

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Weslaco Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interviews, and record reviews, the facility failed to ensure the resident's right to personal personal medical records and to personal privacy during medical treatment for 4 (unknown resident, Residents #20, #111, and #84) of 8 residents reviewed for Privacy. 1.The facility failed to ensure the privacy of the unknown resident by not locking the computer screen on a medication cart, leaving the resident's personal and medical information exposed. 2. The facility failed to ensure MA J closed the door, the privacy curtain and the window during medication administration for Residents #20, #111, and #84 on 07/27/2026. These failures could place residents at risk of resident-identifiable information being accessed by unauthorized persons and of not having their personal privacy maintained during medical treatment. Findings included: 1. Observation and interview on 07/27/26 at 9:48 AM, revealed a computer screen on a medication cart in the 400 hallway was left unlocked. The screen displayed the unknown resident's medication information on the screen. Noted on the screen was unknown resident's photo, date of birth , and a medication log. The surveyor called LVN A, who was nearby and asked who the medication cart belonged to. LVN A informed the surveyor that it belonged to LVN C who was in a room providing care to a resident. LVN A quickly locked the screen and proceeded to locate LVN C. In an interview on 07/27/26 at 9:53 PM, LVN C stated she was called to assist a resident while she was at her computer. LVN C stated that she pressed the lock button on the screen and assumed the screen had locked. LVN C stated she walked away from her computer without verifying the screen had locked. LVN C stated it was important to lock the computer screen when not in use because the screen displayed unknown resident's private personal and medical information. LVN C stated exposing private personal and medical information was a HIPAA (a law that protects patient medical privacy) violation. LVN C stated she was aware not to leave any resident information exposed but had just failed to do it this time. In an interview on 07/28/2026 at 2:20 PM, the DON stated LVN stated there were a lot of things going on and LVN C did not verify that the computer screen was locked. The DON stated LVN C stated to her that she was in a hurry and had stepped away from the computer for just a moment. The DON stated staff had been in-serviced (teaching) frequently on HIPAA. The DON stated that it was important for the computer screen to be locked because it contained protective information, and it was not anyone's business what was on the screen. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/28/26 at 4:32 PM, the Administrator stated LVN C was a senior employee but might have gone too fast and did not verify the screen was indeed locked. The Administrator stated all staff were in-serviced on HIPAA several times throughout the year, such as upon hire, monthly in-services and as needed. The Administrator stated it was important to verify that computer screens were locked because computers contained resident information which could be seen by unauthorized people. The Administrator stated there was not a policy specifically for locking computer screens, but HIPAA regulations were enforced. 2. During an observation on 07/27/2026 at 7:32 a.m., MA J kept the door and the privacy curtain open while administering Resident #20's medications, including eye drops, while his roommate was seated between the two beds. During an observation on 07/27/2026 at 7:40 a.m., MA J kept the door and the privacy curtain open while checking Resident #111's blood pressure. She then proceeded to administer her medications including eye drops. During Resident #111 medication administration, several people walked past the room and looked inside. During an observation on 07/27/2026 at 7:51 a.m., MA J kept the door, the privacy curtain, and the window open while checking Resident #84's blood pressure. She then proceeded to administer her medications. In an interview on 07/27/2026 at 8:09 a.m., MA J stated that she was supposed to close the door, the privacy curtain, and window before checking blood pressures and administering medications. She stated that she forgot to do it. MA J stated that it was important because residents should not have to take their medications with other people watching. MA J stated that closing the door, the curtain, and the window was important to provide the residents with privacy during medication administration. During an interview on 07/28/2026 at 2:12 p.m., ADON M stated that staff should provide privacy while providing care and during medication administration. She stated that the staff had been trained quarterly and as needed. She stated that she conducts medication administration skill checkoffs. ADON M stated that during medication administration, staff should take patients to their room, close the door, pull the privacy curtain, and close the blinds to provide privacy. ADON M stated that these measures were important to provide the residents with dignity and privacy. During an interview on 07/28/2026 at 2:34 p.m., the DON stated that staff were expected to provide privacy while assisting with ADL care, performing invasive procedures, providing wound care, completing bed baths, and administering medications. She stated that staff were trained quarterly and as needed. The DON stated that it was important for staff to provide privacy because it was the residents right and preserved their dignity. Record review of the Facility's Manual revised on 07/14/2020 revealed, Statement of Resident Rights You have a right to: (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(8) have facility information about you maintained as confidential Our Responsibilities In addition to providing you your rights, as detailed above, the federal privacy standard requires us to: Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information. Record review of the Facility's Manual revised on 07/14/2020 revealed, Statement of Resident Rights You have a right to: (8) have facility information about you maintained as confidential Our Responsibilities In addition to providing you your rights, as detailed above, the federal privacy standard requires us to: Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information. Record review of the facility's Medication Administration policy dated 10/24/22 reflected, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: 7. Provide privacy.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids 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 parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for one (Resident #7) of six residents reviewed for intravenous fluids. The facility failed to ensure physician orders were written for IV flush (rinsing an intravenous tube with sterile salt water to keep the line clean, clear, and free of blockages) on 7/16/2026 to 7/27/2026. This failure could place residents at risk for infection, catheter occlusion (blockage), and chemical vessel irritation (inflammation of a vein caused when a harsh medication or fluid passing through an IV irritates the lining of the blood vessel). Record review of Resident #7's face sheet, dated 7/27/26, reflected an [AGE] year-old female with an admission date of 7/06/26. Her diagnoses included unspecified dementia (loss of memory, thinking, and reasoning skills that gets in the way of daily living), diabetes mellitus type 2 (condition where the body has too much sugar in the blood because it cannot use insulin properly or make enough of it to turn that sugar into energy), and venous insufficiency [chronic] [peripheral] (condition where the veins in the lower legs have trouble pumping blood back to the heart causing blood to pool in the lower legs and ankles). Record review of Resident #7's quarterly MDS assessment, dated 7/8/26, reflected a BIMS score of 13, which indicated cognitively intact. Section O (special treatments, procedures, and programs) indicated Resident #7 had IV medication while a resident. Record review of Resident #7's care plan, revised date 7/7/26, reflected Resident #7 has the need for Enhanced Barrier Precautions due to PIV/surgical wound/pressure ulcer and is at risk for infection depression, and decline in physical activity. Interventions: Assess for signs and symptoms of infection such as increased white blood count, fever, redness, swelling. Assess the resident for risk factors or current injuries or treatments that could put the patient at risk for infection (wounds, central lines, catheters). Record review of Resident #7's MAR, dated 7/27/26, reflected orders for ceftriaxone (a prescription-only antibiotic medicine) use 1 gram intravenously at bedtime for UTI until 7/13/2026. Start date: 7/6/26. Flush peripheral IV line (pushing a sterile salt-and-water solution through the IV tube in the arm to keep it clear and working properly) with 10 ML of NS before and after each medication administered every shift for IV patency (being open and unblocked). Start date: 7/06/26. D/C date: 7/16/26. Flush peripheral IV line with 10 ML of NS every shift for IV patency maintenance. Start date: 7/06/26. D/C date: 7/16/26. Record review