STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676119	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Grande City Nursing and Rehabilitation Center	2530 Central Palm Dr Rio Grande City, TX 78582

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676119	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Grande City Nursing and Rehabilitation Center	2530 Central Palm Dr Rio Grande City, TX 78582

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure the residents have the right to be informed of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers, for 1 of 3 residents (Resident #1) reviewed for consent for antipsychotic medications in that: Resident #1 was prescribed and administered Haldol (an antipsychotic) without prior consent based on information of the benefits, risks, and options available. This failures could affect the right to self-determination of all facility residents who receive medication by allowing them to receive medication without their prior knowledge or consent, or that of their responsible party or emergency contacts.The findings included:Record review of Resident #1's admission record dated 11/19/25 reflected, a [AGE] year-old male. His relevant diagnoses included schizophrenia (a serious brain disorder characterized by a distorted perception of reality, with symptoms including hallucinations, delusions, disorganized thinking, and social withdrawal), anxiety disorder (a mental health condition characterized by persistent and excessive worry that interferes with daily life, causing symptoms like a racing heart, fatigue, difficulty concentrating, and physical tension), major depressive disorder (persistent sadness and a loss of interest in activities), and bipolar disorder (a mental health condition characterized by extreme mood swings, including periods of mania and depression). Record review of Resident #1's 5-day MDS assessment dated [DATE], reflected a BIMS score of 7, which indicated his cognition was severely impaired. It further stated he had received antipsychotics on a routine basis only. Record review of Resident #1's initial care plan dated 11/04/25 reflected:Problem: the resident uses Antipsychotic medications d/t schizophrenia (date initiated 04/27/25 and revised on 11/02/25).Interventions: .Haloperidol lactate injection solution 5 MG/ML, inject 1 application intramuscularly one time for aggression for 1 day (date initiated 11/02/25) Record review of Resident #1's order summary report dated 11/19/25, reflected an order for Haldol injection solution 5 mg/ml (Haloperidol lactate) inject 2 ml intramuscularly (injecting medication deep into muscle) every 24 hours as needed for schizophrenia for 14 days=10 mg, with an effective date of 11/06/25. Record review of Resident's #1's progress note dated 11/06/2025 at 9:58 am, authored by ADON A reflected: During the night shift, resident became verbally aggressive toward CNA, insisting to be taken to the kitchen, stating it was morning. Resident refused morning medications and stated to the nurse, te [NAME] a dar [NAME] cachetada (I'm going to slap you). NP was informed and provided new orders to administer Haldo (Haloperidol Lactate) 5 mg/ml, 2 ml IM every 24 hours as needed for 14 days. Medication administered to right deltoid (the large triangular muscle that forms the rounded contour of the shoulder) as ordered. Resident tolerated injection without complications. Resident stayed in bed laying down with his cell phone. n an interview on 11/19/25 at 12:59 pm, ADON A said at the beginning of her 8 am to 5 pm shift on 11/06/25, she was given report by the outgoing CNA that was assigned to Resident #1 (1:1) he had been verbally aggressive towards her and that he had threatened to slap her. She said she immediately called Resident #1's NP, but didn't get an answer, so she left a message. ADON A said while she was in the morning meeting, Resident #1's NP returned her call and gave a new order for a Haldol injection. ADON A said she had quickly left the meeting to go administer the Haldol injection to Resident #1. She said prior to administering the injection, she had called Resident #1's RP for consent, which RP gave verbal consent. ADON A said after she administered Resident #1 the Haldol injection she returned to the morning meeting. She said after the morning meeting, she had emailed Resident #1's RP a consent form for her to sign. ADON A was observed as she reviewed Resident #1's electronic medical record and said she must have forgotten to document that Resident #1's RP had given verbal consent on the progress note she authored on 11/06/25 at 9:58 am. ADON A said after she reviewed Resident #1's electronic medical record the signed consent form for Haldol had not been received/uploaded. ADON A said Resident #1's RP had not returned the signed consent form for Haldol. She was observed as she looked for the email, she had sent Resident #1's RP on 12/01/25 and said she was only able to retrieve the email but did not see an attachment (consent form). ADON A said part of her responsibility as an ADON was to audit new psychotropic orders as they come in to ensure the resident or their RP had given consent prior to being administered. She said she was not sure how or why she had missed Resident #1's RP had not sent back the signed consent form for Haldol. ADON said there were no negative outcome to Resident #1's RP not signing a consent form for the administration of Haldol because RP had verbally consented via phoneIn an interview and observation on 11/19/25 at 1:29 pm, the DON said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676119	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Grande City Nursing and Rehabilitation Center	2530 Central Palm Dr Rio Grande City, TX 78582

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676119	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Grande City Nursing and Rehabilitation Center	2530 Central Palm Dr Rio Grande City, TX 78582

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable, physical, mental, and psychosocial well-being for 1 of 4 CNAs (CNA B) reviewed for competent nursing care. The facility failed to ensure CNA B communicated Resident #2's change of condition to the charge nurse on 12/01/25. This failure could place residents at risk of not having change in conditions assessed, decreased quality of life, and/or death. The findings included:Record review of Resident #2's admission sheet dated 11/18/25, reflected a [AGE] year-old female with an admit date of 10/27/25 and an initial admission date of 09/28/22. Her relevant diagnoses included vascular dementia, pain in left knee, malignant neoplasm of skin, protein-calorie malnutrition, and chronic obstructive pulmonary disease. Record review of Resident #2's significant change MDS assessment dated [DATE], reflected a BIMS score of 7, which indicated her cognition was severely impaired. Record review of Resident #2's initial care plan dated 10/28/25 reflected a:Problem: Resident on 10/01/25 alleging alguen [NAME] me pego (someone here hit me). Resident with pain in the right upper rib pain. Interventions included a 24/48/72 follow up, counseling services referral, investigation initiated and ongoing, law enforcement report completed, psychosocial follow up with social services, x-ray to right ribs (negative for fractures), stat (immediately) CMP/Ammonia (labs), pending CBC, UA for dysuria (pain, burning, or discomfort during urination, 10/01/25 labs and UA reported new orders as follows: iron panel studies, Levofloxacin 750 mg po qd for 5 days for dysuria (date initiated 10/01/25).Record review of Resident #2's change in condition 10/01/25 at 12:15 pm, authored by ADON E reflected, the change in condition was pain to right upper rib area. which started on 10/01/25. and this condition had not occurred before. Mental status changes included increased confusion and new or worsening behavioral symptoms.GU (Genitourinary)/Urine changes .painful urination, increased confusion.Nurse suggestion, lab work, x-ray, and provider visit. Nursing notes: Immediate assessment performed: no visible bruising, redness, swelling, or other signs of trauma noted to right rib area. No other findings noted upon full skin assessment. Resident upon palpation of right upper rib area no complaints of pain or discomfort but when asked if any pain would state that the right upper rib area was the area of pain with a pain scale of 8 out of 10. Resident able to move upper and lower extremities with no discomfort or pain. Resident had PRN pain medication administered at the time due to voiced pain to right upper rib area. Record review of CNA B's written statement taken on 10/01/25 reflected Today around 7:30 am I went with my partner [CNA C] to [Resident #2's] room to assist her to shower chair. She voiced mild discomfort in her right rib area as she sat down.In a telephone interview on 11/18/25 at 10:30 am, CNA B said on 10/01/25 at about 7:30 am, she along with CNA C went to Resident #2's room to transfer her to the shower. She said between her and CNA C transferred Resident #2 to the shower chair. She said while Resident #2 was being transferred to the shower chair, she voiced that she had mild pain to her right side by the rib area and proceeded to touch the area that was hurting her. CNA B said the transfer continued and by the time they got to the shower room, Resident #2 no longer complained and had insisted on washing her own body. CNA B said Resident #2 did not complain of pain to her right side in the shower room, when being transferred back to her room, and when transferred to her wheelchair. CNA B said she did not tell the charge nurse, Resident #2 had voiced pain to her right side because earlier in the morning (between 6 am and 7 am) she had seen Resident #2's PA visit her and she assumed Resident #2 had told her PA of the pain she had on her right side and because once she got to the shower room she no longer complained of pain CNA B said if PA had not rounded earlier in the morning, she would have notified Resident #2's charge nurse, that she had complained of pain to her right side. CNA B said she had been in-serviced on reporting change of condition to the charge nurse regularly but in this case she had assumed Resident #2 had informed her PA when he visited her earlier that morning. In an observation and interview on 11/18/25 at 9:30 am, Resident #2 was observed lying in bed awake. She said she had not been abused by anyone in the facility. She said if anyone abused her, she would notify her nurse immediately. In an interview on 11/18/25 at 10:40 am, LVN E said on 10/01/25 at around 6:00 am, she had accompanied Resident #2's PA for his weekly visit. LVN E said Resident #2 had not complained of any pain and had not mentioned anyone had hit her during the visit. LVN E said during noon hour, Resident #2 was sitting in her wheelchair in the dining room when she saw NP F in the hallway and she called him. LVN E said Resident #2 made an allegation of abuse to NP F. She said NP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676119	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Grande City Nursing and Rehabilitation Center	2530 Central Palm Dr Rio Grande City, TX 78582

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676119	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Grande City Nursing and Rehabilitation Center	2530 Central Palm Dr Rio Grande City, TX 78582

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 3 (Resident #1) residents reviewed for pharmacy services. The facility failed to ensure ADON-LVN A signed off the administration of Haldol injection solution 5 mg/ml (Haloperidol lactate) for Resident #1 on 11/06/25. This failure could place residents at risk of not receiving their medications as ordered by their physician.The findings included:Record review of Resident #1's admission record dated 11/19/25 reflected, a [AGE] year-old male. His relevant diagnoses included schizophrenia (a serious brain disorder characterized by a distorted perception of reality, with symptoms including hallucinations, delusions, disorganized thinking, and social withdrawal), anxiety disorder (a mental health condition characterized by persistent and excessive worry that interferes with daily life, causing symptoms like a racing heart, fatigue, difficulty concentrating, and physical tension), major depressive disorder (persistent sadness and a loss of interest in activities), and bipolar disorder (a mental health condition characterized by extreme mood swings, including periods of mania and depression). Record review of Resident #1's 5-day MDS assessment dated [DATE], reflected a BIMS score of 7, which indicated his cognition was severely impaired. Record review of Resident #1's initial care plan dated 11/04/25 reflected:Problem: the resident uses Antipsychotic medications d/t schizophrenia (date initiated 04/27/25 and revised on 11/02/25).Interventions: .Haloperidol lactate injection solution 5 MG/ML, inject 1 application intramuscularly one time for aggression for 1 day (date initiated 11/02/25)Record review of Resident #1's order summary report dated 11/19/25, reflected an order for Haldol injection solution 5 mg/ml (Haloperidol lactate) inject 2 ml intramuscularly every 24 hours as needed for schizophrenia for 14 days=10 mg effective 11/06/25.Record review of Resident's #1's progress note dated 11/06/2025 at 9:58 am, authored by LVN-ADON A reflected: During the night shift, resident became verbally aggressive toward CNA , insisting to be taken to the kitchen, stating it was morning. Resident refused morning medications and stated to the nurse, te [NAME] a dar [NAME] cachetada (I'm going to slap you). ADON was notified. NP was informed and provided new orders to administer Haldo (Haloperidol Lactate) 5 mg/ml, 2 ml IM (10 MN) every 24 hours as needed for 14 days. Medication administered to right deltoid as ordered. Resident tolerated injection without complications. Resident stayed in bed laying down with his cell phone. Record review of Resident #1's eMAR for the month of 11/2025 did not reflect an entry for a Haldol injection solution 5 mg/ml (Haloperidol lactate) inject 2 ml intramuscularly every 24 hours as needed for schizophrenia for 14 days=10 mg In an interview on 11/19/25 at 12:59 pm, ADON-LVN A said on 11/06/25 during the morning meeting (exact time no given) Resident #1's NP called in a new order for a Haldol injection solution 5 mg/ml (Haloperidol lactate) for his aggressive behavior. She said she was one of the few nursing staff Resident #1 would allow to administer medication so she took it upon herself to step out of the morning meeting to go administer the Haldol injection. She said after she administered the injection, she returned to the morning meeting. She said she must have forgotten to sign off the Haldol injection in Resident #1's electronic medical record because she was in hurry to return to the morning meeting. ADON-LVN said there were no negative outcome to Resident #1 not having his Haldol injection signed off on his electronic medical record because she had documented on his progress notes that it had been administered. In an interview and observation on 11/19/25 at 1:29 pm, the DON was observed as she reviewed Resident #1's electronic medical record and said ADON-LVN A had not signed off the administration of Haldol injection solution 5 mg/ml (Haloperidol lactate) on 11/06/25. The DON said there was no negative outcome to Resident #1 not having his Haldol injection solution 5 mg/ml (Haloperidol lactate) signed off on his electronic medical record because ADON-LVN had made a progress note that indicated the medication was administered that was acceptable. 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 the state, as ordered by the physician and in accordance with professional standard of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines:17. Sign MAR after administered.