

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

Printed: 07/18/2026
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 12/10/2025
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity, and care for each resident in a manner, and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality for one (Resident #2) of three residents reviewed for facial hair. The facility failed to remove Resident #2's facial hair. This failure could affect the residents who require assistance with care from facility staff, by placing them at risk for social isolation, loss of dignity, and self-worth. Record review of Resident #2's Face Sheet, dated 12/08/2025, revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including; need for assistance with personal care, muscle weakness, lack of coordination, and reduced mobility. Record review of Resident #2's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 09 which indicated moderately impaired cognition. The Quarterly MDS assessment also revealed Resident #2 required substantial/maximal assistance on personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands. Record review of Resident #2's Comprehensive Care plan dated 07/07/2025 revealed the resident required a Focus on ADL self-care performance deficit related to bilateral AKA. One of the interventions for this focus was Prefers to have facial hair shaved. Date Initiated: 08/06/2025 Record review of Resident #2 progress notes dated from 09/09/2025 through 12/10/2025 did not include documentation of Resident #2 refusing facial hair being shaved. During an observation and interview on 12/08/2025 at 10:33 am, revealed Resident #2 had long facial hair on her upper lip, chin area and both cheeks which extended from the front of her ears down to her chin. Resident #2 stated it had been about a month since she had been offered to be shaven. Resident #2 stated CNAs offered to shave her about every 2 weeks but this time it was about a month ago. Resident #2 stated that when she was younger, she shaved her face for swimming and felt that it caused her facial to now grow fast. Resident #2 stated she felt she did not want to bother the CNAs in not wanting to ask to be shaved. Resident #2 stated, I'm fine. During an interview on 12/10/2025 at 9:28 am, CNA S revealed CNAs have the task to shave residents, in which she stated shaving falls under personal hygiene task. CNA S stated she was aware Resident #2 had long facial hair. CNA S stated Resident #2 had not been shaven in a while. CNA S stated she had not asked Resident #2 if she wanted to be shaven. CNA S stated that when a resident refused a task such as a shower, or in this case shaving, she would report it to the nurse. CNA S stated she had reported to the nurses several times when Resident #2 had refused showers, but since she had never asked Resident #2 about shaving, she never reported it to the nurse. During an interview on 12/10/2025 at 9:42 am, CNA N revealed she was aware resident had long facial hair. CNA N stated, Yes, I saw she had a beard. CNA N stated she was a shower aide; she was one of two aides that showered residents. CNA N stated that it was mandatory for men to be shaved with every shower while women were not. CNA N stated Resident #2 had never asked her to be shaven nor had she offered Resident #2 to be shaved. CNA N stated CNA M was usually the one that would shave Resident #2. CNA N stated that if a resident is showered, they had to be shaven too. CNA N stated she did not know why she had never offered (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 to be shaven. During an interview on 12/10/2025 at 9:52 am, CNA M revealed she had seen Resident #2 had long facial hair. CNA M stated she was usually the CNA that had shaven Resident #2 previously. CNA M stated the last time she shaved Resident #2's face was about two weeks ago. CNA M stated she had hoped other CNAs would have taken the initiative to shave Resident #2, but they had not. During an interview on 12/10/2025 at 9:59 am, LVN T revealed she recalled only one time that a CNA had come to her to report that Resident #2 had refused to shower along