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	04/14/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record reviews and interviews, the facility failed to send a copy of the residents' discharge notice, prior to discharge, to the representative of the Office of State Long-Term Care (LTC) Ombudsman for 77 of 81 of residents discharged from the facility for the first 3 months in 2026. The facility failed to send a copy of the residents' discharge notice, prior to discharge, to the representative of the Office of State Long-Term Care (LTC) Ombudsman These failures could place residents at risk of not knowing their rights and receiving the services of the state LTC Ombudsman. Findings Included: Record review of the monthly report of discharges dated 04/14/2026 provided by the Social Worker revealed out of a total of 81 residents discharged only 4 discharges of AMA were sent to the LTC Ombudsman for the months of January, February, and March of 2026. Interview with the SW on 04/13/2026 at 4:16 PM she stated she was instructed by the Administrator that only the AMA stated she only sent the discharges of Against Medical Advice to the LTC Ombudsman for the months of January 2026 to March 2026 as instructed by her Administrator. The SW stated she did not have knowledge that she was to be sending all Resident discharges to the LTC Ombudsman bi-monthly or monthly. The SW stated she had sent the report of the discharges as soon as possible once she gathered all of the information. The SW stated she would be sending a monthly report every month to the Ombudsman starting the month of April 2026 that includes all discharges, so the Ombudsman was able to help with referrals to other resources that can help the resident. In an interview on 04/14/2026 at 11:05 AM with the ADON stated she was not aware the ombudsman was to receive notice of all discharges from the facility every month. The ADON stated the discharge procedure began with nursing team giving the social worker notice of a resident's discharge and the social worker was responsible for sending the letter the RP. The ADON stated the procedure for resident discharges would now include the administrator and medical records as a backup to ensure the ombudsman would be receiving a notice of all discharge notices every month. In an interview on 04/14/2026 at 1:23:PM with the Administrator he Stated the facility failed to follow the facility's policy and procedure of giving notice to the LTC Ombudsman monthly of the months of January, February, and March. The SW only sent notice of the discharges for residents leaving AMA for first three months in 2026. The Administrator stated he failed to have knowledge of the policy of the monthly notice as stated in the facility's policy and procedure for Transfer and Discharge. The Administrator stated there was now a backup to the SW that includes the Administrator and medical records to ensure the monthly report to the LTC Ombudsman was sent and received by the Ombudsman. The Administrator stated the facility's admission person did call the discharged residents and made sure the help and resources they needed were contacted and received. The Administrator also stated the DON and ADON were conducting an in-service for all nurses to educate them on what need to be done and who needs to be told about the discharges. The Administrator stated he and the person doing medical records would be doing audits for all residents being discharged as a back up to the SW to ensure the ombudsman is receiving the letters monthly. The Administrator stated the SW never brought the matter of the facility's failure to send the discharge letters to the ombudsman. The Administrator stated the facility admission coordinator did follow up (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the discharged residents to see if all the referrals were completed by the referral agencies. The Administrator stated the negative outcome of the Ombudsman did not have notice of the discharges could affect the resident of being discharged without proper help. In record review of the facility's policies and procedures for Transfer and discharge date d 03/05/2025 stated It was the policy of the facility to permit each resident to remain in the facility and transfer of discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source.5. The facility will maintain evidence that the notice was sent to the Ombudsman.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen. 1. The facility failed to ensure male kitchen staff were wearing beard restraints and wear them properly while in the kitchen.2. The facility failed to discard scratched non-stick pans. 3. The facility failed to wear gloves while cooking raw ground beef for consumption.4. The facility failed to ensure can opener was clean.5. The facility failed to ensure dinner rolls were covered while waiting for baking.6. The facility failed to ensure the air conditioning vents to be free of a black substance surrounding the vents and condensation. 7. The facility failed to ensure the safe distribution of the resident #45's food as the CNA stuck her finger in the residents food while serving the food to the resident causing cross contamination. These failures could place residents at risk of foodborne illnesses. Findings included: Observation and Initial tour of the kitchen on 04/12/24 at 1:30 p.m. revealed two male employees DA E was not wearing a beard restraint, and DA F was not wearing his beard restraint properly over mustache. In observation of dishwash room a set of 11 pans were hanging with a the non-stick coating scratched or peeling. The cook was observed cooking raw ground beef without gloves. In inspection of the can opener a black substance was seen coating the working side of the can opener. In observation of dining on 04/13/2026 at 5:23 PM CNA C was observed serving the Resident #45 with improper infection control procedure. CNA C was seen touching the rim of the drinking glass and dessert cups after removing protective covering. CNA C was seen touching the peaches with her finger as she placed the cup on the table of the resident. In a second observation on 04/13/2026 at 11:11. In observation of the self-standing oven two cookie sheets of rolls were seen uncovered and on sitting on top of self-standing oven. The oven doors were observed open while removing the rolls from the oven and not closed immediately when done. In observation of the 7 out of 9 ceiling air conditioning vents had a black substance surrounding the edges of the vents and condensation that was dripping on to the floor. In record review on 04/13/2026 of Resident #45's face sheet dated 04/13/2026 indicated Resident #45 was a [AGE] year-old female with the diagnoses Alzheimer's Disease with late on set (a progressive disease that destroys memory and other important mental functions), Alzheimer's Disease with late on set (a progressive disease that destroys memory and other important mental functions), Contracture (a permanent, often painful tightening or shortening of muscles, tendons, ligaments, or skin causing ridged deformity and limited joint motion), Dementia (A group of thinking an social symptoms that interferes with daily functioning), Cognitive communication deficit(a communication impairment resulting