STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676133	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to treat each resident with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 2 of 2 Residents (Resident #1 and Resident #2) reviewed for resident rights. CNA E failed to sit down while feeding Resident #1 and Resident #2 during the dinner meal on 6/25/26. This deficient practice could place residents at risk to feelings of poor self-esteem. The findings were:1.Record review of Resident #1's face sheet, dated 6/27/26, revealed he was admitted to the facility on [DATE] with diagnoses which included unspecified Dementia, severe, with other behavioral disturbance (severe cognitive decline where the exact type of dementia is not specifically identified, but the severity and behavioral disturbances are clearly documented), unspecified protein-calorie malnutrition (caused by insufficient intake of protein and calories, leading to impaired body function and tissue loss) and adult failure to thrive (is a syndrome of progressive decline in weight, nutrition, physical function, and cognitive or emotional health). Record review of Resident #1's Care Plan, revised on 9/9/25, revealed The resident has an ADL self-care performance deficit r/t arthritis (range of conditions involving joint inflammation) and SOB and one of the interventions included the resident requires supervision with set up by staff to eat. Record review of Resident #1's 5-day MDS assessment, dated 6/10/26, revealed his BIMS score was 3 of 15 reflective of severe cognitive impairment and he was on a mechanically altered diet. 2. Record review of Resident #2's face sheet, dated 6/27/26, revealed she was admitted to the facility on [DATE] with diagnoses which included unspecified Dementia, severe, with other behavioral disturbance (severe cognitive decline where the exact type of dementia is not specifically identified, but the severity and behavioral disturbances are clearly documented), unspecified Dementia, severe, with anxiety and other specified persistent mood disorders (chronic mood disturbances that do not meet full criteria for major depressive disorder or bipolar disorder). Record review of Resident #2's Care Plan, dated 3/27/26, revealed Resident receives regular, pureed texture, regular liquids diet. has an ADL self-care performance deficit r/t dementia and the resident requires limited assist by staff to eat. Record review of Resident #2's quarterly MDS assessment, dated 5/8/26, revealed her BIMS score was 3 of 15, reflective of severe cognitive impairment, she required substantial/maximal assistance with eating, and she was on a mechanically altered diet. Observation and interview on 6/25/26 at 5:55 PM in the secured unit revealed CNA E fed Resident #1 and Resident #2 at one of the dining room tables. CNA E was standing while feeding the residents. Resident #1 and Resident #2 looked up at CNA E as she fed them. Interview with CNA E revealed she should be sitting but when she started feeding the residents there were no chairs. She stated she gave her chair to one of the residents. Observation revealed there was an empty chair at one of the other dining room tables along the back wall. CNA E stated she had not seen it. She stated she should be sitting while feeding Resident #1 and Resident #2 so she could be at the resident's eye level. CNA E stated standing might cause the residents to feel overwhelmed and uncomfortable. Interview on 6/25/26 at 6:10 PM with ADON D revealed he was in charge of the secured unit. He stated he saw CNA E standing while (continued on next page)

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
	676133	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	feeding Resident #1 and Resident #2 and commented she knew better and should sit while feeding the residents. ADON D stated standing over residents while they ate might make them feel inferior and uncomfortable while eating. Interview on 6/26/26 at 3:46 PM with LVN A revealed she worked in the secured unit on 6/25/26. She stated she did not notice CNA D was standing while feeding Resident #1 and Resident #2. She stated staff would want to be at the resident's level to ensure they could see if the resident was choking. LVN A stated it could also affect the resident's dignity, maybe make the resident feel uncomfortable or maybe even vulnerable. Record review of the facility's, undated, policy, Statement of Resident Rights, read You have the right to: (4) be treated with courtesy, consideration and respect.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676133	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician, notify, consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental or psychosocial status (that was, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 5 Residents (Resident #5) reviewed for notification of changes. RN F failed to consult with Resident #5's physician when she administered two 100 mg tablets instead of two 50 mg tablets of Senna-Docusate.RN F failed to consult with Resident #5's physician when she was unable to successfully re-inject an IV into Resident #5's hand for the administration of Vancomycin (anti-biotic therapy) for the diagnosis of MRSA (Methicillin-resistant Staphylococcus aureus). These deficient practices could affect any resident and could result in a decline of the resident's health status. The findings were: Record review of Resident #5's face sheet revealed she was admitted to the facility on [DATE] with diagnoses which included encounter for other orthopedic aftercare (involves the diagnosis, treatment, and management of conditions related to the bones, joints, and muscles) and Driver injured in collision with unspecified motor vehicles in traffic accident, subsequent encounter. Resident #5 was her own responsible party, and she had been discharged from the facility on 2/14/26. Record review of Resident #5's quarterly MDS assessment, dated 1/19/26, revealed her BIMS score was 15 of 15 reflective of no cognitive impairment. Record review of Resident #5's Care Plan, dated 2/18/26, revealed The resident has constipation r/t decreased mobility, pain and one of the interventions was to monitor/document/report PRN s/sx of complications related to constipation. Record review of Resident #5's order summary report with active orders as of 10/15/25 revealed an order for Senna-Docusate Sodium Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium) Give 2 