of Resident #7's order summary, dated 7/27/2026, reflected there were no orders to flush the IV catheter. During an observation and interview on 7/27/2026 at 10:04 a.m., Resident #7 was sitting up in her wheelchair with an IV catheter (a tiny, flexible plastic tube placed inside a vein to deliver fluids or medicine directly into the bloodstream) to her right hand. There was no redness and no swelling to the IV site. Resident #7 did not complain of pain or discomfort to the area. During an interview on 7/27/26 at 11:37 a.m., LVN I said there was no order to discontinue the IV catheter and there were no current orders for IV flushes. He said he did not flush the resident's IV catheter on 7/27/26 because there were no physician orders. He said the order to discontinue IV flushes was on 7/16/26. He said the resident received IV hydration on 7/18/26. LVN I said the negative outcomes for Resident #7 not having an order for IV flushes were infection to the IV site and IV infiltration (fluid or medicine from the IV line leaks out of the vein into the soft tissue under the skin). He said he received an in-service on IV medication in July 2026 from the ADON/IP. During an interview on 7/27/2026 at 3:30 p.m., the DON verified that the order for IV flushes were discontinued on 7/16/26 and the IV should have been discontinued at the (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	same time. She said the floor nurses were responsible for ensuring physician orders were received to maintain IV patency. She said during the morning meeting she and the nurses discussed resident care and reviewed residents on IVs. She said an in-service on IV medication was given but could not remember the date. The DON said in-services on medication administration were given monthly. She said a negative outcome for Resident #7 from not having her IV flushed included loss of IV patency and infection to the IV site. Record review of facility policy, dated 10/01/19, titled Parenteral Administration, stated, Policy: To provide for the safe and accurate reconstitution of parenteral medication prior to administration, manufacturer information is reviewed and aseptic technique is observed. 9. Administer medication or add to intravenous (IV) solution as directed and complete documentation.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review, the facility failed to 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 6 of 16 (Resident #39, # 84, #94, #45, #7, and #61) residents reviewed for infection control, 1. The facility failed to ensure that an Enhanced Barrier Precaution (EBP) sign was displayed outside the room of Resident #39. 2. The facility failed to ensure that CMA J performed hand hygiene for at least 20 seconds after medication administration for Resident #84. 3. The facility failed to ensure CNA K performed hand hygiene while assisting Resident #94 and Resident #45 with their lunch on 7/26/26. 4. The facility failed to ensure Resident #7's IV dressing was clean and clearly labeled on 7/27/26. 5. The facility failed to ensure CNA G and CNA H performed proper hand hygiene and proper incontinent care for Resident #61. These failures could place residents at risk for healthcare associated cross-contamination and the spread of infection. 1. Record review of Resident #39's face sheet, dated 07/28/2026, reflected a [AGE] year-old male readmitted on [DATE] with an original admission date of 03/01/2025. His pertinent diagnoses included Stage II Pressure Ulcer (open wound also called a bedsore) and Type 2 Diabetes Mellitus (high blood sugar levels). Record review of Resident #39's comprehensive MDS assessment, dated 05/26/2026, revealed a BIMS score of 09, indicating moderate impaired cognition. Record review of Resident #39's care plan not dated, reflected a stage II pressure ulcer to left sacral area (the lower back and the tailbone). Interventions were to follow wound care orders as directed. Monitor area for signs and symptoms of infection and notify MD. There was no care plan implemented to place resident on enhanced based precautions. Record review of Resident #39's Physician's Order Summary dated 07/26/2026 reflected Silvadene External Cream 1% apply to Left Sacral area topically every day shift for Stage II Pressure Ulcer, Apply to sacrum topically every day shift for Stage 2 pressure wound cleanse with wound cleanser spray pat dry with gauze, then apply Silvadene cream to wound bed followed by adaptic gauze, cover with dry dressing and secure with medfix retention tape start date 07/19/2026. There was no EBP order. Observation on 07/26/2026 at 2:55 p.m. revealed there was no EBP sign displayed outside Resident #39's room. During an interview on 07/26/2026 at 3:25 p.m. LVN L stated that she was Resident #39's nurse. She stated that residents requiring an EBP sign were identified if they have a wound, an indwelling catheter, and other open areas. She stated that the floor nurses were responsible for posting the EBP sign immediately once the need for EBP was identified. LVN L stated that it was important to have the EBP signs posted to alert all staff that the residents had an invasive device or an open wound requiring EBP. She stated Resident #39 had a new pressure ulcer wound in the sacral area. LVN L (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	confirmed there was no EBP sign outside Resident #39's room. She stated that the negative outcome was the spread of infection. During an interview on 07/28/2026 at 2:12 p.m., ADON M, stated residents requiring an EBP sign were identified if they have a G-tube, an indwelling catheter, IV access, a midline catheter (a long, flexible IV tube put into a large vein in the upper arm) or a surgical incision. She stated Resident #39 should have a sign posted on the door. ADON M stated the purpose of the sign was to alert staff to wear the appropriate PPE when providing care or engaging in high resident care activities. ADON M stated any staff member could post the EBP sign but ultimately it was the nursing staff who received the order or in this case identified the wound. She stated that the appropriate PPE for EBP included gloves and a gown. ADON M stated the negative outcome of not having the EBP sign posted was that the spread of infection could be transmitted to the resident from another resident. During an interview on 07/28/2026 at 2:34 p.m., the DON stated that anyone could place the EBP sign on the door, but the responsibility ultimately rested with the nurse who received the order. She stated Resident #39 should have a sign posted on the door because he has a wound. The DON stated that the sign at the door alerts staff to gown up when providing care or taking an extensive amount of time at bedside. She stated that the negative outcome of failing to post the EBP sign was the spread of infection. 2. Record review of Resident #84's face sheet, dated 07/28/2026, reflected an [AGE] year-old female admitted on [DATE] with an original admission date of 02/02/2018. Her pertinent diagnoses included Type 2 Diabetes Mellitus (high blood sugar levels), Chronic Kidney Disease (a long-term condition where the kidneys are damaged and slowly lose their ability to filter waste and extra fluid from the blood), and Chronic Congestive Heart Failure (the heart muscle is too weak or stiff to pump blood well). Record review of Resident #84's quarterly MDS assessment, dated 06/09/2026, revealed a BIMS score of 15, indicating intact cognition. Section GG (functional abilities) indicated Resident #84 needed partial/moderate assistance with upper/lower body dressing, personal hygiene, and toileting hygiene. Record review of Resident #84's care plan not dated, reflected resident had Diabetes Mellitus. Goal: The resident would have no complications related to diabetes. Interventions were monitor/document/report as needed any symptoms of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar). During an observation of medication administration on 07/27/2026 at 7:51 a.m., MA J performed hand hygiene for 11 seconds prior to Resident #84's medication administration. After medication administration, MA J performed hand hygiene for 9 seconds. During an interview on 07/27/2026 at 8:09 a.m., MA J stated that handwashing should be done for at least 20 seconds. MA J stated that it was important to properly wash the hands to prevent the spread of infections. She stated that an in-service for infection control was done last month. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/28/2026 at 2:12 p.m., ADON M stated the process for handwashing was to wash hands for at least 20 seconds. She stated that they frequently conduct in-services on proper handwashing. ADON M stated that it was important for staff to have washed their hands properly because it prevented the spread of infection. She stated that she monitored staff to ensure they were following infection control procedures by conducting random skill check offs to assess proper handwashing. During an interview on 07/28/2026 at 2:30 p.m., ADON/IP stated that she was the infection preventionist. She stated staff should have washed their hands for a minimum of 20 seconds. She stated she instructed them to wash for 30 seconds to be on the safe side. ADON/IP stated staff should have washed their hands as often as possible, including before and after medication administration, before and after resident contact, before and after handling food items, and whenever their hands were visibly soiled. ADON/IP stated the negative outcome of not properly washing hands would be the transmission of infection and contamination. During an interview on 07/28/2026 at 2:34 p.m., the DON stated staff should have washed their hands for 20-30 seconds, but for no less than 20 seconds. She stated they have monthly in services on hand hygiene and additional in services as needed. The DON stated it was important to wash hands thoroughly because it kept everyone safe. The DON stated the negative outcome of failing to properly wash hands would be cross contamination. She stated the staff were monitored through annual skill check offs. 3. Record review of Resident #94's face sheet, dated 7/27/2026, reflected an [AGE] year-old female with an admission date of 8/5/15. Her relevant diagnoses included Parkinsonism (group of brain conditions that cause core movement problems like shaking, muscle stiffness, and slowed motion), unspecified dementia (decline in memory and thinking skills that interferes with daily life, but underlying disease causing it has not yet been determined by doctors), and muscle wasting and atrophy (shrinking, thinning, and weakening of muscles caused by a lack of use, aging, or nerve damage). Record review of Resident #94's quarterly MDS assessment, dated 6/8/26, reflected a BIMS score left blank, which indicated the interview was not attempted. Section GG (functional abilities) indicated Resident #94 needed substantial/maximal assistance with eating. Section K (swallowing/nutritional status) indicated Resident #94 had a mechanically altered diet. Record review of Resident #94's care plan, date revised 6/11/26, indicated Resident #94 has an ADL self-care performance deficit r/t cognitive deficits and overall unsteadiness. Interventions: The resident requires substantial/maximal assistance for eating. Record review of Resident #45's face sheet, dated 7/27/26, reflected a [AGE] year-old female with an admission date of 2/24/26. Her relevant diagnoses included cerebral palsy (lifelong physical condition that affects movement, balance, and muscle control due to an early brain injury or unusual brain development), dysphagia (difficulty swallowing), and muscle wasting and atrophy (shrinking, thinning, and weakening of muscles caused by a lack of use, aging, or nerve damage). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #45's quarterly MDS assessment, dated 5/11/26, reflected a BIMS score of 9, which indicated moderate cognitive impairment. Section GG (functional abilities) indicated Resident #45 needed substantial/maximal assistance with eating. Section K (swallowing/nutritional status) indicated Resident #45 had a mechanically altered diet. Resident #45's care plan, date revised 2/27/26, indicated Resident #45 had an ADL self-care performance deficit r/t weakness, limited ROM, impaired balance/coordination. Interventions: The resident requires tray set up and total staff assist x 1 to assist with meals. During an observation on 07/26/26 12:38 p.m., CNA K was assisting two residents with their meals. CNA K was using her right hand to assist Resident #95 and Resident #45 and not performing hand hygiene in between feedings. During an interview on 7/26/26 at 12:52 p.m., LVN C said she oversaw dining for this week beginning Sunday (7/26/26) through Saturday (8/1/26). She said she supervised choking episodes or residents that were not eating and monitored for safety. She said she monitored CNAs aiding residents that needed assistance with their meals. LVN C said she monitored CNAs to ensure the residents were not being rushed and that CNAs were feeding residents one at a time. She said there could be a problem with infection control when assisting two residents at the same time without performing hand hygiene in between. She said her last in-service on infection control was last week. During an interview on 7/26/26 at 1:07 p.m., CNA K said she had her hand sanitizer in her pocket and was unaware she had not performed hand hygiene between feeding Resident #95 and Resident #45. She said the possibility of cross contamination between residents could have happened by not having performed hand hygiene. She said her last in-service on infection control was two weeks ago. CNA K said she was employed for 7 years and knew she had to perform hand hygiene when assisting two residents at the same time with their meals. During an interview on 7/27/26 at 4:06 p.m., the ADON/IP said she had told the CNAs to assist residents with their meals, one at a time. She said feeding a resident one at a time would reduce the risk of infection. The ADON/IP said she performed an in-service on infection control and hand hygiene on 7/26/26. During an interview on 7/28/26 at 1:55 p.m., the DON said she was aware of not feeding multiple residents at one time. She said if staff were feeding more than one resident, they had to perform hand hygiene between feeding the residents. The DON said CNA K had her hand sanitizer on her person but had forgotten to perform hand hygiene. She said CNA K knew she was supposed to perform hand hygiene when assisting more than one resident with their meals. The DON said hand hygiene was performed during mealtimes to prevent cross contamination. She said the last in-service on infection control and dining practices was in May 2026. 4. Record review of Resident #7's face sheet, dated 7/27/26, reflected an [AGE] year-old female with an admission date of 7/06/26. Her diagnoses included unspecified dementia (loss of memory, thinking, and reasoning skills that gets in the way of daily living), diabetes mellitus type 2 (condition where the body has too much sugar in the blood because it cannot use insulin properly or make (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	enough of it to turn that sugar into energy), and venous insufficiency [chronic] [peripheral] (condition where the veins in the lower legs have trouble pumping blood back to the heart causing blood to pool in the lower legs and ankles).Record review of Resident #7's quarterly MDS assessment, dated 7/8/26, reflected a BIMS score of 13, which indicated cognitively intact. Section O (special treatments, procedures, and programs) indicated Resident #7 had IV medication while a resident. Record review of Resident #7's care plan, revised date 7/7/26, reflected Resident #7 has the need for Enhanced Barrier Precautions due to PIV/surgical wound/pressure ulcer is at risk for infection depression, and decline in physical activity. Interventions: Assess for signs and symptoms of infection such as increased white blood count, fever, redness, swelling. Asses the resident for risk factors or current injuries or treatments that could put the patient at risk for infection (wounds, central lines, catheters). Record review of Resident #7's MAR, dated 7/27/26, reflected orders for ceftriaxone use 1 gram intravenously at bedtime for UTI until 7/13/2026. Start date: 7/6/26. Flush peripheral IV line (pushing a safe, clear saltwater liquid through the small plastic tube in the arm to clean it out and keep it from getting blocked) with 10 ML of NS before and after each medication administered every shift for IV patency (IV line is open clear and working correctly so that fluids and medicine can flow smoothly into the vein without any blockages). Start date: 7/06/26. D/C date: 7/16/26. Flush peripheral IV line with 10 ML of NS every shift for IV patency maintenance. Start date: 7/06/26. D/C date: 7/16/26. Monitor peripheral IV site for redness, tenderness, edema, excessive bleeding and any other abnormalities. Notify MD as needed every shift. Start date: 7/6/26. D/c date: 7/16/26. Change peripheral IV site and dressing as needed for infiltration (fluid or medication from an IV accidentally leaks into the tissue under the skin instead of flowing directly into the vein). Start date: 7/6/26. D/C date: 7/16/26. During an interview on 7/27/26 at 11:37 p.m., LVN I said he did not know the last time Resident #7's IV dressing was last changed. He said he could not read the date labeled on Resident #7's IV dressing. LVN I said not having a dressing clearly labeled could have caused a risk of infiltration and an infection to the IV site. He said he received an in-service by the ADON/IP in July 2026 on infection and control and IV medication. During an interview on 7/27/26 at 3:30 p.m., the DON said Resident #7's IV dressing was not legible and that it was the nurse's responsibility to monitor the resident's IV sites. She said the negative outcomes for Resident #7's IV site not being clearly labeled were increased risk of infection and loss of IV patency. The DON said she performed in-services on IV medication and medication administration monthly. During an interview on 7/27/26 at 4:06 p.m., the ADON/IP said she reviewed physician orders to see which residents were on antibiotic therapy and followed up to check the residents' IV sites. She said not having a legible date labeled on Resident #7's IV dressing could increase the risk of infection for the resident, and nurses would not know when it was last changed. The ADON/IP said IV sites were checked frequently, and all staff should have placed eyes on IV sites. She said the last infection control in-service she performed was on 7/26/26. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5.Record review of Resident #61's electronic face sheet dated 7/27/26 reflected a [AGE] year-old female admitted to the facility on [DATE] and an original admission date of 12/6/24 with diagnoses to include: Alzheimer's (progressive brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple tasks), dementia (loss of cognitive functioning, such as thinking, remembering and reasoning to such an extent that it interferes with a person's daily life and activities), and muscle wasting and atrophy (decrease in size or wasting away of a body part or tissue). Record review of Resident #61's undated comprehensive person-centered care plan reflected Resident #61 had an ADL self-care performance deficit r/t HX of RT femur fx, cognitive deficits, and overall weakness Date Initiated: 12/09/2024 Revision on: 03/24/2025. PERSONAL HYGIENE: The resident requires extensive staff assist x 2 withpersonal hygiene and oral care. Date Initiated: 12/09/2024 Revision on: 06/04/2026. TOILET USE: The resident requires total staff assist x 2 with toileting/incontinent care routinely and PRN Date Initiated: 12/09/2024 Revision on: 06/04/2026 Record review of Resident #61's Quarterly MDS Assessment, dated 5/15/26, reflected Resident #61 had a BIMS of 02 which indicated a severe impairment of mental status. Resident #61 was dependent on self-care for toileting hygiene. During an incontinent care observation on 7/27/26 at 3:00 p.m., CNA G and CNA H performed incontinent care on Resident #61. CNA G grabbed a wipe, cleaned the urinary catheter tubing, and reused the same wipe, wiping up and down the urinary catheter two separate times. CNA G removed her gloves, sanitized her hands, and applied clean gloves. CNA G grabbed a wipe, cleaned the vaginal area, and reused the same wipe three separate times. CNA G removed her gloves, did not sanitize her hands, and applied clean gloves. CNA G grabbed a wipe, cleaned the buttocks area, and reused the same wipe three separate times. CNA G removed her gloves, did not sanitize her hands, and applied clean gloves. CNA H changed her gloves three times during incontinent care. She did not sanitize her hands between the last two glove changes. In an interview on 7/27/26 at 3:27 pm, CNA G said she received training for incontinent care and infection control and was checked off on her skills upon hire and annually. CNA G said she was supposed to wipe using a wipe only once then throw the wipe after using. CNA G said she reused the wipe because she was having difficulty removing the cream the resident had in her vaginal area and because she was nervous. CNA G said for the buttocks she accidentally reused the same wipe when trying to remove the BM from the resident's buttocks. CNA G said she should hand sanitize between glove changes. CNA G said maybe she was nervous when changing gloves so she could not recall if she did not use hand sanitizer. CNA G said it could cause contamination if she did not use hand sanitizer between glove changes or reused wipes. In an interview on 7/27/26 at 3:40 p.m., CNA H said the facility provided in-services on infection control and incontinent care about every 3 months. CNA H said when using wipes, she would use one wipe for each labia and one wipe in the center, disposing of each wipe after each use, using one wipe per swipe. CNA H said when she changed gloves, she should use sanitizer between glove changes. CNA H said she used hand sanitizer when she grabbed gloves on the other side of the bed, but when CNA G passed her gloves on two different occasions after that, she said she did not come around to (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the other side of the bed to get hand sanitizer and did not sanitize her hands at those times. CNA H said if she did not hand sanitize between glove changes, infection control could be compromised. In an interview on 7/28/26 at 7:00 p.m., the DON said incontinent care check-offs were done yearly. The DON said with newer staff it would be done a little more frequently until staff were comfortable with providing appropriate incontinent care. The DON said she also did incontinent care training and check-offs as needed as well as spot checks. The DON said CNAs must sanitize hands between glove changes using hand sanitizer. The DON said that was part of the check-off they did. The DON said wipes were used as one and done, swiped from front to back and not reuse a wipe and staff knew this. The DON said if hands were not sanitized between glove changes and wipes were reused, it could introduce bacteria and cause a UTI unnecessarily and unintentionally. Record review of the facility's policy titled Infection Prevention and Control Program, dated 5/13/23, stated Policy Explanation and Compliance Guidelines: . 4. Standard Precautions: 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. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. d. Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies. Record review of the facility's Enhanced Barrier Precautions policy dated 4/5/24 reflected, Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug resistant organisms. Policy Explanation and Compliance Guidelines: 1. Prompt recognition of need: 2. Initiation of Enhanced Barrier Precautions: b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers). 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the residents room. 4. High contact resident care activities include: h. Wound care: any skin opening requiring a dressing. Record review of the facility's Medication Administration policy dated 10/24/22 reflected, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: 4. Wash hands prior to administering medication per facility protocol and product. Record review of the facility's Hand Hygiene policy dated 10/22/24 reflected, Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations withing facility. Definitions: Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 5. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Record review of the Incontinent Care Skills Checklist for CNA G dated 2/13/26 and 7/27/26 indicated she was checked off as skills met on the following: Miscellaneous7 Remove gloves, sanitize hands and apply new gloves.Female Perineal Care .2. Wipe, across the base of the abdomen (just above the pubic area), going from one side to the other in one direction. Use new wipe or washcloth if wiping more than once. 3 Staring with the top/center of the vaginal area wipe from front towards rectum, front to back, using clean stroke. Never wipe back and forth from the back to the top. Using additional wipes or cloths as needed. 4 Separate labia with hand to expose urethral meatus. Use one stroke method to clean front to back. 5 Wipe labia majora and skin folds. Use one stroke method to clean front to back. 6 Cleanse the inside of the first groin area downward from top to bottom, then get a new wipe or cloth and cleanse the other groin area.7 If catheter is present, gently wipe the catheter tubing with new wipe or cloth from the meatus outward for at least 4 inches of tubing.9 Wipe from vagina toward rectum with one stroke, front to back, repeat if necessary with a new wipe or cloth as all feces must be cleaned off. Record review of the Incontinent Care Skills Checklist for CNA H dated 2/13/26 and 7/27/26 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated she was checked off as skills met on the following: Miscellaneous7 Remove gloves, sanitize hands and apply new gloves.Female Perineal Care .2. Wipe, across the base of the abdomen (just above the pubic area), going from one side to the other in one direction. Use new wipe or washcloth if wiping more than once. 3 Starting with the top/center of the vaginal area wipe from front towards rectum, front to back, using clean stroke. Never wipe back and forth from the back to the top. Using additional wipes or cloths as needed. 4 Separate labia with hand to expose urethral meatus. Use one stroke method to clean front to back. 5 Wipe labia majora and skin folds. Use one stroke method to clean front to back. 6 Cleanse the inside of the first groin area downward from top to bottom, then get a new wipe or cloth and cleanse the other groin area.7 If catheter is present, gently wipe the catheter tubing with new wipe or cloth from the meatus outward for at least 4 inches of tubing.9 Wipe from vagina toward rectum with one stroke, front to back, repeat if necessary with a new wipe or cloth as all feces must be cleaned off. Record review of the facility's Hand Hygiene policy dated 10/22/24 reflected, Policy:All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations withing facility.Definitions:Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR).Policy Explanation and Compliance Guidelines:1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.5. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Record review of facility's Perineal Care policy dated 10/24/22 reflected,Policy:It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown.Policy Explanation and Compliance Guidelines: .9. If perineum is grossly soiled, turn resident on side, remove any fecal material with toilet paper, then remove and discard:a. Cleanse buttocks and anus, front to back; vagina to anus in females, scrotum to anus in males, using a separate washcloth or wipes.10. Re-position resident in supine positions. Change gloves if soiled and continue with perineal care.11. Females: .c. Separate the resident's labia with one hand, and cleanse perineum with the other hand by wiping in direction from front to back (from pubic area toward anus).d. Repeat on opposite side using separate section of washcloth or new disposable wipe. e. Clean urethral meatus and vaginal orifice using clean portion of washcloth or a new disposable wipe with each stroke.16. Remove gloves and discard. Perform hand hygiene.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure the right to be free from chemical restraint was provided for 1 (Resident #13) of 6 residents reviewed for unnecessary medications. The facility failed to ensure Resident #13 had an appropriate diagnosis for Zyprexa (used to treat schizophrenia and bipolar disorder). This failure could place residents at risk of receiving unnecessary psychotropic medications. The findings included: In an interview and observation on 7/27/26 at 12:30 pm Resident #13 was located in the dining area eating her lunch. Resident #13 was groomed and dressed appropriately. Resident #13 had no visible injury observed. Resident #13 did not appear to be in any distress. Resident #13 nodded yes that she was doing ok and nodded yes that she liked her food. Resident #13 shook her head no that she had no concerns or complaints about the facility. Resident #13 only answered simple yes or no questions with head nods and head shakes. Record review of Resident #13's electronic face sheet dated 7/28/26 reflected a [AGE] year-old female admitted to the facility on [DATE] and an original admission date of 11/3/19 with diagnoses to include: dementia (a decline in mental ability severe enough to interfere with daily life), depression (a common and serious mood disorder that causes persistent feeling of sadness, loss of interest in activities and changes in how a person thinks, feels, and behaves), restlessness, and agitation. Record review of Resident #13's quarterly MDS assessment dated [DATE], reflected a BIMS score of 03 which indicated severe cognitive impairment. Review of Section N: Medications revealed Resident #13 was receiving an antipsychotic and antianxiety medication. Record review of Resident #13's undated Comprehensive Care Plan reflected: Resident #13 had episodes of smearing her feces/playing with feces Date Initiated: 01/21/2025. Resident #13 had restlessness/agitation Date Initiated: 06/19/2026. Approach resident in a warm, calm, friendly manner Date Initiated: 06/19/2026 Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.) Date Initiated: 06/19/2026 Notify MD/Hospice if medication was no longer effective or if s/s worsen in frequency/severity Date Initiated: 06/19/2026 Redirect and reassure resident as needed Date Initiated: 06/19/2026 Zyprexa. Resident #13 uses antipsychotic medications Date Initiated: 03/19/2025 Revision on: 03/24/2026 Monitor behaviors PRN, Notify MD/hospice of new or worsening behaviors as Necessary Date Initiated: 03/19/2025 Monitor/document/report PRN any adverse reactions of antipsychotic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Date Initiated: 03/19/2025 Resident #13 and her family had elected to receive Hospice services Date Initiated: 09/06/2024. Contact hospice to report changes in condition Date Initiated: 09/06/2024 Refer for Psychiatric/Psychogeriatric consult if indicated Date Initiated: 09/06/2024 Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. Date Initiated: 09/06/2024 Record review of Resident #13's progress notes from 7/24/26 to 7/27/26 reflect resident had been seen by facility staff, the NP, and hospice services. No new orders given. The hospice nurse reordered Zyprexa. Record review of Resident #13's July 2026 MAR reflected: Zyprexa Oral Tablet 2.5 MG (Olanzapine) Give 1 tablet by mouth one time a day for anxiety/agitation and aggressive behavior related to restlessness and agitation -Start Date- 03/12/2026 - No missed doses. Behavior Monitoring -Antipsychotic Behavior Code: 0. None 1. Mania 2. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Auditory hallucinations 3. Visual hallucinations 4. Delusions 5. Paranoia 6. Grandiosity 7. Biting 8. Danger to self 9. Danger to others 10. Smearing feces 11. Kicking 12. Pinching 13. Extreme fear 14. Striking out/ hitting 15. Other (Document in PN) INTERVENTION(S): Document in PN every shift for Zyprexa -Start Date- 03/12/2025 - No behaviors noted. Side Effect Monitoring - antipsychotic Side Effect Codes: 0. None 1. Stiff Neck 2. Confusion 3. Muscle Rigidity 4. Involuntary Movements 5. Drooling 6. Tremors 7. Restlessness 8. Sleep Disturbance 9. Dry Mouth 10. Blurred Vision 11. Constipation 12. Sedation 13. Other (Document in PN) every shift for Zyprexa -Start Date- 03/12/2025 - No behaviors noted. Record review of Resident #13's order summary report reflected: Admit under hospice . under Dr. Dx: atherosclerotic heart disease of native coronary artery without angina pectoris Active 08/01/2024. Behavior Monitoring - Antipsychotic Behavior Code: 0. None 1. Mania 2. Auditory hallucinations 3. Visual hallucinations 4. Delusions 5. Paranoia 6. Grandiosity 7. Biting 8. Danger to self 9. Danger to others 10. Smearing feces 11. Kicking 12. Pinching 13. Extreme fear 14. Striking out/ hitting 15. Other (Document in PN) Intervention(S): Document in PN every shift for Zyprexa Active 03/12/2025 Side Effect Monitoring - antipsychotic Side Effect Codes: 0. None 1. Stiff Neck 2. Confusion 3. Muscle Rigidity 4. Involuntary Movements 5. Drooling 6. Tremors 7. Restlessness 8. Sleep Disturbance 9. Dry Mouth 10. Blurred Vision 11. Constipation 12. Sedation 13. Other (Document in PN) every shift for Zyprexa Zyprexa Oral Tablet 2.5 MG (Olanzapine) Give 1 tablet by mouth one time a day for anxiety/agitation and aggressive behavior related to restlessness and agitation. Review of manufacturers prescribing information for Zyprexa accessed on 7/20/26 at https://pi.lilly.com/us/zyprexa-pi.pdf revealed: ZYPREXA(R) (olanzapine) is an atypical antipsychotic indicated: As oral formulation for the: Treatment of schizophrenia. Acute treatment of manic or mixed episodes associated with bipolar I disorder and maintenance treatment of bipolar I disorder. Adjunct to valproate or lithium in the treatment of manic or mixed episodes associated with bipolar I disorder. As ZYPREXA and Fluoxetine in Combination for the: Treatment of depressive episodes associated with bipolar I disorder. Treatment of treatment resistant depression. In an interview on 7/28/26 at 6:17 p.m., the NP said the diagnoses of anxiety/agitation and aggressive behavior related to restlessness and agitation were inappropriate diagnosis with an appropriate off-label use. The NP said Zyprexa was used more for a psychosis, schizophrenia and bipolar. He said symptoms of psychosis would include delusions, hallucinations, and origins of mood swings. The NP said restlessness and agitation would be behaviors during the manic phases of bipolar. The NP said he knew very little of Resident #13 due to taking over this case load at the facility as of August 1st. The NP said he would complete a thorough review of his patients at that time, but he did not see himself doing any abrupt medication changes right away since it could cause destabilization of the residents' mental health. In an interview on 7/28/26 at 6:45 p.m., LVN F said during his initial report about Resident #13, the medication Zyprexa helped her not become agitated, so she received care without harm to herself or others. LVN F said behaviors of Resident #13 included refusal of care and combativeness at times. LVN F said Zyprexa was an antipsychotic. LVN F said agitation and restlessness would be symptoms of a diagnosis versus schizophrenia which would be an appropriate diagnosis to prescribe Zyprexa. LVN F said not even anxiety would be an appropriate diagnosis for Zyprexa. LVN F said all prescribed medications must be prescribed for an appropriate diagnosis, especially antipsychotics. LVN F said Resident #13 had not experienced adverse side effects, such as drowsiness or inability to be aroused while on Zyprexa and participated in activities at times. LVN F said Resident #13 was a hospice patient and the hospice company regulated their own care plans and medications. LVN F said if there were special circumstances for Resident #13 to be given Zyprexa for off label-use, it should have been placed in the hospice care plan. In an interview on (continued on next page)		

