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	04/24/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 (Resident #1) of 4 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #1 was coded in the MDS for use of a BiPAP device.This failure could place residents at risk of receiving care and services to meet their needs. The findings included:Record review of Resident #1's face sheet dated 4/23/26 reflected Resident #1 was admitted on [DATE] with an initial admission of 7/10/24. Resident #1 had a diagnosis of obstructive sleep apnea (a sleep disorder characterized by repeated episodes of complete or partial collapse of the upper airway, causing oxygen desaturation (decrease in oxygen level in the blood that falls below 90%) or sleep arousal) and hypertension (high blood pressure).Record review of Resident #1's quarterly MDS dated [DATE] indicated the following:, *Section C - Cognitive Patterns reflected Resident #1 had a BIMS of 14 which indicated a mental status of cognitively intact. *Section J - Health Conditions reveal Resident #1 had shortness of breath or trouble breathing when lying flat. *Section O - Special Treatments, Procedures, and Programs, G1. Non-invasive Mechanical Ventilator BiPAP was not checked off.Record review of Resident #1's undated comprehensive care plan reflected: Resident #1 required the use of BiPAP to treat sleep apnea. Date Initiated: 02/19/2026. Interventions included: Apply/remove BiPAP as ordered Date Initiated: 02/19/2026 Monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis (excessive sweating unrelated to heat or exercises), Headaches, Lethargy (severe tiredness, sluggishness, and reduced mental alertness), Confusion, Atelectasis (collapse of lung), Hemoptysis (coughing up of blood or blood-tinged mucous), Cough, Pleuritic (membranes surrounding the lungs) pain, Accessory (muscles recruited for breathing during high effort, such as neck) muscle usage, Skin color. Date Initiated: 02/19/2026 Prevent abdomen compression and respiratory embarrassment by routinely checking the resident's position so that he or she does not slide down in bed. Date Initiated: 02/19/2026 Promote lung expansion and improve air exchange by positioning with proper bodyAlignment. Date Initiated: 02/19/2026 Schedule follow up with specialist as necessary/ordered (Dr. [NAME]) Date Initiated: 02/19/2026Record Review of Resident #1's order summary reflected BiPAP settings: 14/9, place on at night and off in a.m. every evening shift related to obstructive sleep apnea Active Date: 5/07/2025 Start Date: 05/07/2025. Record Review of Resident #1's MAR dated 4/23/2026 reflected BiPAP was used from 4/1/2026 to 4/23/2026. In an interview on 4/24/26 at 2:10 p.m. the DON said normally they care planned everything. She said she had no idea if the BiPAP should be captured on the MDS assessment. She said MDS was responsible for ensuring it was completed. She said the BiPAP not selected on the MDS would not affect the care plan because Resident #1's BiPAP was care planned, so it would not have had a negative effect. In an interview on 4/24/26 at 3:00 p.m., LVN/MDS A said a BiPAP device was on a 7-day lookback period and gets checked off on the MDS if it had been used withing the 7 days prior to completing the assessment. She said that Resident #1 had a history of refusing and removing her BiPAP device. She checked the MAR, and said it reflected Resident #1 used the BiPAP device daily for the month of April. LVN/MDS A said, the BiPAP device should have been reflected on (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's most recent quarterly MDS assessment. LVN/MDS A said she must complete a correction for that quarterly MDS assessment. LVN/MDS A said it would not have had a negative effect on Resident #1's care if the BiPAP device was not checked off on the MDS quarterly assessment, because the BiPAP device was care planned, so it would not change the care she received. LVN/MDS A said the BiPAP device was checked off on the MDS assessment to show what types of nursing services Resident #1 was receiving. LVN/MDS A said if Resident #1 goes to the hospital, the receiving hospital would get a copy of the MAR, so they would know Resident #1 was on a BiPAP device. LVN/MDS A said the same goes for if Resident #1 was transferred to another nursing facility.Record review of CMS's RAI Version 3.0 Manual, CH 3: MDS Items [O] dated October 2025 reflected section:O0110 Special Treatments, Procedures, and Programs. O0110G1, Non-invasive Mechanical VentilatorCode any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through at mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to support their own spontaneous respiration by providing enough pressure when the individual inhales to keep their airways open, unlike ventilators that breathe for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes their own BiPAP/CPAP mask/device. - O0110G2, BiPAPCheck if the non-invasive mechanical ventilator support was a BiPAP.