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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER: Hidalgo Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 4503 S Sugar Rd, Edinburg, TX 78539	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview and record review, the facility failed to ensure residents were free from verbal abuse for 1 of 4 residents (R# 1) reviewed for abuse. The facility failed to prevent CNA A, from verbally abusing R#1 on 05/20/24 when she used obscene language. This failure could place residents at risk of emotional distress, fear, decreased quality of life and further abuse. Findings included: Record review of R#1's admission record dated 01/15/25 reflected a [AGE] year-old male admitted to the facility on [DATE]. His relevant diagnoses included hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) affecting right dominant side, lack of coordination, dementia (A loss of brain function that worsens over time and affects memory, thinking, behavior, and language), cognitive communication deficit (difficulty with communication caused by an impairment in cognitive processes). Record review of R#1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 12, indicating R#1's cognition was moderately impaired. Section E reflected R#1 did not exhibited any behaviors. Record review of R#1's quarterly care plan assessment dated [DATE] reflected [R#1] had the potential to be physically aggressive, hits staff when providing care r/t dementia and poor impulse control. Date initiated 05/20/24 and revised on 05/23/24. R#1's interventions included to assess his needs (food, thirst, toileting, comfort level, body positioning, and pain). (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of R#1's progress notes dated 05/20/24 at 7:00 a.m., authored by LVN B reflected, I was standing outside rm 308 when I heard loud obscene yelling in Spanish coming from rm 310. I immediately went into room [ROOM NUMBER] and saw [R#1] sitting on the side of bed and CNA A standing in from of [R#1] trying to assist him to transfer to wheelchair, but [R#1] was trying to punch CNA A. CNA A was deflecting the punches with her hands and yelling to resident in Spanish que chingado tienes (what the hell is wrong with you) A mi no me vas a pegar (you are not going to hit me) ya parale con [NAME] chingada (damn it, stop it) [R#1] stated he did not want to go to dining room, but did not say why he was hitting CNA. Skilled nurse told [R#1] to stop hitting CNA and that's when resident allowed to be assisted to wheelchair. Once [R#1] was safely seated in wheelchair skilled nursed immediately told CNA A to walk out of room and clock out and go home due to her agitated behavior. Head to toe assessment done on [R#1] with no visible skin issues noted at this time and [R#1] denies pain at this time. Administrator, DON and ADON notified. An observation and interview on 01/15/25 at 5:45 p.m., R#1 was observed in the dining room. R#1 said hace tiempo (some time ago) a CNA (did not remember her name) had used obscene language while she tried to transfer him from his bed to his wheelchair. R#1 said the only details he remembered was that CNA A trying to transfer him to his wheelchair, him punching her and CNA A responded with obscene language. R#1 said he was told by a staff member CNA A no longer worked at the facility. R#1 said after the incident, he felt safe in the facility and had no fears of retaliation or was afraid of any staff or resident. R#1 said the incident did not affect him in any way, the only thing he did not appreciate was the way CNA A had spoken to him. R#1 said he felt content with the investigation, especially LVN B who had walked in when CNA A was talking to him. Record review of the Administrator's written statement with R#1 on 05/20/24 reflected, Administrator interviewed [R#1] after incident occurred on 05/20/24. [R#1] stated CNA that helped him this morning told him bad words and he tried to hit her. He sated while trying to hit her he hit his hands in the wheelchair, and she was redirecting his arms away from her. Resident stated he attempted to pushed away and hit her. Record review of LVN B's written statement he provided on 05/20/24 reflected, On Monday 05-20-24, I [LVN B] was the charge nurse on 300 hall. At approximately 0700 I was standing outside rm 308 when I heard loud obscene yelling in Spanish coming from rm 310. I immediately went into room [ROOM NUMBER] and saw [R#1] sitting on the side of bed and CNA A standing in from of [R#1] trying to assist him to transfer to wheelchair, but [R#1] was trying to punch CNA A. CNA A was deflecting the punches with her hands and yelling to resident in Spanish que chingado tienes (what the hell is wrong with you) A mi no me vas a pegar (you are not going to hit me) ya parale con [NAME] chingada (damn it, stop it) [R#1] stated he did not want to go to dining room, but did not say why he was hitting CNA. Skilled nurse told [R#1] to stop hitting CNA and that's when resident allowed to be assisted to wheelchair. Once [R#1] was safely seated in wheelchair skilled nursed immediately told CNA A to walk out of room and clock out and go home due to her agitated behavior. Head to toe assessment done on [R#1] with no visible skin issues noted at this time and [R#1] denies pain at this time. Administrator, DON and ADON notified. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of R#1's progress notes dated 05/21/24 at 7:02 p.m., authored by SW reflected, SW met with [R#1] at bedside to follow up regarding abuse allegation from CNA during adl care the previous day. Investigation was completed, CNA involved suspended resident will continue to receive adl care assistance from other cna staff in the 300 hall. [R#1] laying down in bed [R#1] in a calm and pleasant mood, well-groomed and oriented x2. [R#1] reports he used the following coping mechanisms: talking to his family member and is trying not to think about the event because it gets him upset. [R#1]expressed no further concerns. SW notified resident outside counseling services will be coming out speak with him tomorrow resident verbalized understanding. Record review of R#1's progress notes dated 05/22/24 at 7:33 p.m., SW met with [R#1] at bedside to follow up regarding abuse allegation. [R#1] laying down in bed [R#1] in a calm and pleasant mood, well-groomed and oriented x2. [R#1] reports he is doing better and is no longer upset. [R#1] expressed no further concerns. [R#1]met with counseling services and enjoyed his session with SW. Outside counseling services will continue to meet with [R#1]. Record review of R#1's counseling notes from an outside source dated 05/23/24 reflected, [R#1] states CNA told him some mean things and used bad words. Resident reports this was the first time this happened . [R#1]was advised that CNA is no longer working at facility and reports he feels comfortable at facility. [R#1] report staff have tried to be helpful with him. [R#1] denied any feelings of not being safe or fear of retaliation. An interview on 01/15/25 at 4:25 p.m., Administrator said on 05/20/24, he received a telephone call from LVN B right before breakfast and advised him that he had overheard CNA A cussing at R#1. He said LVN B quickly intervened and deescalated the situation. He said LVN B instructed CNA A to leave R#1's room and to clock out. He said LVN B assessed R#1 and was fine. The Administrator said as soon as he arrived at the facility, he immediately interviewed R#1. He said R#1 told him CNA A had told him bad words and he admitted to trying to hit her. The Administrator said R#1 did not show any signs or symptoms of distress during his interview. He said he then called CNA A on her cell phone to get statement. The Administrator said CNA A told him she had yelled at R#1 and had told him a mi no me vas a pegar (you are not going to hit me) and used the Spanish word chingado (what the hell). The Administrator said CNA A told him the Spanish word chingado (what the hell) was not a bad word for her and would say it regularly. He said during their conversation, CNA A used the word Spanish word chingado (what the hell) while talking to him. The Administrator said his number one priority was the safety and wellbeing of his residents. He said CNA A was terminated due to her lack of professionalism. He said CNA A admitted to reacting verbally and apologized for using the word chingado (what the hell). The Administrator said CNA A was not referred because he felt she was remorseful. He said all staff were immediately in-serviced on the topic of abuse and neglect on 05/20/24. The Administrator said the facility had taken the following steps to remedy the situation, CNA A was immediately removed from the facility to protect all residents, R#1 was assessed and was found to be physically unharmed, CNA A was suspended while the investigation was on-going, staff were in-serviced on the topic of ANE on 05/20/24, after the investigation, CNA was terminated, reported the allegation of abuse to state, and R#1 was referred and continued receiving counseling services. Record review of facility's complaint/grievance follow-up report completed by the Administrator on 05/20/24 reflected the nature of the complaint was R#1 voiced CNA A was abusive toward him. The final resolution indicated the investigation had been completed, and the allegation were unfounded. (continued on next page)

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