STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676346	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidalgo Nursing and Rehabilitation Center	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 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 interviews and record review, the facility failed to ensure that a resident who needed respiratory care was provided with such care, consistent with professional standards of practice for 1 (Resident #1) of 4 residents reviewed for oxygen management. The facility failed to provide Resident #1 with a BIPAP machine as per doctor's orders. This deficient practice could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of life. Record review of the facility's PIR revealed Resident #1 did not have the BIPAP machine on during the night of 11/26/25. Record review of Resident #1's admission record dated 11/18/25 revealed a [AGE] year-old male with an admission date of 08/01/25 and an initial admission date of 05/28/25. Resident #1's diagnoses included, acute and chronic respiratory failure with hypercapnia (excessive carbon dioxide in the bloodstream, typically caused by inadequate respiration), chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing), dependance on supplemental oxygen, obstructive sleep apnea (a disorder in which a person's breathing repeatedly stops and starts during sleep due to a blockage of the upper airway) and pulmonary hypertension (a serious condition of high blood pressure in the arteries of the lungs).Record review of Resident #1's MDS assessment dated [DATE] revealed respiratory treatment of BIPAP. Resident #1's BIMS score of 15, indicated he was cognitively intact. Record review of Resident #1's physician order dated 05/25/25 revealed BIPAP at HS and PRN 15/8, 15, 2LPM O2. Record review of Resident #1's person-centered care plan dated 05/25/25 revealed Resident #1 had oxygen therapy related to COPD. Intervention included, BIPAP per MD order.Record review of Resident #1's progress note dated 08/26/25 at 4:32 pm, revealed PA G had made a note which indicated Subjective: Patient seen and examined at bedside. Was called a few days ago secondary to patient having gastritis in addition patient with low O2 sat and now when uses BIPAP machine. Plan: Increased O2, educated on importance of using BIPAP machine.Record review of in-services given during the facility's investigation revealed RT J attended and signed off on in-services titled, Following Dr. Orders, indication and initiation of BIPAP use, proper documentation, use of back up equipment, and equipment malfunction. RT J's signature was dated 08/29/25. Interview on 11/18/25 at 5:05 pm, RT J stated he was the RT on shift for the night of 08/26/25. RT J stated his shift was from 6:00 pm through 6:00 am. RT J stated that at 11:50 pm, Resident #1 had on the BIPAP machine, but he had to remove it due to Resident #1 having to take medication. When Resident #1 finished taking his medication, RT J said he attempted to reapply the BIPAP mask, but the machine indicated an error message. RT J stated he attempted to troubleshoot the machine but could not get it to work again. RT J stated he placed Resident #1 on oxygen. RT J stated he was not aware there was a back-up BIPAP machine. RT J stated he realized there was a back-up BIPAP machine at around 3:00 am but by that time Resident #1 was already asleep and didn't want to disturb him. RT J stated that he and the overnight nurse continued to check on Resident #1 throughout the night. RT J stated Resident #1's saturation levels were fine, and Resident #1 did not have any shortness of breath. RT J stated had there been an emergency, 911 would have been called. RT J stated a negative outcome could have been that Resident #1's respirations levels and saturation levels could have been low, and Resident #1 could have had shortness of breath. Interview on 11/19/25 at 9:20 am, RT C stated Resident #1 required respiratory treatments such as nebulizer treatments, continuous oxygen and the use of BIPAP machine. RT C stated Resident #1 had those treatments upon admission. RT C stated he received report in the morning from the night shift RT. RT C stated that RT J had stated to him that Resident #1 used the BIPAP machine up until 2-3:00 am but then the machine malfunctioned. RT C stated that RT J informed him that Resident #1 was then placed on oxygen and was fine throughout the rest of the morning. RT C stated there is a backup BIPAP machine in the respiratory storage room. RT C stated all RTs are aware of the backup BIPAP machine because the BIPAP machine needs to be checked for functionality at the beginning and end of every shift. RT C stated that once the BIPAP machine has been checked, there is a sign off sheet that is signed by the RT. RT C stated that a negative outcome for a resident not using the BIPAP could cause a resident to become short of breath. RT C stated that the BIPAP machine is used to get rid of carbon dioxide in the body and helps the resident breath better. RT C stated that high levels of carbon dioxide in the body could cause increased sleepiness, confusion and other health problems. Interview on 11/19/25 at 10:54 am, RN F stated he was given report at the beginning of his shift from RT C that Resident #1 had not slept with the BIPAP machine. RN F stated he