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 (Resident #1) of 4 residents reviewed for care plans.1. The facility failed to ensure Resident #1's most current undated care plan reflected the use of grab bars.2. The facility failed to follow Resident #1's care plan when she was identified with scabbed over scratches on left wrist and did not report findings to MD/NP. This deficient practice could place residents in the facility 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:Record review of Resident #1's face sheet dated 4/23/26 reflected Resident #1 was admitted on [DATE] with an initial admission of 7/10/24. Resident #1 had diagnoses of vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), Parkinsonism (neurodegenerative disease (cells of the central nervous system stop working or die) which manifest with motor symptoms such as rigidity, tremors, bradykinesia, and unstable posture), and hemiplegia (severe or complete loss of strength leading to paralysis (loss of muscle function) on one side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following cerebral infarction affecting left dominant side. Record review of Resident #1's quarterly MDS dated [DATE] indicated the following: *Section C - Cognitive Patterns reflected Resident #1 had a BIMS of 14 which indicated a mental status of cognitively intact. *Section GG - Functional Abilities - GG0130 Self-Care reflected Resident #1 was dependent on lower body dressing and putting on/taking off footwear. *Resident #1 required substantial/maximal assistance with personal hygiene, upper body dressing, shower/bathe self, and toileting hygiene.Record review of Resident #1's most recent undated comprehensive care plan indicated the following:*Did not include Resident #1's use of grab bars. *Resident #1 was at risk for impaired skin integrity r/t decreased mobility, friction/shear, and incontinence Date Initiated: 07/12/2023 Revision on: 02/25/2024. Encourage resident to avoid scratching and keep hands and body parts from excessive moisture as much as possible. Keep fingernails short/trimmed Date Initiated: 03/13/2024. SKIN inspection with care and PRN, Observe for redness, open areas, scratches, cuts, bruises, and report changes to the Nurse. Date Initiated: 03/13/2024*Resident #1 had c/o DRY SKIN Date Initiated: 04/23/2026. Notify MD/NP of changes in skin condition Date Initiated: 04/23/2026 SKIN inspection with care and PRN, Observe for redness, open areas, scratches,cuts, bruises, and report changes to the Nurse Date Initiated: 04/23/2026.*Resident #1 had c/o ITCHING/PRURITUS (itchy skin) Date Initiated: 02/25/2024 Revision on: 08/08/2024. Notify MD of changes to skin condition or if medication/treatment was no longer effectiveDate Initiated: 02/25/2024 SKIN inspection with care and PRN, Observe for redness, open areas, scratches,cuts, bruises, and report changes to the Nurse. Date Initiated: 02/25/2024Record review of Resident #1's quarterly MDS dated [DATE], Section C - Cognitive Patterns reflected Resident #1 had a BIMS of 14 which indicated a mental status of cognitively intact. Section GG - Functional Abilities - GG0130 Self-Care reflected Resident #1 was dependent on lower body dressing and putting on/taking off footwear. Resident #1 required substantial/maximal assistance with personal hygiene, upper body dressing, shower/bathe self, and toileting hygiene. Record Review of Resident #1's order summary did not include orders for use of grab bars.Record review of Resident #1's skin assessment dated [DATE] at 07:19 a.m. reflected no new skin issues found this evaluation by LVN/Treatment Nurse. In an interview on 4/23/26 at 2:30 p.m. the LVN/Treatment Nurse said Resident #1 was seen by a Dermatologist due to skin related issues. LVN/Treatment Nurse said Resident #1 had medications (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescribed by the Dermatologist that the floor nurses applied due to skin related issues. The LVN/Treatment Nurse states she did head-to-toes weekly skin assessments on Resident #1 to rule out any bruises, skin breakdown, and DTIs. She said her last skin assessment on Resident #1 was on 4/21/26 early in the morning and she did not notice any scratches to resident's left wrist area. The LVN/Treatment Nurse also said no one had reported any scratches to her prior. The LVN/Treatment Nurse said Resident #1 was also good at informing staff if she sustained any injury. She said if she noted scratches on Resident #1, she would report them to the floor nurse and MD immediately, even if the scratches were not big or healed so they can be monitored because they can get infected and get cellulitis. The LVN/Treatment Nurse went to check on the resident's scratches, returned, and said she had