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/28/26 at 7:00 p.m., the DON said Zyprexa was prescribed to Resident #13 by the hospice's medical director due to Resident #13 being combative when provided care by the CNAs. The DON said Resident #13 also scratched herself and played with her own feces. The DON said the facility asked hospice if they could use their own psychiatrist to treat Resident #13, and the hospice medical director said no he would manage her care. The DON said Resident #13 was not as combative as she used to be and her quality of care was better with the Zyprexa, so it helped. The DON said staff monitored Resident #13 for any adverse side effects, such she stayed asleep all the time, and there were none. The DON said Resident #13's hospice nurse checked on her weekly. The DON said Zyprexa should be prescribed for an appropriate diagnosis. The DON said she was not sure why the doctor went straight to prescribing Zyprexa, but since Resident #13 was hospice, the facility must follow their diagnoses. The DON said agitation and restlessness were considered more behavior rather than diagnoses, but the behaviors could be related to an actual diagnosis. The DON said Resident #13 did not have a diagnosis of psychosis, schizophrenia, or bipolar. Record review of the facility's Medication Monitoring policy dated 10/1/19 reflected: Policy: The facility employs a system to assure that medication usage is evaluated on an ongoing basis. Procedure: 1. The interdisciplinary team reviews the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis in accordance with the policy on Medication Management. 2. When a resident receives a new medication, the medication order is evaluated for the following: A. The dose, route of administration, duration, and monitoring are in agreement with current clinical practice, clinical guidelines, and/or manufacturer's specifications for use. B. A written diagnosis/indication support the use of the medication. G. The prescriber documents the clinical rationale in the resident's active record for using a medication outside these state guidelines.		

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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 interview, and record review, the facility failed to develop and implement a person-centered care plan for each resident that included 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 of 8 residents (Resident #39) reviewed for comprehensive care plans in that: The facility failed to develop and implement a comprehensive person-centered care plan for Resident #39's Enhanced Based Precautions. These failures could place residents at risk of not receiving the appropriate care, services or treatment needed in a timely manner. Record review of Resident #39's face sheet, dated 07/28/2026, reflected a [AGE] year-old male admitted on [DATE] with an original admission date of 03/01/2025. His pertinent diagnoses included Stage II Pressure Ulcer and Type 2 Diabetes Mellitus (high blood sugar levels). Record review of Resident #39's MDS assessment, dated 05/26/2026, revealed a BIMS score of 09, indicating moderate impaired cognition. Record review of Resident #39's care plan not dated, reflected resident had a stage II pressure ulcer to left sacral area. Interventions were to follow wound care orders as directed. Monitor area for signs and symptoms of infection and notify MD. There was no care plan implemented to place resident on enhanced based precautions. Record review of Resident #39's Physician's Order Summary dated 07/26/2026 reflected Silvadene External Cream 1% apply to Left Sacral area topically every day shift for Stage II Pressure Ulcer, Apply to sacrum topically every day shift for Stage 2 pressure wound cleanse with wound cleanser spray pat dry with gauze, then apply Silvadene cream to wound bed followed by adaptic gauze, cover with dry dressing and secure with medfix retention tape start date 07/19/2026. There was no EBP physician order. During an interview on 07/28/2026 at 10:01a.m. LVN A stated that she was one of the MDS nurses. She stated that she was responsible for developing the care plan for Resident #39. LVN A stated that enhanced based should have been care planned but there was no order. She stated that the negative outcome of not care planning would have been the spread of infection. During an interview on 07/28/2026 at 2:34 p.m., the DON stated that any nurse could develop the EBP care plan but ultimately the nurse who gets the order would enter it right away. She stated that enhanced based precautions should have been care planned but there was no physician order in place. The DON stated that it was important for it to be completed to make sure that the resident has a patient centered care plan. Record review of the facility's Comprehensive Care Plans policy, dated 10/24/22 revealed: 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 residents medical, nursing, and mental and psychosocial needs that are identified in the residents comprehensive assessment. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the residents strengths and needs and will incorporate the residents personal, and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma informed. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the residents needs as identified in the residents comprehensive assessments.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Weslaco Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have services provided by qualified persons in accordance with each resident's written plan of care for 1 of 1 resident (Resident #26) reviewed for care plan in that: CNA D administered liquid cough medication to Resident #26 on 7/23/26, which was not in her scope of practice. This failure could place residents who received medication at risk for improper care. Findings included: Record review of Resident #26's face sheet, dated 7/28/26, reflected a [AGE] year-old male with an admission date of 11/14/26. His relevant diagnoses included dysphagia (difficulty swallowing), paraplegia (loss of movement and sensation in the lower half of the body), and fibromyalgia (long-term medical condition causing widespread body pain, extreme tiredness, and sleep problems). Record review of Resident #26's quarterly MDS assessment, dated 6/30/26, reflected a BIMS score of 15, which indicated intact cognition. Section GG (functional limitation in range of motion) indicated the resident had impairment on both sides to his lower and upper extremities (arms, legs, hands, and feet). Record review of Resident #26's care plan, date revised on 12/31/25, reflected Resident #26 has c/o cough at times, PRN medication in place to treat. Interventions: Administer medication as ordered. Record review of Resident #26's physician orders, dated 7/27/26, reflected orders for guaifenesin oral liquid 200 MG/10 ML give 10 ML by mouth every 4 hours as needed for cough. Order date: 3/18/25. During an interview on 07/27/26 at 10:28 a.m., Resident #26 said CNA D had given him cough medicine last week. He said the nurse was supposed to bring it to him. Instead, the medication was brought by the CNA. During an interview on 7/27/26 at 1:34 p.m., CNA D said Resident #26 had told her that he wanted his cough medicine. She said she informed RN E that Resident #26 wanted his cough medicine. CNA D said she had told RN E that if he wanted, she could give the resident the medicine. She said RN E was supervising her as he stood by the resident's door. CNA D said CNAs were not authorized to give medication and that it was her error by giving it. She said the medication was in liquid form and was for his cough. CNA D said she gave him the medicine about one week ago but was not sure of the exact date. She said a negative outcome for the resident from her giving him the cough medicine was that he could have spilled it, or the resident could have had difficulty swallowing it. She said the last in-service she had was last week on ANE. During an interview on 7/28/26 at 1:55 p.m., the DON said she was informed by Resident #26 that CNA D had given him cough medicine. She said the resident filed a grievance, and she followed up with CNA D and RN E. She said she counseled both employees and provided further education and in-services on medication administration for RN E. During an interview on 7/28/26 at 2:46 p.m., RN E said Resident #26 was angry at him and had asked him for cough medicine. He said he poured the medication in a cup as ordered and handed the cup to CNA D while he stood at the resident's doorway to ensure safety. He said CNA D and Resident #26 were within his sight. He said the DON had given him an extensive lecture about medication administration and had an in-service on the five rights of medication administration. RN E said there was no negative outcome for Resident #26 from having the CNA administer the cough medicine. Record review of complaint/grievance follow-up report, dated 7/23/2026, indicated a grievance filed by Resident #26 regarding medication given by the CNA. The resolution to the grievance indicated there were no negative outcomes for Resident #26. Record review of facility policy titled Medication Administration, dated 10/24/22, stated, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Record review of CNA job (continued on next page)		

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

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	description, undated, stated, Essential functions: Assist resident in customary daily requirements and tasks in care and treatment such as bathing, feeding, dressing, observing intake of food, care of hair, nails, moving residents from area to area, responding to calls. Carry out duties and responsibilities in accordance with resident care policy and procedures. Measure and record vital signs as assigned by Charge Nurse. Detect and report situations that may cause resident accidents or injuries. Contribute knowledge of resident's conditions/needs to resident care plans. Observe and report symptoms, reactions and changes of condition to residents to Charge Nurse.		

