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	02/12/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 4 residents (Resident #247) reviewed for care plans, in that: The facility failed to ensure Resident #247's care plan revised on 01/17/25 reflected he required a mechanical lift to be transferred to and from bed. This deficient practice could place residents in the facility at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs. The Findings included: Record review of Resident #247's admission sheet, dated 02/12/25, reflected a [AGE] year-old-male admitted on [DATE]. His relevant diagnoses included intervertebral disc degeneration (a condition where one or more discs in the spine deteriorates due to age, which results in back or neck pain), muscle wasting and atrophy (loss of muscle mass and strength), abnormalities of gait and mobility (disruptions in a person's walking pattern, including issues with balance and coordination), and history of falling. Record review of Resident # 247's MDS quarterly assessment dated [DATE], reflected a BIMS score of 11, which indicated his cognition was moderately impaired. Further review indicated Resident #247 required a wheelchair as a mobility device and required substantial/maximal assistance (helper does more than half of the effort) for chair/bed-to-chair transfer and tub/shower transfer. Record review of Resident #247's care plan dated 01/17/25, reflected he had an ADL self-care performance deficit related to intervertebral disc degeneration of lumbar region with discogenic back pain(a type of back pain that originates from the degeneration of the intervertebral disc), history of falls, lack of coordination, and abnormal gait and mobility. Date initiated 11/20/24 and revised on 01/2025. Resident #247 required extensive assistance by 2 staff for transferring. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 02/09/25 at 3:22 p.m., Resident #247 was observed awake in bed. His bed was set to the lowest position and his call light was within reach. Resident #247 said he did not want to talk to anyone and to leave his room. An interview on 02/12/25 at 10:00 a.m., CNA A said Resident #247 was a two person assist for all his ADL's. She said whenever Resident #247 was given a shower, she and her partner would transfer him to and from bed to the shower chair. She said they would use a mechanical lift for his and their safety. She said Resident #247 was a big man. She said she was not sure if the charge nurses knew they used a mechanical lift to transfer him. CNA B was not able to verify if the Kardex system indicated Resident #247 required a mechanical lift for transfer. She said the morning CNAs knew he required a mechanical lift for transfers due to his size. An interview on 02/12/25 at 10:45 a.m., CNA B said Resident #247 was a two person assist for all his ADL's. She said whenever Resident #247 was given a shower, she and her partner would transfer him to and from bed to the shower chair. She said they would use a mechanical lift for his and their safety. She said she did not remember how long he had been transferred by a mechanical lift. She said was not sure if the LVNs knew the CNAs used a mechanical lift to transfer Resident #247 to shower chair. CNA B was not able to verify if the Kardex system indicated Resident #247 required a mechanical lift for transfer. She said the morning CNAs knew Resident #247 was a mechanical transfer. An interview on 02/12/25 at 11:00 a.m., LVN C said she was not aware CNAs were using a mechanical lift to transfer Resident #247 to and from his bed to shower chair. She was not able to say if his care plan included that he was a mechanical lift for transfers. She said she would have to check with the DON before she answered any other questions. LVN C was not able to mention if there were any negative outcome to Resident #247's care plan not including that he required a mechanical lift for transfer. An observation and interview on 02/12/25 at 1:56 p.m., the DON checked Resident #247's medical electronic record and said he was a two person assist for bathing/showering and transfers. She said his care plan did not indicate he required a mechanical lift for transfer. She said she was not aware the CNAs had been using a mechanical lift to transfer Resident #247 to and from bed to shower chair. The DON said Resident #247 had not sustained any negative outcome for not having his care plan include that he required a mechanical lift for transfer. An interview on 02/12/25 at 2:12 p.m., Rehab Director, said she had been approached by one of Resident #247's CNAs and had asked if it was ok if they continued using a mechanical lift to transfer him to and from the shower chair. She said her response was yes just for safety measures. She said Resident #247 was a big guy and had uncoordinated movements so mechanical lift would be safer. She said after her conversation with the CNA , she advised the facility's DON of her recommendation. She said Resident #247 was currently receiving occupational, speech, and physical therapy five times a week and had no end date. The Rehab Director said had nothing to do with care plans, therefore, could not say if Resident #247 sustained any negative outcome that his care plan did not include, he required a mechanical lift for transfer. Record review of the facility's Comprehensive Care Plans policy dated 10/24/22 reflected: Policy: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 3. The comprehensive care plan will describe, at a minimum, the following: a) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing.