tablets by mouth two times a day for constipation; Vancomycin HCl Intravenous Solution Reconstituted 1 GM (Vancomycin HCl) Use 1 application intravenously at bedtime for MRSA to surgical wound right rear malleolus (refers to the bony prominences on the right ankle) and right medial ankle (inner ankle), start date 11/14/25 until 11/24/25. Record review of Resident #5's MAR for October 2025 revealed she received Senna-Docusate on 10/20/25 but it did not reflect any discrepancies. Record review of Resident #5's MAR for November 2025 revealed on 11/17/26 it was coded 5 for the administration of Vancomycin which was defined as hold/see progress note and on 11/19/25 revealed it was coded 9 for the administration of Vancomycin which was defined as other/see progress note. Record review of Resident #5's progress notes for 11/17/26 and 11/19/26 did not reveal documentation to reflect why Resident #5 did not receive the dose of Vancomycin ABT on these dates or Resident #5's physician was contacted. Telephone interview on 6/25/26 at 11:35 AM with former Resident#5 revealed she had multiple problems during her stay at the facility. She stated she was a nurse as well and she addressed her concerns with nursing staff. Resident #5 stated one evening she received two white pills, a generic brand for stool softener. Resident #5 stated she did not recognize the pills but took them anyway. She stated the more she thought about it the more it bothered her, so she asked RN F to bring her the bottle of pills. She stated RN F returned with another staff member and handed her the bottle of pills. Resident #5 stated she noted the Docusate in the bottle were 100 mg tablets. She stated she told the nurse she was taking 50 mg tablets and not 100 mg tablets. Resident #5 stated she was upset because RN F gave her double the amount of the medication and expressed her frustration to RN F. Resident #5 stated RN F commented it's just a laxative. Resident #5 stated she did not experience any adverse reaction as a result. Further interview with Resident #5 revealed she developed MRSA on her surgical incision and was ordered Vancomycin ABT. She stated on the same night (date unknown) when the medication error occurred, she noticed the drip on the IV was very slow. She alerted RN F who stated there was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676133	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nothing wrong with the IV. Resident #5 stated she kept asking RN F to check the access point and then after looking at it again, RN F stated it was clogged. Resident #5 stated RN F made two attempts to re-insert the IV on the back of her right hand with no success. Resident #5 stated RN F did not want to try again and left the room without further explanation. She stated RN F did not tell her if she was going to get another nurse or if she was going to call anyone else to assist. Resident #5 stated she did not receive the dose of Vancomycin 1 gram that night. Resident #5 stated she was upset about the lack of communication and what appeared to RN Fs lack of clinical knowledge. Interview on 6/25/26 at 6:25 PM with RN F revealed she remembered Resident #5 getting upset because she administered two 100 mg tablets instead of two 50 mg. tablets of Docusate. RN F stated she did not look at the orders and instead grabbed the OTC bottle of Docusate. She stated she thought Resident #5 was asking for a PRN dose and did not know it was scheduled. RN F stated administering the wrong milligrams could give Resident #5 diarrhea and it would be considered a medication error. She stated she reported the incident to ADON G but did not call the doctor to report the error. Further interview revealed RN F stated she also remembered Resident #5 developed MRSA and was ordered Vancomycin ABT. She stated one night Resident #5 reported the IV was not dripping at a normal rate. She stated she checked and the IVs access point was clogged. RN F stated she attempted to re-inject the IV with two failed attempts which was the maximum amount of times she could try. RN F stated she called ADON G for assistance, and he told her he was not available. RN F stated she did not administer the dose of Vancomycin that night; she stated she could not remember the date. RN F stated she did not call the doctor per facility policy and to get implement any changes per physician orders. She stated she should have followed facility policy. RN F stated Resident #5's infection could have become worse, or they would have had to prolong the ABT because of the missed dose. Resident #5 stated the wound improved but she was concerned the Vancomycin labs would not accurately reflect whether or not it was being effective. Interview on 6/27/26 at 10:13 AM with ADON G revealed he was in charge of the hall where Resident #5 was previously placed. He stated he remembered talking with Resident #5 about RN F giving her two 100 mg tablets of Docusate instead of two 50 mg. tablets. ADON G stated he did not remember the exact conversation he had with Resident #5 and did not remember if RN F called him about it. ADON G stated the incident would be considered a medication error which would require RN F to notify the doctor. ADON G stated after reviewing Resident #5's EHR, there was no documentation that RN F called Resident #5's doctor. ADON G stated as a result of Resident #5 receiving the wrong dose of Docusate, she could have developed diarrhea which could have led to dehydration, or it could have resulted in a negative interaction with other prescribed medications. In addition, ADON G stated he did not remember anyone calling him about not being able to re-inject Resident #5's IV. He stated Resident #5 was receiving Vancomycin, ABT, for MRSA. He stated per policy a nurse could attempt 3 times if the resident allowed and then another nurse could also attempt. If unsuccessful, the charge nurse should call the physician and get a new order to send the resident to the ER for midline or PICC line placement if the resident agreed. ADON G stated not administering Vancomycin per physician orders could affect the Vancomycin lab values; they would read low. He stated the Vancomycin levels had to fall within a therapeutic range to determine the medication was being effective to rid of the infection. ADON G stated such an incident would warrant a call to the physician. ADON G stated per review of Resident #5's EHR, he stated there was not any documentation RN F contacted Resident #5's physician about the incident. Interview on 6/27/26 at 3:00 PM with the DON revealed she was not notified of the incident involving Resident #5 receiving the wrong dose of Senna-Docusate and Resident #5 not receiving a dose of Vancomycin due to the charge nurse not being able to re-insert the IV. She stated she could not speak to the incidents, but stated both incidents required the charge nurse to contact Resident #5's physician and report the change of condition. The DON stated not doing so could contribute to the resident's change in health status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676133	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 3 of 26 resident rooms (room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]) in that: The facility failed to ensure the vents were cleaned and rid of excess lent in Resident rooms #203, #213 and #215. This deficient practice could place residents at risk of being in an uncomfortable and unsanitary environment.Findings included: Observation on 6/27/26 at 11:35 PM during a tour of the secured unit with ADON D revealed the vents mounted on the ceiling in room [ROOM NUMBER], #213 and #215 and 3 of the vents in the dining room had black residue on the outside of the vents. The vents also had built up lint all around the edging of the vents. Interview with ADON D revealed the dirty vents could cause the residents to develop a respiratory infection and get sick. ADON D stated he understood the MS cleaned the vents on a schedule according to the maintenance application he used but did not know the last time the vents were cleaned in the secured unit. ADON D stated the vents were dirty. Interview on 6/26/26 at 10:30 AM with Resident #3's family member revealed she visited Resident #3 multiple times a week. The family member stated she noticed the vents in Resident #3's room were full of lint. The family member stated this could get Resident #3 sick as well as other residents in the secured unit. The family member stated she reported her concern to ADON D, the MS, the DON and the ADM. She stated the administrative staff did not listen to her. Interview on 6/27/26 at 12:30 PM with the DON revealed the MS was supposed to clean the vents in the secured unit during March 2026 when the concern was brought up to her and the ADM's attention. She stated Resident #3's family member complained about the vents being dirty in the secured unit. Record review of the facility's, undated, policy, General Housekeeping policies, read The facility provides sufficient housekeeping and maintenance personnel, equipment and supplies to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. All housekeeping personnel utilize the accepted practices and procedures to keep the facility free from offensive odors, accumulations of dirt, rubbish, dust and hazards.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676133	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident had a right to and the facility provided prompt efforts to resolve grievances the resident may have for 1 of 5 Residents (Resident #3) reviewed for grievances. The facility failed to promptly act upon concerns a family member voiced to the ADM and DON on Resident #3's behalf involving her care during her stay in the secured unit. This deficient practice could place residents at risk of not being made aware of any corrective actions taken by the facility leading to frustration. The findings were: Record review of Resident #3's face sheet, dated 6/27/26, revealed she was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease with late onset (developing after age [AGE] and characterized by progressive memory loss and cognitive decline) and Dementia in other Diseases classified elsewhere, severe, with other behavioral disturbance (severe cognitive decline where the exact type of dementia is not specifically identified, but the severity and behavioral disturbances are clearly documented). Record review of Resident #3's quarterly MDS assessment, dated 6/12/26, revealed her BIMS was 0 of 15 reflective of severe cognitive impairment. Record review of Resident #3's Care Plan, dated 8/22/23 revealed Admit to Cognitive Impairment Unit d/t poor safety awareness r/t to Dementia and high risk for elopement. One of the interventions was to Try to keep a routine such as bathing, dressing, and eating. Record review of incident/accident log for Resident #3 from October 2025 to June 2026 revealed the following incidents:On 10/17/25 Resident had a skin tear to her lower leg (shin area). CNA reported and Resident #5 was unable to state what happened. Cleansed with normal saline, pat dried, cleaned with st. gauze and covered with st. gauze.On 10/27/25 Resident had a skin tear on her right arm near the elbow. Noted a scant amount of blood to area. Cleansed with normal saline, pat dried, cleaned with st. gauze and covered with st. gauze. Resident unable to state what happened.On 12/26/26 Resident had abrasion to right foot 3rd toe and intact blister on right foot 4th toe. Wound care nurse provided treatment. Resident was unable to state what happened.On 1/24/26 Resident sustained skin tear to right shin while CNAs were transferring Resident from chair to bed. Resident sustained skin tear. Injury occurred due to sharp skin tie end attached to foam on chair. Family member expressed concern through camera and nurse explained what happened.On 1/28/26 read Female resident residing in the memory care unit was found in her room during routine CNA rounds with a male resident lying next to her in bed. Both residents appeared to be asleep at the time of discovery. No physical contact, sexual activity or inappropriate behavior was observed. Resident was unable to state what happened. Male resident was promptly removed from the room. Nurse assessed Resident and no injuries, redness, bruising or skin breakdown noted. Resident denied pain, at normal baseline.On 4/24/26 Resident had skin tear on outer forearm. CNA reported noted it when getting Resident ready to the dining room. Noted active bleeding. Area cleansed and appropriate dressing applied. Resident unable to state what happened.On 6/3/26 Resident had a skin tear on right medial calf. It was noted during wound treatment. Resident unable to state what happened. Area assessed by treatment nurse and cleansed per facility protocol. Record review of a letter written by Resident #3's family member, dated 3/27/26 and submitted to corporate office revealed the following concerns r/t Resident #3: a. skin tears incurred by Resident #3 on her arms and legs on multiple consecutive weeks.b. the lack of adequate nursing staff, lack of experience by some of the nursing staff and the lack of rounding on Resident #3 during the night shift by nursing staff;c. the lack of supervision in the secured unit leading to a male Resident (Resident #4) wandering into Resident #3's room on one occasion and lying in bed with Resident #3 for at least 30 minutes and on the second occasion Resident #4 laid in Resident #3's bed and was found sleeping for an underdetermined period of time. Record review of the facility grievances from October 2025 to June 2026 did not reveal any grievances related to the letter Resident #3's family member submitted to the corporate office dated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676133	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/27/26. Interview on 6/26/26 at 10:13 AM with Resident #3's family member revealed she was disappointed and very unhappy with the care Resident #3 was receiving in the secured unit at the facility. She stated she tried to address her concerns with administrative staff including the ADM, DON, HR and ADON D to no avail. She stated they would not listen to her, consider her suggestions and would not provide answers to any of her questions regarding the skin tears she noted on Resident #3 or the incident when the male Resident walked into Resident #3's room. The family member stated she saw it on the camera and the male resident walked in and laid in bed with Resident #3 for about 30 minutes. She stated he would stick his left hand into his pants and with the same hand would lightly tap Resident #3's arm, chest area (over her gown) and tap his hand on her hair. The family member stated the male resident did not touch Resident #3 inappropriately but was disgusted by what she was viewing and did not understand how the facility could allow this to happen. The family member stated she would watch the footage on the camera in Resident #3's room and would often note the CNAs would not check in on Resident #3 between 10 and 12 hours at a time. She complained about the lack of supervision and stated Resident #3 was found on the floor. The family member stated she often complained to administrative staff about the lack of nurse staffing or the lack of experience some of the staff had who were assigned to the secure unit. She stated there were a number of CNAs who were exceptional and suggested to administrative staff assign these particular staff to work in the secured unit on a regular basis. The family member stated she was tired of staff ignoring her and decided to escalate her concerns and submitted a letter to the facility's corporate office and to HHSC. She stated to date no one from the facility had contacted her to address her concerns. Interview on 6/25/26 at 9:30 AM with the DON revealed Resident #3's family member submitted a lengthy letter to the corporate office. She stated she, the ADM and a Corporate Representative had a telephone conference with the RP. She stated they reviewed the letter and discussed the concerns with the RP as documented on the letter. The DON stated the RP did not express any concerns r/t care and was grateful Resident #3 was placed in the facility. The DON stated the RP told her she reviewed the video r/t the family member's concern involving the male resident who was lying in bed with Resident #3. The RP stated the male resident did not touch Resident #3 in a sexual manner; he laid in bed with Resident #3 but did not touch her inappropriately. The DON stated she completed two grievances and provided nursing staff an in-service r/t the letter the family submitted to the corporate office on 3/27/26 but again stated she discussed the findings with the RP. The DON stated she informed the family member staff were trained to manage resident's behaviors with a dementia diagnosis. She stated they did not have dedicated staff in the secured unit but all staff who worked in the unit received dementia training. Interview on 6/26/26 at 9:00 AM with the DON and ADM revealed the ADM was the grievance officer. The ADM stated he would appoint the grievances to department heads as the grievance applied to their department. The department heads would address the reported concerns and return the grievance back to him. He stated he also addressed a lot of the concerns himself, and he would call the person submitting the grievance to discuss corrective action the facility took to resolve the concerns. The ADM stated most individuals who he talked to were satisfied with the resolution. The ADM and DON stated their corporate office forwarded the letter the family member submitted to them. The DON again re-iterated details provided per the discussion on 6/25/26 at 9:30 AM. She and the ADM both stated they discussed the concerns provided in the letter written by the family member with the RP. They stated they addressed concerns r/t Resident #3's care right away with the RP but did not include the family member in any of their discussions. The DON stated the family member requested incident reports r/t Resident #3's s/t's and demanded explanations. The DON stated nursing staff would report all incidents to the RP. The ADM and DON stated the RP gave them permission to share information with the family member but made it clear she was the decision maker. They stated to avoid conflict they discussed concerns r/t to Resident #3's care with the RP even though they both stated typically the process would require they discuss the concerns and resolution with the person who reported the concern or who submitted (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676133	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a grievance. The ADM and RP stated they understood why Resident #3's family member believed they did not listen to her or believed nothing was being done. They stated they thought the RP and the family member talked about corrective action taken by the facility regarding any concerns the family member presented to them. Record review of the facility's policy, Resident and Family Grievances, dated 10/4/25, read It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal.Prompt efforts to resolve include facility acknowledgement of a complaint/grievance and actively working toward resolution of the complaint/grievance.1. Administrator has been assigned as the Grievance Officer.2. The Grievance Officer is responsible for overseeing the grievance process; receiving and tracking through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with the grievance; issuing written grievance decisions to the resident and coordinating with state and federal agencies as necessary in light of specific allegations.4. A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns related to their LTC facility stay.7. Grievances may be filed in the following forums:a. Verbal complaint to a staff member or Grievance official.b. Written complaint to a staff member or Grievance official.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676133	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 4 Residents (Resident #1) reviewed for ADL's. Nursing staff failed to change Resident #1's shirt which was covered with skin flakes all over his chest area. This deficient practice could place residents at risk to feelings of dissatisfaction or poor self-esteem. The findings were: Record review of Resident #1's face sheet, dated 4/27/26, revealed he was admitted to the facility on [DATE] with diagnoses which included unspecified Dementia, severe, with other behavioral disturbance (serious cognitive disorder marked by profound memory loss and significant behavioral changes), unspecified protein-calorie malnutrition (condition caused by insufficient intake or absorption of protein and calories, leading to impaired body function and tissue loss) and adult failure to thrive (syndrome of progressive decline in weight, nutrition, physical function, and cognitive or emotional health). Record review of Resident #1's Care Plan, dated 9/9/25, revealed The resident has an ADL self-care performance deficit r/t arthritis and SOB and one of the interventions included The resident requires limited assistance by staff to dress. Record review of Resident #1's 5-day MDS assessment, dated 6/10/26, revealed his BIMS score was 3 of 15 reflective of severe cognitive impairment. Resident #1 required substantial/maximal assistance with upper body and lower body dressing. Observation and attempted interview on 6/24/26 at 5:00 PM with Resident #1 revealed he was sitting at one of the dining room tables. He was leaning to the right side. He had a black sweatshirt on with multiple white speckled debris covering his chest. Attempted interview with Resident #1 revealed he did not respond to questions. Interview with LVN A revealed she did not know what was on Resident #1's shirt. She stated maybe it was something he ate earlier for lunch. Further interview with LVN A revealed she had not noticed the front of Resident #1's shirt was full of white debris, but staff should change a resident's shirt when it was dirty. Observation on 6/24/26 at 5:20 PM revealed CNA B approached Resident #1 who was sitting at one of the dining room tables. Interview with CNA B revealed she had not noticed Resident #1's shirt was dirty. ADON D joined CNA B and Resident #1. CNA B asked Resident #1 if he wanted her to change his shirt. He nodded, yes, and she propelled him out of the dining room. Interview on 6/24/26 at 6:00 PM with ADON D revealed he saw the front of Resident #1's shirt was full of white residue of some sort. He stated he did not see it until it was pointed out. ADON D stated the CNAs should help the residents maintain good hygiene by ensuring they were clean. ADON D stated it could be a dignity issue if Resident #1 felt embarrassed because he had on a dirty sweatshirt. He stated Resident #1 was cognitively impaired and probably would not notice his shirt was clean, but he might feel different if he was not cognitively impaired or a family member might be bothered Resident #1 was wearing a dirty shirt. Interview on 6/26/26 at 3:26 PM with LVN A revealed Resident #1's sweatshirt (chest area) was full of skin flakes. She stated she saw a few dry skin flakes on his neck before but never saw that many flakes on his person. LVN A stated any nursing staff who saw his shirt dirty should change it and keep him clean. LVN A stated it might be a dignity issue and Resident #1 might feel bad about himself while sitting in the dining room with a dirty shirt. Record review of the facility's policy, Activities of Daily Living (ADLs), dated 5/26/23 read The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure: Care and services will be provided for the following activities of daily living:bathing, dressing, grooming and oral care .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676133	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 of 4 (Resident #4) reviewed for accidents and hazards. Nursing staff failed to ensure they cleaned up a puddle of water on the floor underneath Resident #4's chair during dinner time. This deficient practice could place residents at risk and of avoidable accidents. The findings were: Record review of Resident #4's face sheet, dated 6/27/26, revealed he was admitted to the facility on [DATE] with diagnoses which included dementia in other diseases classified elsewhere, severe with other behavioral disturbance (occurs as a manifestation of another underlying disease), Alzheimer's disease with late onset (developing after age [AGE], characterized by progressive memory loss, cognitive decline, and changes in judgment and behavior) and Anxiety Disorder (frequently have intense, excessive and persistent worry and fear about everyday situations). Record review of Resident #4's Care Plan, dated 11/11/25 revealed Resident at risk of episodes of hypotension (low blood pressure with symptoms including dizziness and nausea), the resident is at high risk for falls r/t unsteady gait, history of falls, poor safety awareness. Interventions included needs a safe environment with: (SPECIFY: even floors free from spills. Record review of Resident #4's significant change in status MDS assessment, dated 6/10/26 revealed his BIMS score was 3 of 10 reflective of severe cognitive impairment. Observation and interview on 6/25/26 at 5:57 PM revealed Resident #4 sitting at one of the dining room tables eating dinner in the secured unit. Resident #4 was sitting and there was a large puddle of liquid underneath his chair. The staff were busy assisting other residents. Interview with LVN A revealed she did not see the puddle of what she thought was water. She went to get a towel and placed it over the puddle of liquid. LVN A stated Resident #4 was able to walk and was a fall risk. She stated the spilled water was a safety hazard. LVN A stated Resident #4 could slip and fall if he stepped on the spill. Interview on 6/25/26 at 6:10 PM with ADON D revealed he was in charge of the secured unit. He stated he did not see the spilled water underneath Resident #4's chair. ADON D stated the resident ambulated, was not steady and could slip and fall if he stood up and stepped on the water. He stated staff should be proactive and always consider the safety of the resident's first. ADON D stated Resident #4 could sustain injuries from a fall. Interview on 6/26/26 at 3:46 PM with LVN A revealed she did not believe the puddle underneath Resident #4's chair was urine because his pants were not wet and it did not smell like urine. LVN A stated Resident #4 was a fall risk because sometimes he tried to run and was not oriented to self or his surroundings. LVN A stated it was the responsibility of nursing staff to ensure the resident environment was free of accident hazards and should always be aware the surroundings. LVN A stated working the secured unit was a challenge because the residents were active, some would spontaneously stand and walk around while attending to another resident. She stated they had to be constantly looking around and watching the residents because they were a fall risk. LVN D stated the residents could get hurt if they had a fall. Record review of the facility's, undated, policy Fall Prevention Program, read Falls can cause people to restrict their activities, lead to depression, helplessness, social isolation, loss of confidence in independent mobility, injuries and even death. Most falls occur as a result of multiple intrinsic and extrinsic factors. A successful fall risk management program requires organizational commitment and an interdisciplinary team approach to prevent and minimize falls. Care Plan: A current care plan for fall risk management and injury prevention includes: Measurable goals for fall risk management and injury prevention.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676133	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pharmaceutical services (including procedures that assured the accurate acquiring, receiving, dispensing, and administrating of all drugs and biologicals) to meet the needs of each resident for 1 of 5 Residents (Resident #5) reviewed for pharmacy services. RN F failed to administer the correct milligrams of Senna-Docusate to Resident #5. This deficient practice could place residents at risk of diarrhea and dehydration. The findings were: Record review of Resident #5's face sheet revealed she was admitted to the facility on [DATE] with diagnoses which included encounter for other orthopedic aftercare (involves the diagnosis, treatment, and management of conditions related to the bones, joints, and muscles) and driver injured in collision with unspecified motor vehicles in traffic accident, subsequent encounter. Resident #5 was discharged from the facility on 2/14/26. Record review of Resident #5's physician's order summary report with active orders as of 10/15/25 revealed an order for Senna-Docusate Sodium Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium) Give 2 tablet by mouth two times a day for constipation. Record review of Resident #5's quarterly MDS assessment, dated 1/19/26, revealed her BIMS score was 15 of 15 reflective of no cognitive impairment. Record review of Resident #5's Care Plan, dated 2/18/26, revealed The resident has constipation r/t decreased mobility, pain and one of the interventions was to monitor/document/report PRN s/sx of complications related to constipation. Record review of Resident #5's MAR for October 2025 revealed she received Senna-Docusate on 10/20/25 but it did not reflect any discrepancies. Telephone interview on 6/25/26 at 11:35 AM with former Resident#5 revealed on 10/20/25 she received two white pills, a generic brand for stool softener. Resident #5 stated she did not recognize the pills but took them anyway. She stated the more she thought about it the more it bothered her, so she asked RN F to bring her the bottle of pills. She stated RN F returned with another staff member and handed her the bottle of pills. Resident #5 stated she noted the Docusate in the bottle were 100 mg tablets. She stated she told the nurse she was taking 50 mg tablets and not 100 mg tablets. Resident #5 stated she was upset because RN F gave her double the amount of the medication and expressed her frustration to RN F. Resident #5 stated RN F commented it's just a laxative. Resident #5 stated she did not have an adverse reaction as a result. Interview on 6/25/26 at 6:25 PM with RN F revealed she remembered Resident #5 getting upset because she administered two 100 mg tables of Docusate instead of two 50 mg. tablets of Docusate. RN F stated she did not look at the orders and instead grabbed the OTC bottle of Docusate. She stated she thought Resident #5 was asking for a PRN dose and did not know it was scheduled. RN F stated administering the wrong milligrams would be considered a medication error but did not complete a medication error report which she was supposed to do. She stated she reported the incident to ADON G. Interview on 6/27/26 at 10:13 AM with ADON G revealed he was in charge of the hall where Resident #5 was previously placed. He stated he remembered talking with Resident #5 about RN F giving her two tablets of Docusate at 100 mg a piece instead of two 50 mg. tablets. ADON G stated he did not remember the exact conversation he had with Resident #5 and did not remember if RN F called him. ADON G stated the incident would be considered a medication error which would require RN F complete a medication error report, notify the doctor and enter a progress note describing the incident. ADON G stated per record review, RN F did not complete a medication error report and there was no documentation that she called Resident #5's doctor. ADON G stated Resident #5 could have developed diarrhea, lead to dehydration or contributed to a negative reaction with other prescribed medications. Record review of the facility's policy, Medication Administration, dated 10/24/22, read 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. 1. Identify Resident by photo (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676133	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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	in the MAR.10. Review MAR to identify medication to be administered.11. Compare medication source (blister pack, vial, etc.) with MAR to verify resident name, medication name, form, source, dose, route and time.17. Sign MAR after administered. 20. Correct any discrepancies and report to nurse manager.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676133	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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 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 interview 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 and accurately documented for 1 of 5 Residents (Resident #5) reviewed for complete and accurate records. Nursing staff failed to complete a medication error report when RN F administered two 100 mg. versus two 50 mg tablets of Senna-Docusate to Resident #5 and failed to complete an SBAR when she was unable to successfully inject an IV into the back of Resident #5's right hand for the administration of Vancomycin (anti-biotic therapy) for the diagnosis of MRSA. ADON D failed to document a progress note reflecting he notified Resident #5 when an allergy medication was changed from scheduled to PRN administration. These deficient practices could place residents at risk for not having an accurate account of prescribed medications. The findings were: Record review of Resident #5's face sheet revealed she was admitted to the facility on [DATE] with diagnoses which included encounter for other orthopedic aftercare (involves the diagnosis, treatment, and management of conditions related to the bones, joints, and muscles) and driver injured in collision with unspecified motor vehicles in traffic accident, subsequent encounter. Resident #5 was discharged from the facility on 2/14/26. Record review of Resident #5's physician order summary report with active orders as of 10/15/25 revealed an order for Senna-Docusate Sodium Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium) Give 2 tablets by mouth two times a day for constipation, Vancomycin HCl Intravenous Solution Reconstituted 1 GM (Vancomycin HCl) Use 1 application intravenously at bedtime for MRSA to surgical wound right rear malleolus (refers to the bony prominences on the right ankle) and right medial lateral foot, start date 11/14/25 until 11/24/25, and Loratadine Oral Tablet Chewable 10 MG (Loratadine) Give 1 tablet by mouth one time a day for seasonal allergies. Record review of Resident #5's quarterly MDS assessment, dated 1/19/26, revealed her BIMS score was 15 of 15 reflective of no cognitive impairment. Record review of Resident #5's Care Plan, dated 2/18/26, revealed The resident has constipation r/t decreased mobility, pain and one of the interventions was to monitor/document/report PRN s/sx of complications related to constipation; the resident has infection to surgical wound right rear malleolus and right medial lateral foot. One of the interventions included Administer antibiotic as per MD orders; Resident with dx: seasonal allergies receiving medication. One of the interventions was to administer medication per MD orders.Record review of Resident #5's MAR for October 2025 revealed she received Senna-Docusate on 10/20/25 but it did not reflect any discrepancies. Resident #5 received Loratadine per physician orders. Record review of Resident #5's MAR for November 2025 revealed on 11/17/26 it was coded 5 for the administration of Vancomycin which was defined as hold/see progress note and on 11/19/25 revealed it was coded 9 for the administration of Vancomycin which was defined as other/see progress note. Record review of Resident #5's progress notes for 11/17/26 and 11/19/26 did not reveal documentation to reflect why Resident #5 did not receive the dose of Vancomycin ABT on these dates. Further review did not reveal documentation to reflect Resident #5 received two 100 mg. tablets instead of two 50 mg. tablets of Senna Docusate (laxative) or that the allergy medication, Loratadine was changed from scheduled to a PRN basis during October or November 2025. Telephone interview on 6/25/26 at 11:35 AM with former Resident#5 revealed she had multiple problems during her stay at the facility. Resident #5 stated one evening she received two white pills, a generic brand for a stool softener. Resident #5 stated she did not recognize the pills but took them anyway. She stated the more she thought about it the more it bothered her, so she asked RN F to bring her the bottle of pills. She stated RN F returned with another staff member and handed her the bottle of pills. Resident #5 stated she noted the Docusate in the bottle were 100 mg tablets. She stated she RN F she was taking 50 mg tablets and not 100 mg tablets. Resident #5 stated she was upset because RN F gave her double the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676133	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	amount of the medication and expressed her frustration to RN F. Resident #5 stated RN F commented it's just a laxative. Resident #5 stated she developed MRSA on her surgical incision and was ordered Vancomycin ABT. She stated on the same night (dated unknown) when the medication error occurred, she noticed the drip of the IV was very slow. She alerted RN F who stated there was nothing wrong with the IV. Resident #5 stated she kept asking RN F to check the access point and then after checking it again RN F stated it was clogged. Resident #5 stated RN F made two attempts to re-insert the IV on the back of her right hand with no success. Resident #5 stated RN F did not want to try again and left the room without further explanation. She stated RN F did not tell her if she was going to get another nurse or if she was going to call anyone else to assist. Resident #5 stated she did not receive the dose of Vancomycin that night. Resident #5 also stated she was receiving allergy medication on a scheduled basis and learned the pharmacy changed it to be administered on a PRN basis. She stated she talked to ADON D the morning her throat was feeling swollen with mucous. She stated ADON D told her the pharmacy recommended the allergy medication be administered on a PRN and her physician agreed. Resident #5 stated she expressed concern and frustration because she had been hospitalized in the past when her allergies flared up causing her to have an asthma attack. She stated she did not remember the exact dates when all these incidents took place. Interview on 6/25/26 at 6:25 PM with RN F revealed she remembered Resident #5 getting upset because she administered two 100 mg tablets of Docusate instead of two 50 mg. tablets of Docusate. RN F stated administering the wrong milligrams would be considered a medication error but she did not complete a medication error report. RN F stated Resident #5 developed MRSA and was ordered Vancomycin ABT. She stated one night Resident #5 reported the IV was not dripping at a normal rate. She stated she checked and stated the IVs access point was clogged. RN F stated she attempted to re-inject the IV with two failed attempts. RN F stated she called ADON G for assistance, and he told her he was not available. RN F stated she did not administer the dose of Vancomycin that night; she stated she could not remember the date. RN F stated she did not complete a progress note or COC/SBAR for either incident per facility policy. She stated she should have followed facility policy and documented the incidents to ensure all nursing staff were aware of the changes involving Resident #5.Interview on 6/27/26 at 10:13 AM with ADON G revealed he was in charge of the hall where Resident #5 was previously placed. He stated he remembered talking with Resident #5 about RN F giving her two 100 mg tablets of Docusate instead of two 50 mg. tablets. ADON G stated he did not remember the exact conversation he had with Resident #5 and did not remember if RN F called him about it. ADON G stated the incident would be considered a medication error which would require RN F to complete a medication error report and to enter a progress note about the incident at the time it happened. ADON G stated after reviewing Resident #5's EHR, RN F did not complete a medication error report and did not write a progress note. ADON G further stated he did not remember anyone calling him about Resident #5 did not receiving a dose of Vancomycin. ADON G stated such an incident would warrant the completion of an SBAR and progress note at the time of the incident. He stated per review of Resident #5's EHR, there was not an SBAR or a progress note completed r/t to the incident. ADON G stated he remembered talking to Resident #5 about Loratadine being changed from scheduled to a PRN basis per pharmacy recommendation. He stated ADON D received all pharmacy recommendations and requested he talk to Resident #5 about her concerns regarding the changes. ADON G stated it was important to document all incidents to ensure the accurate accounting of medication administration. Interview on 6/27/26 at 11:06 AM with ADON D revealed he remembered the pharmacy recommended Loratadine, allergy medication, was administered on PRN basis instead of scheduled for Resident #5. He stated he contacted Resident #5's physician and he agreed. He stated he notified Resident #5 of the recommended changes but then a few days later she complained about it stating she should receive it regularly to keep her allergies under control. ADON D stated Resident #5 stated she was experiencing s/sx of not receiving the medication. ADON D stated he should have written a progress note of the changes of his discussion with Resident #5 but did not write a progress note. He stated it (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676133	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was important to document changes so all nursing staff were aware of the changes and for continuity of care. ADON D stated he did not remember the date the changes took place. Interview on 6/27/26 at 3:00 PM with the DON revealed she was not notified of the incidents involving Resident #5 including receiving the wrong dose of Senna-Docusate, (two 100 mg. tables instead of two 50 mg. tablets), her allergy medication being changed from scheduled to PRN and not receiving a dose of Vancomycin due to the charge nurse not being able to re-insert the IV. She stated she could not speak to what happened but stated nursing staff should complete an SBAR and or a progress note per facility policy for any changes of a resident's treatment. The DON stated she would provide a policy for maintaining complete and accurate medical records for the residents. The DON did not provide a policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676133	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 1 of 1 dining room in that: The facility failed to ensure the vents were cleaned and rid of excess lent in the dining room in the secured unit. This deficient practice could place residents at risk for feeling uncomfortable and lead to cross contamination. Findings included: Observation on 6/24/26 at 5PM in the secured unit revealed residents were walking around the hallway, and some residents were sitting in the dining room. Observation on 6/27/26 at 11:35 PM during a tour of the secured unit with ADON D revealed 3 of the vents in the dining room had black residue on the outside of the vents. The vents also had built up lint all around the edging of the vents. Interview with ADON D revealed the dirty vents could cause the residents to develop a respiratory infection and get sick. ADON D stated he understood the MS cleaned the vents on a schedule according to the maintenance application he used but did not know the last time the vents were cleaned in the secured unit. ADON D stated the vents were dirty. Interview on 6/26/26 at 10:30 AM with Resident #3's family member revealed she visited Resident #3 multiple times a week. The family member stated she noticed the vents in the dining room were especially dirty and covered with lint. The family member stated this could get Resident #3 sick as well as other residents in the secured unit. The family member stated she reported her concern to ADON D, the MS, the DON and the ADM. She stated the administrative staff did not listen to her. Interview on 6/27/26 at 12:30 PM with the DON revealed the MS was supposed to clean the vents in the secured unit during March 2026 when the concern was brought up to her and the ADM's attention. She stated Resident #3's family member complained about the vents being dirty in the secured unit. Record review of the facility's, undated, policy, General Housekeeping policies, read The facility provides sufficient housekeeping and maintenance personnel, equipment and supplies to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. All housekeeping personnel utilize the accepted practices and procedures to keep the facility free from offensive odors, accumulations of dirt, rubbish, dust and hazards.