

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675933	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Treasure Hills Healthcare and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 1 of 6 resident rooms (Resident #2), reviewed for environment. The facility failed to ensure Resident #2's room was free of food crumbs on the bed linens and floor. This deficient practice could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings included: Record review of Resident #2's admission record, dated 6/10/2026, reflected a [AGE] year-old female with an admission date of 10/13/25. Her diagnoses included cognitive communication deficit (trouble speaking, listening, or understanding others, caused by problems with thinking skills), dysphagia (difficulty swallowing), muscle weakness, need for assistance with personal care, and reduced mobility. Record review of Resident #2's quarterly MDS assessment, dated 6/1/26, reflected a BIMS score of 8 which indicated moderate cognitive impairment. Section GG, titled eating: was coded at 05 which indicated she required setup or clean-up assistance. Record review of Resident #2's quarterly care plan, dated 6/10/2026, reflected [Resident #2] has ADL Self Care Performance Deficit r/t dementia, limited mobility, intermittent confusion. Revision on 2/12/26. Interventions included: Eating: I require tray set-up to eat independently. Revision 2/12/26. During an observation on 6/09/2026 at 11:22 a.m., Resident #2 was lying in bed awake. 10-15 black ants were observed on top of the resident's blanket. The resident's blanket had food crumbs. Food crumbs were seen on the floor around and under Resident #2's bed. The CNAs immediately removed the bed linens and placed them in a plastic bag. No ants were seen on the resident's body during toileting and dressing. Resident #2 was transferred to the wheelchair, and no further ants were seen. The resident's wheelchair was clean, and the resident did not complain of itching or discomfort to her skin. During an interview on 6/09/2026 at 11:45 a.m., the RN said a negative outcome for a resident having a dirty and wet floor was that they could slip and fall, attract pests, and be bitten. She said housekeeping cleaned the rooms daily and as needed. The RN performed a skin assessment, and no indications of ant bites were seen. During an interview on 6/09/2026 at 12:00 p.m., the Housekeeping Supervisor said housekeeping cleaned the floors when the resident was up for her meals. She said if the resident is up and out of her room in the mornings, housekeeping would go into the room and clean. She said she was notified by the staff of the ants and performed spot checks for pests and notified maintenance if needed. She said maintenance keeps a log on pest management. The Housekeeping Supervisor said the residents' rooms were cleaned every day and as needed. She said having an unclean room can cause ants and a wet floor could cause a resident to slip and fall. The Housekeeping Supervisor said once meals were brought out to the resident's room, housekeeping could not clean due to the chemicals being used and would start to clean after the resident's meal trays were picked up. During an interview on 6/10/2026 at 5:25 p.m., the DON said in-services were started with the staff and were informed to keep residents' areas clean and to inform housekeeping of crumbs and food seen on the floors. She said increased monitoring of room cleanliness was done. She said an IDT meeting was held to discuss environment and pests and to ensure immediate notifications (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were made to supervisors if and whenever pests were seen. The DON said an uncleaned room could possibly attract insects and pests, causing residents to be bitten. She said a skin assessment was done on Resident #2 and there were no injuries. On 6/10/2026 at 5:45 p.m., the Administrator said that on 6/04/26, pest control was in the building and sprayed. She said the maintenance supervisor sprayed on 6/09/2026 and pest control returned on 6/09/26. She said she had created a timeline that started at 6 a.m. when the administrative assistant entered the resident's room and noted almost every half hour afterwards, different staff members entered Resident #2's room and did not see food crumbs around the resident's bed. She said, the housekeeper was let go on 6/9/26 because she had failed to clean under the resident's bed earlier that morning when she entered the room. The Administrator said an in-service was done on environment services and cleanliness. She said it was everyone's responsibility to keep the residents' rooms clean. Record review of the facility's Housekeeping policy, revised on 5/2025, reflected: Cleaning Routines A. Routine schedules must be established for the cleaning of: Floors, Fixtures, Furniture etc.		

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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** Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care was provided with such care consistent with professional standards, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 (Resident #1) of 3 residents reviewed for respiratory care. The facility failed to ensure Resident #1's oxygen was administered on 6/09/2026 as ordered by the physician. This deficient practice could place residents who receive respiratory care at an increased risk of developing complications and decreased quality of care. Findings included: Record review of Resident #1's admission record, dated 6/09/26, reflected an [AGE] year-old female with an admission date of 6/06/26. Her relevant diagnoses included acute respiratory failure with hypoxia (lungs suddenly stopped working properly to get oxygen into the blood, resulting in low oxygen levels throughout the body), asthma (long-term condition that caused the breathing tubes in the lungs to swell, tighten, and fill with thick mucus), and chronic obstructive pulmonary disease (an ongoing lung disease that makes it hard to breathe). Record review of Resident #1's Nursing Home PPS MDS assessment, dated 6/10/2026, reflected her BIMS score was left blank, which reflected her cognition was severely impaired. Record review of Resident #1's initial care plan, dated 6/06/26, reflected Resident #1 has Oxygen therapy r/t SOB Date initiated: 6/06/2026. Interventions included: Apply oxygen via NC at (2) LPM continuous to keep saturation at or above 90% every shift for SOB date initiated 6/09/2026. Record review of Resident #1's Medication Administration Record, dated 6/10/2026, indicated Apply oxygen via NC at (2) LPM continuous to keep saturation at or above 90% every shift for SOB order date: 6/06/2026. During an observation on 6/09/2026 at 11:18 a.m., Resident #1 was observed lying in bed awake. The oxygen concentrator was on, and the setting was at 2 liters per minute. Resident #1 did not have a nasal canula in place. The nasal canula tubing was at the head of the bed under the resident's head. During an interview and observation on 6/09/2026 at 12:04 p.m., the RN checked the resident's oxygen saturation, and it was at 93%. The nurse positioned the nasal canula in place and asked Resident #1 how she felt. Resident #1 responded, I feel fine. Resident #1 said she could not remember whether she had removed the nasal canula or it had fallen off. The RN said she had last checked the nasal canula placement at 10:24 a.m. She said negative outcomes to Resident #1 not receiving oxygen as ordered could be possibly go into distress or become confused. It can take longer for O2 sats to go up. During an interview on 6/10/2026 at 5:20 p.m., the DON said the facility does not have a respiratory therapist in-house. She said the nurses provided respiratory care services to the residents. The DON said the nurses receive annual training on respiratory care, upon hire, and as needed. She said Resident #1's oxygen saturations were checked daily and as needed and received nebulizer treatments as needed. She said respiratory assessments were done by the nurses daily. She said Resident #1 did not have a negative outcome from the nasal canula not being in place. Record review of the facility's Oxygen Administration policy, revised 5/2026, reflected: .12. Place the oxygen delivery device on the resident, adjusting it to achieve comfort: A. Nasal Canula 1) Place prongs in resident's nostrils. 2) Adjust head strap or chin for comfort, making sure cannula is secure.		