with shaving. LVN T stated that at time, she educated Resident #2 on the importance of good hygiene. During an interview on 12/10/2025 at 1:49 pm, the DON revealed Resident #2 did not like to shave. The DON stated that she had often asked Resident #2 if she wanted to shave and Resident #2 had refused every time. The DON stated she did not document Resident #2's refusal of care. The DON stated that CNAs were supposed to offer Resident #2 to shave when they offered her to shower. The DON stated there was nothing on the ADL tracking sheet to inform the CNAs to shave the residents. The DON stated the CNAs were just supposed to know to provide care, including shaving female facial hair. The DON stated that when a resident refused care, the CNAs were to notify the nurse. The DON stated that if a resident had not been shaven, it would affect his or her demeanor or how the person feels. Record review of the facility's undated policy on Resident Rights reflected the following: Dignity and Respect: The Resident has the right to be treated with dignity, courtesy, consideration and respect.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 5 residents (Resident #13) reviewed for assessments:Resident #13's quarterly MDS assessment, dated 9/29/2025, did not include a diagnosis of Displaced Unspecified Fracture of Right Great Toe. Initial Encounter for Closed Fracture.This failure could place residents at risk for inadequate care due to inadequate assessments.The findings included:Record review of Resident #13's electronic face sheet dated 12/10/2025 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included: End Stage Renal Disease (permanent kidney damage forcing waste and fluid to build up in the body which causes tiredness, nausea, and swelling requiring dialysis), Diabetes Mellitus Type II (a condition where the body either doesn't produce enough insulin or doesn't use insulin properly, leading to high blood sugar levels), Displaced unspecified fracture of right great toe, initial encounter for closed fracture, Age related osteoporosis without current pathological fracture (silent disease where bone density declined, increasing future fracture risk.Record review of Resident# 13's physician order summary, dated 09/24/2025, reflected a diagnosis of Displaced Unspecified Fracture of Right Great Toe, Initial Encounter For Closed Fracture.Record review of Resident # 13's care plan, dated 9/24/25, reflected Focus: Resident #13 has right great toe proximal phalangeal Fracture r/t Osteoporosis, Mild osteoarthritis.Record review of Resident #13's Quarterly MDS dated [DATE] reflected: Section I - Active DiagnosesMusculoskeletal I4000. Other Fracture. The facility did not check off active diagnosis. I8000. Additional active diagnoses. The facility did not add Displaced Unspecified Fracture of Right Great Toe, Initial Encounter For Closed Fracture.In an interview on 12/10/2025 at 11:32 AM with the MDS Coordinator stated she was responsible for completing the MDS assessments for the facility which includes adding the diagnoses. She said the diagnosis of Displaced Fracture of Right Great Toe should have been included on the MDS assessment for Resident #13 and was not included as an oversight.In an interview on 12/10/2025 at 1:39 PM with the DON stated the MDS coordinator completed a course on MDS, and the facility provided routine in-house training. MDS nurse resources were available to the MDS coordinator and provide monthly training. The DON said they provided training on a quarterly basis by an outside resource training company. She said MDS is a compilation of all assessments done by all departments. The DON said not adding a diagnosis on the MDS would not directly impact the residents and billing could be affected due to the coding.Record review of the CMS's RAI Version 3.0 User's Manual dated October 2025, reflected section: I: Active Diagnoses I: Active Diagnosis in the last 7 Days- Check all that apply Musculoskeletal I4000, other fracture. Other- I8000, additional active diagnoses. There may be specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist of active diagnosis.		

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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** Based on observations, interviews, and record reviews 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 2 of 4 residents (Resident #1, Resident #91) reviewed for comprehensive person-centered care plans. 1.The facility failed to ensure Resident #1's care plan included his code status. 2.The facility failed to ensure Resident #91's care plan had the correct interventions for her DNR code status. This deficient practice 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 included:1.Record review of Resident #1's admission record dated [DATE] reflected a [AGE] year-old male with an admit date of [DATE]. His relevant diagnoses included pneumonia (lung infection that inflames the air sacs, causing them to fill with fluid or pus), and acute respiratory failure with hypoxia (a life-threatening condition where the lungs can't get enough oxygen into the blood (severe low oxygen) due to sudden lung injury from things like pneumonia). His advanced directive was DNR/ Do Not attempt Resuscitation (the emergency process of reviving someone whose breathing or heartbeat has stopped).Record review of Resident #1's admission MDS assessment dated [DATE] reflected a BIMS score of 5, which indicated his cognition was severely impaired.Record review of Resident #1's order summary dated [DATE] reflected a DNR/Do Not Attempt Resuscitation order effective [DATE].Record review of Resident #1's care plan assessment dated [DATE] did not include his code status.In an interview and observation on [DATE] at 1:55 pm, MDS C said Resident #1 had been admitted as a short-term resident. She said His code status was DNR. She was observed as she reviewed Resident #1's electronic medical record and said his dashboard indicated he was a DNR, he had an order for a DNR status, and his DNR form had been uploaded to his electronic medical record. MDS C said she did not find a code status on his care plan. MDS C said if Resident #1 were to code, the nursing staff would check his dashboard, order and DNR form on his electronic medical record. She said the nursing staff would not check his care plan. MDS C said there were no negative outcomes to Resident #1 not having his code status included on his care plan. MDS C said it was the responsibility of the facility's SW to ensure a resident's code status appeared correctly on their care plan.2.Record review of Resident #91's admission record dated [DATE] reflected a [AGE] year-old female with an admit date of [DATE] and an initial admission date of [DATE]. Her relevant diagnoses included chronic obstructive pulmonary disease (a progressive lung condition making it hard to breath), cognitive communication deficit (difficulty in expressing or understanding messages due to impaired thinking skills like attention, memory problem-solving, or organization), and vascular dementia (a decline in thinking skills due to reduced blood flow to the brain, often from strokes). Her advanced directive was DNR/Do not attempt resuscitation ((the emergency process of reviving someone whose breathing or heartbeat has stopped).Record review of Resident #91's quarterly MDS assessment dated [DATE] reflected a BIMS score of 3, which indicated her cognition was severely impaired. Record review of Resident 91's order summary dated [DATE] reflected a DNR/Do Not Attempt Resuscitation order effective [DATE].Record review of Resident #91's quarterly care plan dated [DATE] reflected a Focus: [Resident #2] has elected DNR status. Interventions in part included, Do not sent to hospital (date initiated [DATE]), Initiate full code measures in case of cardiac arrest, include CPR and AED use (date initiated [DATE]) .In an interview and observation on [DATE] at 2:00 pm, MDS B said Resident #91 was a long-term resident. She reviewed her electronic medical record and said Resident #91 had a code status of DNR. She said prior to [DATE], Resident #91 had a full code status. She said her intervention of initiate full code measures in case of cardiac (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	arrest, include CPR and AED us was incorrect. She said that intervention was for residents who were full code. MDS B said it was the responsibility of the facility's SW to ensure a resident's code status appeared correctly on their care plan. MDS B said there was no negative outcomes to Resident #91 not having the correct intervention for her focus of DNR because her dashboard indicated she was a DNR, there was an order for DNR, and the DNR form had been uploaded in her electronic medical record. In an interview on [DATE] at 2:20 pm, the SW said it was her responsibility to ensure a resident's code status was care planned. She said whenever a resident was admitted or modified his code status, she would immediately include it in their care plan. She said she was part of the IDT meetings and quarterly, she would discuss the resident's code status with them or their RP to ensure that was the code status they wanted. She said I think I just skipped over it referring to Resident #1 and #91's care plan. She said Resident #91 had been a full code at one up until [DATE] and she must have not removed the intervention that read to initiate full code measures in case of cardiac arrest, to include CPR and AED use. She was not able to say if there were any negative outcomes to Residents #1 or #91 for not having their correct code status on their care plan. In an interview on [DATE] at 1:40 pm, the DON said in case a resident coded, the nursing staff would go directly to their order and reviewed their DNR form. The DON said she had been advised by the facility's SW that Resident #1 did not have his code status included on his care plan and that Resident #91 had an incorrect intervention. The DON said there were no negative outcomes to Resident #1 or Resident #91 for not having their care plan reflect their code status/interventions. Record review of the facility's Advance Directive Documentation policy revised on 12/2019 reflected: Procedures: 1. The admission Coordinator or Social Service Director, shall: General: C. Document in the resident's health record. Record review of the facility's Comprehensive Person-Centered Care Planning policy dated 11/2016 and revised on 01/2022 reflected: Policy: It is a policy of this facility that the interdisciplinary team shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives time frames to meet a resident medical, nursing, mental and psychosocial needs, that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum health care information as necessary to properly care for each resident and instructions needed to provide expressive and person-centered care that meets professional standards of quality care. Procedures: The residence comprehensive plan of care will be reviewed and or revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments.		

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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 residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 4 (Resident #47) residents reviewed for respiratory care. The facility failed to ensure Resident #47's oxygen was administered at the correct setting of 3 liters per minute on 12/8/2025 as ordered by the physician. This deficient practice could place residents at an increased risk of developing respiratory complications and a decreased quality of care. The findings included: Record review of Resident #47's admission record dated 12/8/2025 reflected a [AGE] year-old male with an admission date of 09/23/2025. Pertinent diagnoses included Shortness of Breath, Chronic Obstructive Pulmonary Disease (a progressive lung condition causing airflow blockage, making breathing difficult, and includes emphysema and chronic bronchitis), and Dependence on supplemental oxygen (a medical necessity for individuals whose bodies cannot get enough oxygen from the air to keep the organs functioning properly). Record review of Resident #47's admission MDS assessment, dated 09/29/2025 reflected Oxygen Therapy while a resident. Record review of Resident #47's person-centered care plan, initiated date 9/23/2025 reflected Resident #47 used oxygen therapy related to SOB, COPD, CHF. Intervention included oxygen settings: O2 via nasal cannula at 3 liters per minute continuous humidified. Record review of Resident #47's physician order dated 12/8/2025, reflected O2 at 3 LPM via NC every shift with a start date 10/2025. During an observation of Resident #47 on 12/8/2025 at 8:59 a.m. revealed the oxygen level on the oxygen concentration machine was at 2.5Liters Per Minute via nasal cannula. Observation of Resident #47 revealed the resident was in bed with head of the bed slightly elevated. No signs of respiratory distress noted. In an interview on 12/8/2025 at 9:05 a.m. RN A stated she was the nurse for Resident #47. RN A stated the O2 setting was set at 2.5 Liters Per Minute. She stated the oxygen setting was supposed to be at 3 Liters Per Minute per physician orders. She stated that she checked the settings at the beginning of her shift. She was not sure who might have moved it. RN A stated that she checked Resident #47's oxygen tubing and saturation in the mornings. She stated that she usually checked the oxygen every 2 hours on her shift. RN A stated that the negative outcome of keeping Resident# 47's oxygen setting at 2.5 Liters Per Minute was that the resident could go to respiratory distress, shortness of breath or hypoxia (low oxygen levels). In an interview on 12/10/2025 at 1:40 p.m. with the DON, stated that the nurses assigned to that hall were responsible for checking the Oxygen settings. She stated that the nurses were to check the setting twice per shift and as needed. The DON stated they were to follow oxygen settings on physician orders. The DON stated that the negative outcome could be that the resident could have difficulty breathing and hypoxia (low oxygen levels). Record review of the facility policy named Oxygen Administration not dated, revealed: It is the policy of this facility that oxygen therapy is administered, as ordered by the physician .		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 reviews, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 4 residents (Resident #51) reviewed for accuracy of records. The facility failed to ensure LVN D documented Resident #51's change of condition on 12/01/25. This failure could place residents at risk of not receiving appropriate care through inadequate documentation resulting in deterioration in condition, exacerbation of disease process, overmedication, and increased risk of harm or injury. The findings included: Record review of Resident #51's admission record dated 12/09/25 reflected a [AGE] year-old-female with an admit date of 08/23/23 and an initial admission date of 03/18/23. Her relevant diagnoses included congestive heart failure, lack of coordination, legal blindness, end stage renal disease, and chronic obstructive pulmonary disease. Record review of Resident #51's quarterly MDS assessment dated [DATE] reflected a BIMS score of 14, which indicated her cognition was intact. Record review of Resident #51's quarterly care plan dated 10/08/25 reflected a focus of [Resident #51] is on pain medication therapy r/t left knee subacute patellar fracture (date initiated 12/09/25). Interventions in part included administer medication as ordered (date initiated 12/09/25). Record review of Resident #51's progress note dated 12/06/25 at 3:56 am, authored by LVN D reflected Tylenol Oral Tablet 325 MG. Give 2 tablet by mouth every 6 hours as needed for pain (650 mg) not to exceed 3gm in 24hrs. Record review of Resident #51's progress note dated 12/06/25 at 4:56 am, authored by LVN D reflected Tylenol Oral Tablet 325 MG. Give 2 tablet by mouth every 6 hours as needed for pain (650 mg) not to exceed 3gm in 24hrs. PRN Administration was: Effective Follow-up Pain Scale was: 0. Record review of Resident #51's progress note dated 12/07/25 at 9:01 am, authored by LVN E reflected Tylenol Oral Tablet 325 MG. Give 2 tablet by mouth every 6 hours as needed for pain (650 mg) not to exceed 3gm in 24hrs left knee pain. Record review of Resident #51's progress note dated 12/07/25 at 12:20 pm, authored by LVN E reflected Tylenol Oral Tablet 325 MG. Give 2 tablet by mouth every 6 hours as needed for pain (650 mg) not to exceed 3gm in 24hrs. PRN Administration was: Effective Follow-up Pain Scale was: 0. Record review of Resident #51's progress note dated 12/08/25 at 6:45 am, authored by LVN E reflected Tylenol Oral Tablet 325 MG. Give 2 tablet by mouth every 6 hours as needed for pain (650 mg) not to exceed 3gm in 24hrs left knee pain. Record review of Resident #51's progress note dated 12/08/25 at 9:00 am, authored by LVN E reflected Placed call to Dr. resident complained of pain to left knee when bending knee no discoloration noted. New order for Xray of left knee and Tylenol administered. Called Rp and notified Rp. Record review of Resident 51's x-ray of her left knee taken on 12/08/25 reflected that she had mild knee osteoarthritis was present. There was a subacute patellar fracture. In an interview on 12/08/25 at 9:30 am, Resident #51 said her left knee started hurting couple of days ago. She said she had informed her nurse and had been administered pain medication which alleviated the pain. She said she thought the pain to her left knee was because of the cold weather since she did not remember hurting it. In a telephone interview on 12/10/25 at 3:56 pm, LVN D said Resident #51 had called her into her room on 12/06/25 at 3:56 am and told her she had pain in her left knee. She said she had conducted a lifted Resident #51's nightgown to assess her left knee. She said Resident #51 did not have any swelling or discoloration to her left knee. She said Resident #51 had told her left knee pain was probably due to the change in weather. She said she had administered pain medication which Resident #51 had told her it alleviated from 4 out of 10 to a zero. LVN D said 12/06/25 was the first night Resident #51 had complained of left knee pain. LVN D said she had not created a progress note in Resident #51's electronic medical record related to her complaint of left knee pain on 12/06/25 and said she did not remember if she notified the incoming nurse (LVN E). LVN D was not able to say if Resident #51 had any negative outcomes for her not documenting and informing the incoming nurse of (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her left knee pain. In an interview on 12/10/25 at 9:18 am, LVN E said Resident #51 had first complained of left knee pain on 12/07/25 at 9:01 am. She said Resident #51's pain level was 4 out of 10 and administered pain medication. LVN E said she had conducted a pain follow-up assessment and her pain was zero. LVN E said the following day 12/08/25, Resident #51 had again complained of left knee pain and that time her pain level was 6 out of 10. She said she administered pain medication which had reduced her pain to a zero. She said she called Resident #51's MD since it was the second consecutive day Resident #51 had complained of left knee pain. She said Resident #51's MD ordered an x-ray of her left knee. LVN E said she had not received report from the outgoing nurse of any changes to Resident #51 on 12/06/25, 12/07/25, or 12/08/25. In a telephone interview on 12/10/25 at 1:50 pm, MD said he was notified by the facility that Resident #51 had pain in her left knee. He said he ordered an x-ray of her left knee and was later notified by the facility she had a subacute fracture patellar fracture (kneecap). He said a subacute fracture referred to a fracture that was already in the healing process. He said the only treatment for a subacute fracture was to keep it immobilized and to apply ice for pain. The MD said he suspected Resident #51's subacute fracture to be between 2 weeks to 3 months old. The MD said he came to see Resident #51 on the evening of 12/08/25. An interview on 12/10/25 at 1:40 PM, the DON said Resident #51 first complained of left knee pain on 12/06/25 at 3:56 am to LVN D. She said LVN D had assessed her and had given her pain medication but had failed to document in Resident #51's electronic medical record the specifics of her pain. The DON said Resident #51 had complained of left knee pain again on 12/07/25 at 9:01 am and was given pain medication by LVN E. She said on 12/08/25, Resident #51 complained of left knee pain to LVN E at 6:45 am and was given pain medication and her MD was notified, and a change of condition was done. The DON said Resident #51's left knee pain had been alleviated by the administration of pain medication on 12/06/25, 12/07/25, and 12/08/25. She said Resident #51's MD ordered an x-ray of her left knee. The DON said there was a lack of communication between LVN D to LVN E to identify Resident #51's change of condition. She said outgoing nurses must give report to the incoming nurse of any changes, special instructions to residents. She said the negative outcome to Resident #51 was that now she has a fracture that could have been identified sooner. The DON said she was going to check if the facility had a policy for documentation but did not provide one.		

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 12/10/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of disease and infection for 1 (Resident #100) of 3 residents reviewed for isolation precautions. Resident #100's RP did not don PPE on 12/8/2025 before entering Resident #100's room. Resident #100 was under contact isolations per physician orders. This failure could place residents who resided in the facility, as well as employees and visitors, at risk of communicable diseases. The findings included: Record review of Resident #100's face sheet dated 12/8/25 revealed a [AGE] year old male admitted to the facility on [DATE], with the diagnosis of UTI/MRSA (a dangerous type of staph bacteria resistant to common antibiotics, making UTIs harder to treat, especially in hospitalized patients or those with catheters. MRSA enters the urinary tract, causing symptoms like pain or urgency, but its resistance means standard treatments fail, requiring specific antibiotics and increasing risks for severe complications like sepsis). Review of Resident #100 Physician Orders dated 12/9/2025 revealed Contact Isolation Dx: MRSA bacteremia (bacteria that make them resistant to several common antibiotics, making infections harder to treat.) Review of Resident #100's care plan dated 12/4/2025 revealed the resident has infection of the urinary tract related to MRSA. Interventions: Contact isolation precautions for a DX of MRSA bacteremia. Observation on 12/8/25 12:00 p.m. revealed outside Resident #100's room was an isolation sign, but was not visible. There was personal protective equipment on the door that had masks, gloves and gowns available. Resident #100's RP was inside Resident #100 (contact isolation precautions) room up to the foot of the bed without any personal protective equipment. In an interview on 12/8/2025 at 12:00 p.m., Resident #100's RP stated that he was not notified that he needed to use the protective equipment. Resident #100's RP said that he knew that Resident #100 was on antibiotics. In an interview on 12/8/2025 at 12:05 p.m., RN A stated the isolation cart should contain gown, gloves, and mask outside of room and available to staff and family that enter the rooms when a resident was diagnosed with contact isolation precautions for MRSA to the urine. RN A stated that family was aware of the contact isolation. RN A stated that all staff and visitors should have worn personal protective precautions before entering rooms to prevent the spread of infection to other residents. In an interview on 12/10/25 at 1:40 PM, DON stated contact Isolation precautions should be followed by all staff because of the potential for spreading infections to other residents. DON stated that in-services (training) on infection control were the key to prevent this to happen again. Review of facility's policy titled Infection Prevention and Control Program with a revision date 12/2023 revealed; the infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of quality assurance and performance improvement program. Review of CDC guidelines revealed: https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html: Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning Personal protective equipment upon room entry and properly discarding before exiting the patient room is done to contain pathogens.		