 05/15/25, reflected a BIMS score of 99, which indicated his cognition was severely altered. Record review on Resident #3's quarterly care plan dated, 04/15/25 reflected:Focus: [Resident #3] has the potential to demonstrate physical behaviors r/t made contact to throat and chest on another resident (date initiated (02/25/25). Interventions: in part included to analyzed key times, places, circumstances, triggers and de-escalate behavior and document and document and observe behavior and attempted interventions (date initiated: 03/04/25). Record review of Resident #3's Risk Management report with an effective date and time of 02/24/25 at 8:49 p.m. and authored by the DON reflected This shift resident made hand contact ot other resident throat and upper chest area. [Resident #3] noted to be getting up from wheelchair and has been walking around facility aimlessly, immediate action take: assessment, call placed to [NP] to inform of resident's status. At this time gave order for Benadryl 50 mg im x 1 dose. Call placed to [RP] to inform of his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675933	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treasure Hills Healthcare and Rehabilitation Cente	2204 Pease St Harlingen, TX 78550

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675933	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treasure Hills Healthcare and Rehabilitation Cente	2204 Pease St Harlingen, TX 78550

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to incorporate the recommendations from the PASRR Level II determination and the PASRR evaluation report for 1 of 12 residents (Resident #1) reviewed for PASRR. The facility failed to initiate an NFSS within 20 business days following the date the services were agreed upon in the IDT meeting for Resident #1. This failure could affect residents by placing them at risk of their specialized needs not being met. Findings included: Record review of Resident #1's admission record dated 08/18/25 reflected an [AGE] year-old female admitted on [DATE]. Her relevant diagnoses included, lack of coordination, unsteadiness on feet, age-related osteoporosis (increased fracture risk due to declining bone mass and strength), and seizures (uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain). Record review of the resident's quarterly MDS assessment dated [DATE] reflected, a BIMS score of 99, which reflected her cognition was severely impaired. Further review indicated she required a wheelchair (manual or electric) for mobility. Record review of Resident #1's quarterly care plan dated 08/12/25 reflected: Focus: [Resident #1] is receiving PASRR services for IDD PASRR positive diagnosis (date initiated 07/11/25). Interventions: in part included occupational, speech, and physical therapy with long- and short-term goals. During an observation on 08/19/25 at 9:00 a.m., Resident #1 was observed sitting on her specialized wheelchair in the dining room. She was not interviewable. Record review on 08/20/25 of Resident #1's LIDDA's Individual Profile-Nursing Facility dated 01/09/25 reflected:Adaptive Aids and Medical Supplies: Due to recent falls, team agreed to specialized mattress, bolsters and concave mattress to support her from falling off the bed. An interview and observation on 08/19/25 at 9:20 a.m., MDS/RN B said she was responsible for submitting PASRR specialized services through the Simple Online Portal, but that she was not working at the facility when Resident #1 had her initial Interdisciplinary Team meeting on 01/09/25. She said the facility had 20 days to submit a completed request for nursing facility specialized services on the Simple Online Portal after the Interdisciplinary Team meeting. She was observed as she reviewed Resident #1's electronic medical record and said Resident #1's initial interdisciplinary team meeting was held on 01/09/25 and what was recommended was independent living skills training, physical therapy, occupational therapy, speech therapy, and a specialized wheelchair. She said she did not find a request for any durable medical equipment (support surface mattress). An interview on 08/19/25 at 9:45 a.m., DOR said she had been present during Resident #1's initial Interdisciplinary Team meeting held on 01/09/25. She said she remembered discussing Resident #1 required a specialized wheelchair and the possibility of a concave mattress. She said she remembered she received a call from the Administrator asking her if a specialized mattress had been ordered during the Interdisciplinary Team meeting, because she had received an email from the PASSR state office coordinator inquiring on it. She said she had told the Administrator that Resident #1 had been assessed by an Occupational Therapist and it was determined that she did not require a specialized mattress only bolsters (because she was a fall risk). Record review on 08/20/25 of Resident #1's LIDDA's Individual Profile-Nursing Facility dated 01/09/25 reflected:Adaptive Aids and Medical Supplies: Due to recent falls, team agreed to specialized mattress, bolsters and concave mattress to support her from falling off the bed. Record review on 08/20/25 of Resident #1's progress note dated 01/09/25, authored by the DOR reflected, Initial IDT meeting for [Resident #1] held with LIDDA. Resident chose not to participate in meeting. [The DOR] requested specialized wheelchair through PASRR as well as concave mattress if possible. An interview on 08/20/25 at 10:00 a.m., the DON said her involvement with PASSR was very minimum. She said she did not know the timeframes after the IDT meeting, she said the MDS nurse in charge of that. An interview on 08/20/25 at 10:20 a.m., the Administrator said she had been present during Resident #1's initial Interdisciplinary Team meeting held on 01/09/25. She said she remembered the team had not requested a specialized mattress. She said what was requested was a specialized wheelchair, therapy (physical, occupational, and speech), and a provider to visit resident daily. She said it's the LIDDA caseworker responsibility to upload a resident's Individual Profile to LTC Simple portal after the Interdisciplinary Team meeting. She said since a specialized mattress had not been requested during the IDT meeting, she did not follow-up on it. The Administrator said she remembered she received an email from PASSR (state office) inquiring on a specialized mattress and she had forwarded it to the current MDS/RN B to handle it. She said the current MDS/RN B had responded to the email. The Administrator said MDS/RN B received an email

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675933	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treasure Hills Healthcare and Rehabilitation Cente	2204 Pease St Harlingen, TX 78550

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles for 1 (Cart 1) of 5 medication carts. The facility failed to ensure that the nurses medication cart for 100 hall was secured by a lock when it was left unattended by RN A. These failures could place residents at risk of injury if medication left unsecured were consumed. Findings included: During an observation on 08/20/2025 from 02:40 PM revealed the A Wing Hall nurse's medication cart was left unlocked and unattended against the nurse's station. During the observation RN A approached the nurses' medication cart and notice that was unlocked and the RN A secured the cart by locking it. During an interview on 08/20/2025 at 02:42 PM with RN A revealed she was responsible for the nurse's medication cart that was left unlocked. She stated he was expected to lock the nurse's medication cart when she walked away from it. She stated if it was left unlocked then a resident could open a drawer and take anything that was not for them. She stated he had left the cart unlocked because she just went to another cart to use the computer. During an interview on 08/20/2025 at 04:18 PM with the DON revealed numerous staff, including her and the ADON, were responsible for ensuring medications carts were locked. The DON stated her expectation of staff when they walk away from the medication cart was to lock it. DON stated that the negative outcome for leaving the cart unlocked was that a resident or visitor could grab the medication from the cart, and it could harm them. She stated she had provided in-services to the staff, and she visually monitored daily. Record review of undated facility policy Medication Access and Storage: revealed It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications