| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676037 | A. Building<br>B. Wing | 03/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Weslaco Nursing and Rehabilitation Center | 422 E 18th St<br>Weslaco, TX 78596 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761<br><br>Based on interview and record review, the facility failed to ensure that all alleged violations involving neglect, were reported immediately to the State Survey Agency, not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, for 1 of 5 residents (Resident #1) reviewed for abuse/neglect.<br><br>The facility failed to report an allegation of physical resident abuse by CNA B and CNA C of Resident #1 during a bed bath.<br><br>This failure could place all residents at increased risk for potential abuse to unreported allegations of abuse and neglect.<br><br>The findings included:<br><br>Record review of Resident #1's Admission Record dated 03/31/25, revealed a [AGE] year-old female, originally admitted to facility on 11/03/19. Resident #1's diagnoses included: Dementia (a group of thinking and social symptoms that interfere with daily functioning), chronic kidney disease (a condition characterized by a gradual decline in kidney function over a period of at least three months), atherosclerotic heart disease (a buildup of fats, cholesterol, and other substances in and on the artery walls causing obstruction of blood flow), hypertension (high blood pressure), encounter for palliative care (a specialized form of medical care that focuses on improving the quality of life for people with serious or life-limiting illnesses).<br><br>Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 07, indicating severe cognitive impairment.<br><br>(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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Hospice Complaint Report dated 03/12/25 at 12:00 PM, revealed on 03/12/25 at 11:30 AM Hospice CNA A notified RNHA D of the following: Hospice CNA A REQUESTED ASSISTANCE WITH THE PATIENTS BATH FROM THE FACILITY NURSE AIDES AS THE PATIENT'S HAIR AND HANDS CONTAINED FECES. SHE REPORTS TWO NURE AIDES CAME INTO THE PATIENT'S ROOM TO ASSIST HER. SAN [NAME] REPORTED THE FOLLOWING: THE NURSE AIDES IN A 'HARSH WAY TOOK OVER THE BED BATH ONE ON EACH SIDE OFTHE BED ONE WAS HOLDING HER HANDS WHILE THE OTHER ONE WAS POURING WATER ON HER HEAD WITH HER HANDS Resident #1 WAS VERY UPSET I TOLD THEM TO STOP THAT I WOULD DO IT MYSELF THEY MOVED AND I TOOK OVER SHE WAS UPSET AND THIS HAPPENED ON MONDAY I REPORTED THIS TODAY TO THE HALL NURSE [NAME] AND SHE WENT AND REPORTED TO ADON AND ADMINISTRATOR.' Hospice CNA A STATES THIS OCCURRED ON 3/10/25; INCIDENT WAS REPORTED ON 3/12/25 AT ABOUT 11:30 AM. Report goes on, RNHA D wrote, CALL PLACE TO ADMINISTRATOR AT NURSING FACILITY. RNHA D INFORMED Administrator ABOUT THE REPORT RNHA D HAD RECEIVED FROM OUR HOSPICE AIDE. AS PER NF Administrator, THEY WERE AWARE OF THE REPORT. SHE STATES THE FACILITY ADON CONDUCTED A PATIENT ASSESSMENT OF THE PATIENT. NF Administrator STATES SHE ASKED THE PATIENT ABOUT THE OCCURENCE AND IN ADDITION ASKED THE PATIENT IF SHE FELT SAFE. PER NF Administrator, THE PATIENT STATED SHE FELT SAFE AND NO OTHER CONCERNS WERE NOTED DURING HER INVESTIGATION. NF Administrator STATES SHE HAS AN UPCOMING INSERVICE FOR HER STAFF OF TIMELY REPORTING OF ANY SUSPECTED ABUSE OR NEGLECT AND THAT SHE WILL REINFORCE ZERO TOLERANCE OF ANY SORT. PER NF Administrator, HER INVESTIGATION DID NOT RESULT IN SIGNED OF MISTREATING OF THE PATIENT. Hospice STAFF VISITS FOR THE PATIENT ON 3/12/25. NO CONCERNS WERE REPORTED AFTER COMPLETION OF VISITS.<br><br>Record review of Resident #1's Care Plan dated 03/19/25 revealed:<br><br>FOCUS: o Resident #1 has episodes of smearing her feces/playing with feces Date Initiated: 01/21/2025<br><br>GOAL: o The resident will have fewer episodes through lookback period Date Initiated: 01/21/2025 Target Date: 06/17/2025<br><br>INTERVENTIONS/TASKS: o Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.) Date Initiated: 01/21/2025 LN o Encourage and assist resident to clean hands/nails after episodes and PRN Date Initiated: 01/21/2025 Revision on: 01/30/2025 CMA LN o Notify MD if episodes increase or of changes in condition Date Initiated: 01/21/2025 LN o Provide incontinent care routinely and PRN Date Initiated: 01/21/2025 CNA LN o Redirect and reassure resident as needed/when possible Date Initiated: 01/21/2025 Revision on: 01/21/2025 CNA LN<br><br>In an interview on 03/26/25 at 11:25 AM RNHA D stated, Hospice CNA A had told her about the alleged abuse of Resident #1, a resident at NF. RNHA D stated they did their investigation with their (Hospice) Social Worker and nurse. RNHA D stated she did follow-up with the NF facility administrator, who said the facility did their own investigation and did not find any abuse.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Weslaco Nursing and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 422 E 18th St Weslaco, TX 78596 | |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 03/26/25 at 04:16 PM CNA A stated she was a CNA for hospice. CNA A stated she went to the facility to take care of her patient, Resident #1, on that Monday (03/10/25). CNA A stated on 03/10/25, Resident #1 was covered in BM when she went in. CNA A said BM was even under Resident #1's fingernails. CNA A stated she wanted to give Resident #1 a bed bath and asked two CNAs from the facility to help because Resident #1 was handsy and always trying to touch her. CNA A stated the facility CNAs took over the bed bath. CNA A stated she felt like they were being a little rough with Resident #1. CNA A stated they seemed angry at having to help her. CNA A stated the one CNA (CNA B) was putting water over Resident #1's head and the other CNA (CNA A did not know her name) was attempting to hold her hands while Resident #1 was telling them to leave her alone. CNA A was upset with the two CNAs for the way they were being to Resident #1 and taking over, CNA A stated she told the two CNAs that she would finish the bed bath and the two CNAs left the room. CNA A stated she did not think Resident #1 liked those two CNAs just by the way she was acting with them. CNA A stated she did not tell the nurse on the hall of the two CNAs roughness until Wednesday, 03/12/25, when she went to take care of Resident #1 again.<br><br>In an interview on 03/31/25 at 11:06 AM, Resident #1 stated, the one woman from the place who comes to give me baths is very good and very nice. Two of the ones here do not like me. Those two do not like me. They (CNAs) have ones they like and me, they don't like. Resident #1 stated she did not want to tell surveyor the names of the two who did not like her.<br><br>In an interview on 03/31/25 at 01:05 PM the administrator stated they did not have to report allegation of abuse from the Hospice CNA because they investigated and unsubstantiated the findings. The administrator stated the Hospice CNA did not report the allegation until days later. She said she spoke with the hospice administrator and she was aware of the facility's findings.<br><br>In an interview on 03/31/25 at 02:30 PM CNA B stated she had worked at the facility for 3 years in April. CNA B stated she gave showers to the residents. CNA B stated when the Hospice CNAs ask for help, they would help them with their bed baths and showers. CNA B stated if once in the shower/bed bath, the resident changed their mind and told you to leave them alone, CNA B stated they would stop the bed bath or shower right away and change the resident, so they are comfortable. CNA B stated if there was soap on the resident, they would tell the resident they were rinsing the soap and would finish after that. CNA B stated they notify the nurse the resident did not want a bed bath or shower. CNA B stated if the resident were grabbing at you, pinching you, trying to hit you, she would try to calm them and would tell them to relax. CNA B stated she would tell the nurse the resident had been aggressive. CNA B stated she would not hold their hands so they could not hit or pinch because she could cause a skin tear if she did. CNA B stated they had skill check offs on bed baths/showers. CNA B stated every year they had a check off around August. CNA B stated she probably did give showers on 03/10/25. CNA B stated she helped the hospice CNA change sheets one day, but she has not helped give a bed bath. CNA B stated if the Hospice CNA needed assistance for a bed bath, the Hospice CNA could ask either one of them.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 03/31/25 at 02:35 PM CNA C said she had been working at the facility for one year. CNA C stated she gave showers. CNA C stated when the Hospice CNA asks for help they would help with bed baths and showers. CNA stated if once in the shower/bed bath, the resident changed their mind and told her to leave them alone, she would try to convince the resident to let her finish the bath and if she could not, she would terminate the shower/bed bath. CNA C stated if the resident was grabbing at her, pinching her, trying to hit her, she would try to calm them. CNA stated she would tell the nurse the resident had been aggressive. CNA C stated she would not hold the resident's hands to prevent them from hitting her. CNA C stated the CNAs were given skills check off every year. CNA C stated she and CNA B went in to help the Hospice CNA with a bed bath that day (03/10/25). CNA C stated Resident #1 refused the bed bath and the Hospice CNA said she would finish.<br><br>In an interview on 03/31/25 at 05:48 PM the DON stated neither Resident #1 or CNA B or CNA C had ever alleged abuse to her.<br><br>In an interview on 03/31/25 at 06:15 PM the administrator stated neither Resident #1, the nurses nor the CNAs have alleged abuse to her concerning Resident #1.<br><br>Review of facility's Abuse, Neglect, Exploitation Policy dated 08/15/22, revealed:<br><br>Policy:<br><br>It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.<br><br>VII. Reporting / Response<br><br>A. The facility will have written procedure that include:<br><br>1.Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:<br><br>a. 