not noticed them before. She said Resident #1 told her she was scratching herself. The LVN/Treatment Nurse said she informed the charge nurse and that the charge nurse said it was reported to MD already. In an interview on 4/24/26 at 9:38 a.m. LVN B said Resident #1 was a 2-person Hoyer lift with transfers and did not assist with transfers. LVN B said Resident #1 did not help much with any care completed in bed. LVN B said grab bars were for bed mobility for residents who can grab and were there for Resident #1 when she needed them to reach for something on her own. LVN B said Resident #1 was unable to grab them to assist with turning or repositioning and she cannot turn or reposition on her own. LVN B said she believed grab bars should be care planned. LVN B said she was not aware of any negative outcomes if they were not because the grab bars were in place for Resident #1 if needed. LVN B said the last time she worked with Resident #1 was on Tuesday, 4/21/26 during her scheduled 6:00 a.m. to 2:00 pm shift. LVN B said she noted some dry, scabbed over, and healed scratches that were already blending into Resident # 1's skin. LVN B said there was no redness or swelling to the area, and Resident #1 did not have any open areas to other areas. She said Resident #1 was known for scratching herself and complained of itching. LVN B said even though it was care planned to report scratches, she did not report since the scratches were healed and scabbed over. LVN B said the scratches were not open and she only needed to report open wounds or scratches that were at risk for infection. LVN B said there was not a risk of any worsening since the scratches were scabbed and dried over.In an interview on 4/24/26 at 2:10 p.m. the DON said normally they care planned everything. The DON said she knew LVN/MDS A worked on them. The DON did not know if the grab bars were added to the care plan or not. The DON said Resident #1 was able to use the grab bars. The DON said Resident #1 assisted when repositioned to help remain on her side. The DON was not sure if Resident #1 could use the grab bars on her own, but probably not. The DON said no adverse outcome would happen if the grab bars were not care planned. The DON said if Resident #1 requested the bed to go with her during a room change it would. The DON said they would make modifications to another bed. The DON said grab bars do not need orders because they were considered a nursing intervention. The DON said there was no assessment completed for grab bars or halos because they were aids for turning and repositioning. The DON said if staff were not familiar with the resident, they would not know if she needed the grab bars. The DON said she was made aware of Resident #1's scratches. The DON said Resident #1 had cream prescribed for itching. The DON said if a resident were seen with scratches, staff would call the doctor or the NP to inform and see if it were an actual skin tear for treatment, and staff would enter a progress note. The DON said she called the NP and since the scratches were very superficial, the NP told her to continue with the creams she was currently on. The DON said if staff noted the scratches on Tuesday, 4/21/26, they should have reported the scratches. If a CNA saw the scratches they must report it to the nurse. If a nurse saw the scratches, they must call the MD and RP just so everyone was on the same page with treatment. The DON said even if the scratches were dried and scabbed over, staff must always report since we did not know how she got the scratches. The DON said maybe staff who initially noticed the scratches thought the scratches were reported before. The DON said the scratches were superficial, but if they were larger and not reported, it could have caused an infection. In an interview on 4/24/26 at 3:00 p.m. the LVN/MDS said Resident #1 used the grab bars to hold on. The LVN/MDS said grab (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bars had usually cared planned, but it depended on how long they had been in use. The LVN/MDS said if grab bars were not care planned for Resident #1, it could have been the grab bars were placed after the last care plan was reviewed, so they would be showing up after the next care plan review. The LVN/MDS said she was not aware of any negative outcomes since the grab bars were in place.Record review of facility's Comprehensive Care Plans policy dated 10/24/22 reflected:Policy:It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.Policy Explanation and Compliance Guidelines:6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.8. Qualified staff responsible for carrying out interventions specified in the are plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. In an interview on 4/24/26 at 2:10 p.m. the DON stated the facility did not have a policy addressing assessment of grab bars.