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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** 40872 Based on interview and record reviews, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 1 resident (Resident #11) reviewed for residents needs as identified through resident assessments. The facility failed to ensure LVN P documented resident #11's assessment on 01/29/25 after CNA O informed her she had noticed redness on Resident #11's leg. This deficient practice could affect residents whose records are maintained by the facility and could place them at risk of not having assessments documented resulting in potential delayed treatment and decreased quality of life. Findings included: Record review of R#11's admission record dated 02/12/25 reflected an [AGE] year-old female with an admitted [DATE]. Her diagnoses included Unspecified Dementia (loss of brain function that affects memory, thinking, behavior, and language) Unspecified Severity with Mood Disturbance, Cognitive Communication Deficit (difficulty communicating), Other Lack of Coordination, Age-Related Osteoporosis (bone disease that weakens bones, more likely to break), Without Current Pathological Fracture, and Rheumatoid Arthritis (inflammation and pain in joints) Without Rheumatoid Factor, Multiple Sites. Record review of Resident #11's quarterly MDS assessment dated [DATE] reflected a BIM score of 99 indicating resident was unable to complete the interview. MDS also reflected Resident #11 used a wheelchair to ambulate and was a substantial/maximal assist with chair to bed, bed to chair transfers. Record review on 02/11/25 of Resident #11's electronic medical record revealed no documentation done by LVN P on 01/29/25 or 01/30/25 on assessment done for Resident #11 after CNA O informed LVN P. An interview on 02/09/25 at 2:33 p.m. Resident #11 was alert, however, did not respond to questions and was heard repeating numbers. An interview on 02/10/25 at 8:19 p.m. LVN P said CNA O told her to check Resident #11. LVN P said CNA O had not told her what to assess Resident #11 for. She said she assessed the Resident for flu symptoms since there was another resident she had just assessed with those symptoms so she said she thought it was the same thing Resident #11 had. She said she did not do a skin assessment and did not document anywhere on Resident #11's medical record that she had assessed the resident. LVN P also said she did not let the oncoming nurse of the concern brought up by CNA O. She said she should have documented the assessment and said she didn't because she had a lot of things going on with other residents that day. She said they are in serviced on documenting residents assessments. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 02/11/25 at 1:44 p.m. CNA O said when she was changing Resident #11, she said she had noticed redness on Resident #11's leg, below her knee. She said she had told LVN P and had shown her exactly where on the resident's leg was where she had seen redness. CNA O said the nurse assessed it and said she would document it. An interview on 02/11/25 at 2:40 p.m. CNA T said when she worked with Resident #11 on 01/30/25 she had not seen any bruising on her. She also had not seen the resident show any pain when she was providing care. She said they often get in-services on reporting abuse or neglect and they are told to report anything they see that's different in a resident. An interview on 02/11/25 3:30 p.m. LVN N said she completed a weekly assessment on Resident #11 on 01/30/25 and had not seen redness or bruising on Resident #11's leg. She also said had not seen signs or symptoms of pain. She said if she had, she would have reported and documented it. An interview on 02/12/25 at 1:31 p.m. the DON said the staff has been given in-services on documenting when assessing residents. When asked if LVN P should have documented what she assessed, DON said she couldn't tell me why LVN P did not document anything. She said LVN P and the rest of the staff was given an in-service on documenting. Record review of facility's policy dated 10/24/22, titled Documentation in Medical Record Policy: Each resident's medical record shall contain an accurate representation of actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.