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<br><br>b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761<br><br>Based on observation, record review, and interview, the facility failed to establish and maintain an infection prevention and control program, designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for 1 of 6 Residents (Resident #2) that were reviewed for infection control and transmission-based precautions policies and practices, in that:<br><br>1. CNA E failed to don the appropriate PPE before she entered Resident #2's room.<br><br>These failures could place residents at risk for infection through cross-contamination of pathogens and infectious diseases.<br><br>The findings include:<br><br>1. Record review of Resident #2's face sheet, dated 03/31/25, revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: Heart failure, type 2 diabetes mellitus (high levels of sugar in blood), ESBL to urine (type of antibiotic resistance gene found in bacteria that can produce enzymes that break down certain antibiotics, including penicillins, and cephalosporins.<br><br>Record review of Resident #2's Minimum Data Set assessment, dated 02/24/25, revealed Resident #2 had a BIMS score of 12, indicating he was cognitively intact.<br><br>Record review of Resident #2's physician's orders, retrieved on 03/31/25, revealed orders for<br><br>Contact isolation DX: ESBL/URINE every shift for UTI ESBL until 04/02/25 2359 (11:59 PM) with a start date of 03/25/25.<br><br>Observation of Resident #2's signage posted on the outside of Resident #2's door on 03/31/25 at 11:25 AM revealed Resident #2 was on contact precautions. CNA E entered Resident #2's room moved Resident #2 while he was sitting in his wheelchair and moved the bedside table to in front of Resident #2 readying him for lunch, without donning gown or gloves.<br><br>Interview on 03/31/25 at 11:28 AM CNA E came out of Resident #2's room and was asked why she did not have on a gown and gloves. CNA E pointed to Contact Precautions sign and stated she did not have contact with the resident so she did not have to put on a gown or gloves.<br><br>In an interview on 03/31/25 at 11:30 AM LVN F stated the Contact Precautions signage meant that if the CNA were changing a resident or having direct contact, the CNA would need to put on a gown and gloves. LVN F stated Resident #2 had ESBL to urine. LVN F stated the negative outcome of going into a room on contact precautions could be whoever entered without using PPE could spread the infection or catch the infection.<br><br>In an interview on 03/31/25 at 11:34 AM CNA E stated by entering a room on Contact Precautions and not putting on a gown and gloves, she could get the infection or spread the infection.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 03/31/25 at 11:35 AM CNA G stated when there is a Contact Precautions sign on a resident's door, everyone every time must put on PPE before entering the room. CNA G stated if PPE were not put on, the infection could spread.<br><br>In an interview on 03/31/25 at 04:30 PM LVN ADON H stated when there was Contact Precautions signage, the resident had an infection. PPE was to be put on outside and then go in the room. LVN ADON H stated every time they would go in the room they put on PPE. LVN ADON H stated if PPE is not worn and infection control is not observed, cross contamination can occur. LVN ADON stated the Enhanced Barrier signage was for when they put on PPE for wounds, midlines, foley or colostomy with resident contact for infection control. LVN ADON H stated Infection Control in-services are on-going all the time. LVN ADON H stated the other ADON had the in-servicing for Infection Control.<br><br>03/31/25 05:48 DON stated Contact Precautions signage was put on a resident's door when the resident had an infection. The DON stated everyone puts on their PPE outside and then they go in the room. The DON stated every time they go in the room they put on PPE. The DON stated if PPE was not worn and infection control was not observed, spread of the infection and cross contamination could occur. The DON stated Enhanced Barrier signage. DON stated Enhanced Barrier precautions was to prevent infection. She stated PPE was worn for wounds, midlines, foley or colostomy with contact for infection control. The DON stated Infection Control in-service are weekly or every other week or at least several times a month. The DON stated the ADON gave the in-servicing for Infection Control and she helps.<br><br>Record review of facility policy titled, Infection Prevention and Control Program with an implemented date of 05/13/23, revealed:<br><br>Policy:<br><br>This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.<br><br>4. Standard Precautions:<br><br>a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services.<br><br>c. All staff shall use personal protective equipment (PPE)according to established facility policy governing the use of PPE.<br><br>5. Isolation Protocol (Transmission-Based Precautions):<br><br>a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines. |