STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676037	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weslaco Nursing and Rehabilitation Center	422 E 18th St 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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 ensure residents received treatment and care in accordance with professional standards of practice for 1 (Resident #2) of 5 residents reviewed for quality of care. The facility failed to perform a head-to-toe skin assessment immediately after finding a new skin tear on Resident #2 on 10/22/25. The failure could affect residents currently residing in the facility, resulting in not receiving needed care to maintain optimal health and placing them at risk for injury or deterioration in their condition. The findings included:Record review of Resident #2's face sheet, dated 11/13/25, reflected a [AGE] year-old female with an admission date of 12/06/24. Resident #2's pertinent diagnosis included Alzheimer's Disease (a progressive brain disorder that affects thinking, memory, and language, leading to a decline in the ability to perform daily activities). Record review of Resident #2's Quarterly MDS assessment, dated 10/02/25, reflected a BIMS score of 5 which indicated severe impairment. Record review of Resident #2's comprehensive care plan, dated 11/13/25, reflected the problem [Resident #2] is at risk for impaired skin integrity [related to] incontinence, friction/shear, and decreased mobility initiated on 12/26/24 and revised on 03/24/25. An intervention listed for the problem included Conduct skin inspections / examinations weekly and as needed. Document findings initiated on 12/26/24. Record review of Resident #2's order summary reflected a current order for cleanse skin tear to left outer forearm with [normal saline], pat dry with 4X4 gauze, apply steri strips X1. Monitor [every day] for signs and symptoms of infection until healed initiated on 10/24/25. Record review of Resident #2's Progress Notes reflected a note written by the MDSN at 5:07 PM on 10/22/25. The note stated MDSN was called into Resident #2's room to remove a sleeve over her left arm. After removing the sleeve, MDSN noted a skin tear to her left forearm was found. MDSN noted she notified the charge nurse of skin tear to left forearm. Record review of Resident #2's assessments reflected a skin assessment was not conducted on 10/22/25. During an observation of Resident #2 at 2:01 PM on 11/13/25, the skin tear to her left forearm was almost completely healed. The area still had a little redness. An interview was attempted at that time but Resident #2 was not able to be interviewed. In an interview with the WCN at 2:51 PM on 11/13/25, the WCN stated Resident #2 sustained a skin tear on her left forearm, but there was no drainage or blood. The WCN stated she was not informed of the skin tear until 10/24/25 when the order to clean the wound was input. The WCN stated she had treated the skin tear and it had improved since it was first brought to her attention. The WCN stated after a skin tear was found on the resident, a head-to-toe assessment should have been performed by either the nurse that found the skin tear or the charge nurse. The WCN stated it was important to perform a skin assessment after finding a new wound to ensure no other new wounds or skin tears were also present. In an interview with the MDSN at 3:56 PM on 11/13/25, the MDSN stated she found out about the skin tear on Resident #2 on 10/22/25. The MDSN stated she told the LVN B who was the charge nurse at that time about the skin tear. The MDSN stated she filed an incident report about the skin tear, but she did not conduct a full head-to-toe assessment on the resident. The MDSN stated she thought the charge nurse was going to conduct a full head-to-toe assessment on the resident. The MDSN stated it was important to do a full head-to-toe assessment on a resident after a new skin tear or wound was found to ensure there was not any other damage to the resident. In an interview with LVN B at 4:28 PM on 11/18/25, LVN B stated she was the charge nurse for Resident #2 on 10/22/25. LVN B stated she remembered the MDSN told her about the skin tear on Resident #2 on 10/22/25. LVN B stated she thought the MDSN was just informing her about the skin tear, and not that it had just been found. LVN B stated she thought the skin tear had been found on a previous shift. LVN B stated she did not perform a full head-to-toe skin assessment on Resident #2 on 10/22/25. LVN B stated it was important to do a full head-to-toe assessment on a resident after a new skin tear was found to ensure there were no other new wounds. In an interview with the DON at 5:28 PM on 11/18/25, the DON stated Resident #2 should have had a full head-to-toe skin assessment on 10/22/25 immediately after the new skin tear was found. The DON stated Resident #2 did receive treatment for her skin tear and it looked a lot better now than it did before. The DON stated it was important to conduct the assessment to see if new orders were needed and to examine the extent of the damage. Record review of the facility's policy Skin Assessment, dated 4/24/25, reflected the following policies: .7. Documentation of skin assessment:a. Include date and time of the assessment, your name, and position title.b. Documents observations.c. Document type of wound.d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain) e. Documents if

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from any significant medication errors for one of five residents (Resident #1) reviewed for medication errors. The facility failed to hold administration of Resident #1's nifedipine (blood pressure medication) when Resident #2's blood pressure was outside parameters on 10/01/25. This failure could place residents at risk for complications due to discomfort or their health being jeopardized.The findings include: Record review of Resident #1's face sheet, dated 10/13/25, reflected a [AGE] year-old female with an initial admission date of 07/10/23 and current admission date of 03/21/24. Resident #1's pertinent diagnosis included Essential Hypertension (high blood pressure with no known specific cause). Record review of Resident #1's Quarterly MDS assessment, dated 09/01/25, reflected a BIMS score of 12 which indicated moderate impairment. Record review of Resident #1's comprehensive care plan, dated 11/13/25, reflected the problem [Resident #1] has hypertension initiated on 07/12/23 and revised on 02/25/24. An intervention listed for the problem included Give anti hypertensive medications as ordered. initiated on 07/12/23 and revised on 02/25/24. Record review of Resident #1's order summary reflected an active order for Nifedipine Extended Release 90 mg Give 1 tablet by mouth one time a day for hypertension hold if SBP <100 or HR <60, notify nurse initiated on 03/21/24. Record review of Resident #1's MAR from October 2025 reflected on 10/01/25 Resident #1's blood pressure was measured at 155/66 while her HR was measured at 56. Further review reflected nifedipine ER 90 mg was administered on 10/01/25 by LVN A after the heart rate was measured to be outside of ordered parameters. In an interview with LVN A at 11:48 AM on 11/13/25, LVN A stated before administering blood pressure medications she always measured the resident's blood pressure and heart rate. LVN A stated if the resident's heart rate or blood pressure was outside of the ordered parameters on the medication she would hold the medication and inform the charge nurse. LVN A stated it was important to follow the doctor's orders because administering medication outside of the parameters may harm the resident. LVN A stated she did not remember specifically if she notified the nurse and got the okay to administer the nifedipine to Resident #1 on 10/01/25. In an interview with the DON at 12:06 PM on 11/13/25, the DON stated a resident's blood pressure and heart rate were measured before administering blood pressure medication. The DON stated if a resident's heart rate or blood pressure was outside parameters for a medication the nurse should hold the medication and notify the nurse or physician depending on the order. The DON stated the nifedipine should not have been administered to Resident #1 on 10/01/25 unless LVN A had been given the go ahead by the nurse or physician. The DON stated there was no documentation that LVN A had talked to the nurse or physician about nifedipine on 10/01/25. The DON stated it was important to follow doctor's orders on blood pressure medications to protect residents from negative effects like weakness, lethargy, and dizziness. Record review of the facility's policy Medication Administration, dated 10/24/22, reflected the following policies: .8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters.14. Administer medication as ordered in accordance with manufacturer specifications.