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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 such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 3 (Resident #133) residents reviewed for respiratory care. The facility failed to ensure Resident #133's oxygen was administered on 07/26/26 as ordered by the physician. This deficient practice could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care. The findings included: Record review of Resident # 133's admission record dated 07/26/26 revealed a [AGE] year-old female with an admission date of 07/22/24. The diagnoses for Resident #133 included: combined congestive heart failure (when the heart muscle both weakens (failing to pump properly) and stiffens (failing to relax and fill adequately)), acute (it can happen very fast) and chronic (build up slowly over a long period of time) respiratory failure (not enough oxygen passes from your lungs to your blood), dyspnea (shortness of breath), and essential hypertension (high blood pressure). Record review of Resident #133's admission BIMS assessment dated [DATE] revealed resident had a score of 15 which indicated resident was cognitively intact. Record review of Resident #133's admission MDS dated [DATE] revealed MDS was still in progress therefore not completed at the time of the record review. Record review of Resident #133's admission Care Plan dated 07/23/26 revealed Problem: [Resident #133] has oxygen therapy r/t respiratory failure. Interventions: OXYGEN SETTINGS O2 via nasal cannula (a thin plastic tube with two short prongs that delivers supplemental oxygen directly into the nostrils) as ordered per MD Date Initiated: 07/23/2026. Record review of Resident #133's active Physicians Order Summary Report dated 07/26/26, revealed an order dated 07/23/26 for Oxygen at 2 LPM via NC every shift for hypoxia (low levels of oxygen in your body tissues) related to acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia (having too much carbon dioxide in the blood). During an observation and interview of Resident #133 on 07/26/26 at 2:56 pm, revealed resident was on oxygen therapy. Resident #133 had a nasal cannula (a thin plastic tube with two short prongs that deliver supplemental oxygen directly into the nostrils). The oxygen concentrator machine (a medical device that filters ambient air to deliver oxygen) was at the level of 2.5 LPM. Resident #133 was in bed, with the head of the bed elevated. No signs of respiratory distress were noted. Resident #133 stated she had to be on oxygen therapy all the time; if she did not have oxygen, she would be short of breath. Resident #133 stated she knew the oxygen level had to be on 2 LPM. Resident #133 stated the nurses managed her oxygen therapy. Resident #133 stated she was not able to reach the concentrator. During an observation and interview on 07/26/26 at 3:17 pm, LVN B stated Resident #133 had an order for oxygen at 2 LPM. LVN B observed Resident #133's oxygen concentrator machine and stated that the current reading was just a little above the ordered setting. LVN B stated he checked on Resident #133 every 2-3 hours in which he also checked the setting of the oxygen concentrator. LVN B stated the last time he had checked on Resident #133 was around 12:00 pm and the oxygen setting was at 2 LPM. LVN B stated he did not know how the oxygen setting was moved but stated it could have been caused by the vibration of the oxygen concentrator itself. LVN B stated it was important to check the oxygen setting to make sure Resident #133 was getting the accurate amount of oxygen. LVN B stated that if Resident #133 did not receive the correct amount of oxygen, she would get hypoxia and go into respiratory distress. In an interview on 07/28/2026 at 2:20 pm, the DON stated the charge nurse was in charge of checking the oxygen settings. The DON (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated LVN B checked on Resident #133 right after the observation and resident was satting (amount of oxygen being carried in the red blood cells) at 99% (representing optimal blood-oxygen levels between 95% and 100%). The DON stated it was important to check Resident #133 to ensure she was getting the correct oxygen amount. The DON stated that the facility did not have a policy regarding oxygen settings. In an interview on 07/28/26 at 4:32 pm, the Administrator stated that all the halls are rounded (walk throughs to check on the wellbeing of residents) frequently. The administrator stated that all staff had been in-serviced (teaching) on how to read the oxygen flow meter (device used to measure and adjust the flow rate of oxygen) on the oxygen concentrator. The Administrator stated that all oxygen concentrators have been serviced as a preventive measure to ensure all oxygen concentrators were working properly.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles for 1 (hall 300 med aide cart) of 4 medication carts reviewed for storage and labeling. The facility failed to ensure three boxes of eye drops were labeled with an open date on 7/26/26 at 2:10 p.m This failure could place residents at risk for adverse effects and not having received the therapeutic effects of the medication or treatment. Findings included: During an observation on 7/26/26 at 2:10 p.m. of the Hall 300 med aide medication cart, with CMA J, revealed there were two boxes of Brimonidine (used to treat elevated pressure in the eye) eye drops and one box of fluorometholone (steroid used to treat swelling redness and itching of the eye) eye dops that were not labeled with an open date. During an interview on 7/26/26 at 2:20 p.m., CMA J said medication aides labeled eye drops with an open date when they were first opened. She said the ADON and the pharmacy consultant checked eye drops to ensure they were labeled with an open date. She said it was the medication aide's responsibility to check and ensure eye drops were labeled. She said the eye drops expired 30 days after the day they were opened. CMA J said she would not know when the medication expired without the open date written on the eye drops. She said the last in-service she received was in June 2026 on medication administration. During an interview on 7/28/2026 at 2:15 p.m., the DON said they label OTC medications with an open date as well as insulin and eye drops. She said the charge nurses and the medication aides were responsible for checking and ensuring eye drops were labeled. She said she and the ADONs performed spot checks and checked for expired medication, medication labeled with an open date, checked for loose pills, and pulled out medication from the medication carts that were discontinued. She said it was important to know when eye drops were opened because then the nurse would know the life expectancy of the medication and when to discard the medication. The DON said in-services on medication administration were done every quarter and as needed. Record review of the facility policy titled, Expiration Dating and Expired Medication, dated 10/01/19, stated . 8. It is the responsibility of all nurses who administer medications to monitor the expiration dates of the medications. Expired medications will not be administered in the facility. All expired medications will be disposed of per facility policy. 9. A continuous monitoring system will be designated by the Director of Nursing to identify expired medications and remove the from the medication system.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. On 07/26/26, the facility failed to ensure drink items in the refrigerator were labeled and dated. On 07/26/26, the facility failed to ensure a drink item in the refrigerator was covered and sealed to prevent exposure to air and cause cross contamination. These failures placed all residents who had drinks served by the kitchen at risk for food-borne illness. Findings included: Observation of the refrigerator on 07/26/26 at 10:15 AM revealed 3 juice pitchers not labeled or dated when made. One of the juice pitchers did not have a lid on it. In an interview on 07/26/26 at 10:17 AM, the [NAME] stated she did not know why the food items had not been labeled. The [NAME] stated it was important to label the juice pitchers because of the 1st in 1st out rule (a system that rotates food so that the oldest items are used first). The [NAME] stated that if the rule was not used, food that was not used could expire. The [NAME] stated if expired food was served to residents, they could get sick or get food poisoning. The [NAME] stated that it was important for items to be covered to prevent things from falling inside the container that could cause residents to get sick. In an interview on 07/27/26 at 9:45 AM, the DM stated it was the responsibility of the person that made the food or drink, to label it. The DM stated it was important for every food item to have a label because items could expire and if served to the residents, the residents would become sick. In an interview on 07/28/26 at 2:20pm, the DON stated that the DM was in charge of overseeing the kitchen therefore she did not get involved in the finding. The DON did not have further comments. In an interview on 07/28/26 at 4:32pm, the Administrator stated that as a dietitian, she had no concern with the pitchers of juice not being labeled or covered. The Administrator stated that as long as the pitchers were used for immediate service, she did not worry about it. Record review of the Food Storage Policy with a revised date of 06/01/19 revealed the following: 2. Refrigerators a. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage.		

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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 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 observation, interviews and record review, the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete, accurately documented, readily accessible, and systematically organized for 1 of 16 residents (Resident #39) reviewed for resident records. The facility failed to ensure a physician order was written for enhanced barrier precautions for Resident #39 on 07/19/2026. This failure could place residents at risk for incorrect treatment decisions, evaluation, and treatment plans compromising patient safety due to inaccurate medical records. Record review of Resident #39's face sheet, dated 07/28/2026, reflected a [AGE] year-old male admitted on [DATE] with an original admission date of 03/01/2025. His pertinent diagnoses included Stage II Pressure Ulcer (open wound also called a bedsore) and Type 2 Diabetes Mellitus (high blood sugar levels). Record review of Resident #39's MDS assessment, dated 05/26/2026, revealed a BIMS score of 09, indicating moderate impaired cognition. Record review of Resident #39's care plan not dated, reflected a stage II pressure ulcer to left sacral area (the lower back and the tailbone). Interventions were to follow wound care orders as directed. Monitor area for signs and symptoms of infection and notify MD. There was no care plan implemented to place resident on enhanced barrier precautions. Record review of Resident #39's Physician's Order Summary dated 07/26/2026 reflected Silvadene External Cream 1% apply to Left Sacral area topically every day shift for Stage II Pressure Ulcer, Apply to sacrum topically every day shift for Stage 2 pressure wound cleanse with wound cleanser spray pat dry with gauze, then apply Silvadene cream to wound bed followed by adaptic gauze (a special medical mesh coated in petroleum jelly), cover with dry dressing and secure with retention tape start date 07/19/2026. There was no EBP order. During an interview on 07/26/2026 at 3:25 p.m., LVN L stated that the person who was responsible for entering the enhanced based precaution order was the nurse who found the wound. She did not know that there was no enhanced based precaution order for Resident #39. LVN L stated it was important to have a physician order in place to make sure that the order was followed through for safety. During an interview on 07/28/2026 at 2:12 p.m., ADON M stated that the nurses were responsible for entering physician orders. She stated the nursing staff who received the order should be the one who entered it. ADON M stated the physician order needed to be placed in the record as soon as the nurse got the order. She stated that she was not aware Resident #39 did not have a physician order for enhanced based precautions. ADON M stated that a physician order needed to be in place to implement necessary precautions for staff. During an interview on 07/28/2026 at 2:34 p.m., the DON stated the person responsible for entering the physician order were the nurses. She stated the order should be entered as soon as they get the orders. The DON stated it was important for the order to be in place to ensure the intervention was care planned, appropriate signage was posted, and the resident was protected from unnecessary bacteria that could have been transmitted from staff clothing when providing care. Record review of the facility's Enhanced Barrier Precautions policy dated 4/5/24 reflected, Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug resistant organisms. Policy Explanation and Compliance Guidelines: 1. Prompt recognition of need: 2. Initiation of Enhanced Barrier Precautions: b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds. 4. High contact resident care activities include:		

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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 - Potential for minimal harm Residents Affected - Some	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 residents' status for 1 of 8 residents (Resident #10) reviewed for assessments: Resident #10's Quarterly MDS assessments dated 03/12/2026 and 06/08/2026, were not coded to include his diagnosis of Anxiety. This failure could place residents at risk for inadequate care due to inaccurate assessments. Record review of Resident #10's face sheet, dated 07/27/2026, reflected a [AGE] year-old male admitted on [DATE]. His pertinent diagnoses included Depression, Anemia, Muscle Wasting and Atrophy (a wasting away or progressive decline of the muscle), and Type 2 Diabetes Mellitus (high blood sugar levels). Record review of Resident #10's Quarterly MDS assessment, dated 06/08/2026, reflected a BIMS score of 07, indicating he was severely cognitively impaired. Section I - Active Diagnoses, Psychiatric/Mood Disorder: Did not have Anxiety Disorder checked off. Quarterly MDS dated [DATE], reflected a BIMS score of 05, indicating he was severely cognitively impaired. Section I - Active Diagnoses, Psychiatric/Mood Disorder: Did not have Anxiety Disorder checked off. Record review of Resident #10's care plan not dated, reflected resident had Anxiety. Interventions were to administer medication as ordered. Behavioral health consults as needed. Notify MD and RP if signs and symptoms of anxiety not relieved with medication or if signs or symptoms of anxiety increase in frequency and intensity. Record review of Resident #10's physician order summary, dated 07/28/2025, reflected the resident had medication order for Buspirone 10 mg tablet for Anxiety Disorder with start date of 02/25/2026. During an interview on 07/28/2026 at 10:01a.m. LVN A stated that she was one of the MDS nurses. She stated that she was responsible for completing the MDS assessments for Resident #10. She confirmed that the diagnosis for Anxiety had not been coded on quarterly MDS assessments dated 03/12/2026 and 06/08/2026. LVN A stated that the diagnosis of Anxiety should have been included in both MDS assessments for Resident #10 but had been omitted. She stated that there was no negative outcome related to the accuracy of the MDS assessment. During an interview on 07/28/2026 at 2:34 p.m., the DON stated that the MDS nurse was responsible for completing the MDS assessments. She stated the regional MDS reviewed the assessments for accuracy but was unsure why the diagnosis was missed on both quarterly assessments. The DON confirmed that Resident #10 had a diagnosis of Anxiety. She stated that it was important for the MDS assessments to be completed accurately to ensure compliance. Record review of the CMS's RAI Version 3.0 Manual dated October 2025, revealed Section I: Active Diagnoses. Intent: the items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status. I0100-I8000: Active Diagnoses in the Last 7 Days-Check all that applyPsychiatric/Mood DisorderI5700. Anxiety Disorder Record review of the facility policy, titled Documentation in Medical Record, dated 10/24/22, revealed: Policy: Each residents medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the residents progress through complete, accurate, and timely documentation.		