from underlying cognitive issues such as memory, attention executive function and information processing rather than primary language deficits. In an interview on 04/13/2026 at 9:31 AM with Resident #45 the interview was unsuccessful as the resident could not answer the state surveyors' questions. In an interview with on 04/12/2026 at 2:01PM with DA E he stated he forgot to put on the beard restraint but did normally have one on every day. DA E stated he knew it was important to have a beard restraint on to prevent the resident's food becoming cross contaminated. In an interview with on 04/12/2026 at 2:17 PM with DA F he stated that he forgot to put on the beard restraint correctly covering his mustache. DA E stated he did not realize the beard restraint was not placed on face correctly. DA E stated it was important to have the beard restraint on when preparing food and in the kitchen, so the residents' food did not become cross contained possibly making the residents ill. In an interview on 04/12/2026 at 1:47 PM with the cook she stated she was not aware that she was to be wearing gloves while cooking food as she was using utensils and not touching food with bare hands. The cook stated she did wear gloves if she handled food with bare hands like cutting vegetables. In an interview with the DM on 04/12/2026 at 1:56 PM she stated the male employee would be reeducated with an in service about the importance (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of wearing beard restraints. The pans that were scratched were thrown away and would do a reeducation on why scratched nonstick pans are not to be used and need to be thrown away so they are not accidentally used for cooking. The DM stated she had an in-service with the staff on the importance of cleaning the can opener daily to ensure the food in the can did not become contaminated. The DM stated she did not realize the rolls were not covered and would reeducate the staff on the importance of food being covered at all times if not in a container to prevent them from being exposed to air and becoming contaminated. The DM stated the can opener was cleaned every day and it was all the staff's responsibility to clean the can opener after being used and could not say when it was last cleaned. The DM stated she would do an in-service with the staff about the importance of wearing gloves while handling raw meat and vegetables with a gloved hand to prevent cross contamination while preparing food. The DM stated she would reeducate the staff on the importance of not leaving the oven doors to prevent food from becoming contaminated and add to the heat in the kitchen that cause the condensation on the air condition vents in the ceilings dripping on to the floor and possible falling in to already cooked food and could cause the residents to become ill. The DM stated she did not realize the vents were producing condensation and dirty, but she would let the maintenance man know of the condensation on the vents and the black substance surrounding the vents. In an Interview on 04/14/2026 at 1:16 PM with the Maintenance Man stated he would be contacting the ac vac company for maintenance on temperature and condensation. The Maintenance Man stated he did preventive maintenance service for the air conditioning unit every month and had not seen any condensation. The Maintenance Man stated the weather was getting hotter, so the air conditioning unit was being used more frequently to keep the kitchen cool and with the heat from cooking might be the reason for the condensation on the vents. The Maintenance Man stated the air conditioning company only got called out for a service call if the unit was not working properly. The Maintenance Man would be wiping down and cleaning the area around the vents and stated the vents were just replaced last month. The maintenance Man would be monitoring the condensation to prevent it from happening again. In record review of the policy for Food Preparation and Handling dated 06/01/2019 the policy stated To ensure that all food severed by the facility was of good quality ad safe for consumption, all food would be prepared and handled according to the state and US Food Codes HACCP Guidelines. c. Prepare food with the least manual contact possible. Do not allow bare hands to touch raw food directly. In record review of Employee Sanitation policy dated 10/01/2018 stated The Nutrition & Foodservice employees of the facility would practice good sanitation practices in accordance with the state and US Food Codes in order to minimize the risk of infection and food borne illnesses. b. Hairnets, headbands, caps beard coverings and other effective hair restraints must be worn to keep hair from food and food-contacts surfaces.d. No fingernail polish or artificial fingernails can be worn when working with exposed food or unwrapped utensils unless wearing intact gloves in good repair. In record review of the Food Storage policy dated 06/01/2019 to ensure that all food served by the facility was of good quality and safe for consumption, all food would be stored according to the state, federal and US Food Codes and HACCP guidelines. g. Use the first-in-first out (FIFO)rotation method. Date packages and place new items behind existing supplies, so that the older items are used first.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **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 incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and restore continence to the extent possible for 1 of 3 residents (Resident#19) reviewed for quality of care. The facility failed to prevent Resident#19's urinary catheter tubing (bag) from touching the floor on 4/12/26. This failure could place residents at risk for cross contamination and urinary tract infections.Findings included: Record review of Resident#19's face sheet revealed a [AGE] year-old female originally admitted on [DATE]. Resident#19 had admitting diagnosis of neuromuscular dysfunction of bladder (is a condition where nerve damage disrupts the signals between the brain, spinal cord, and bladder muscles). Record review of Resident #19's MDS assessment dated [DATE], revealed Resident #19 had a BIMS score of 1 which indicated Resident #19 had severe impaired cognition. Resident #19 had an indwelling catheter. Record review of Resident #19's care plan dated 11/27/2018 revealed Resident #19 had a foley catheter for neuromuscular dysfunction of the bladder date initiated 11/25/24 and revised on 12/9/25. Intervention/tasks listed Resident #19 had an 18 french 30 milliliters balloon indwelling position catheter bag and tubing below the level of the bladder and away from entrance room door. Record review of Resident #19's Order Summary revealed order Foley Catheter 18 # French with 30milliliters balloon every night shift starting on the 18th and ending on the 18th every month. During an observation conducted on 04/12/26 at 5:15 PM, Resident #19's indwelling catheter bag was noted laying on the floor on the left side of Resident #19's bed. During an interview with LVN D on 04/12/26 at 5:25 PM, LVN D was informed Resident #19's catheter bag was laying on the floor. She stated it should not be touching the floor. She replied that a negative outcome of foley catheter bag being on the floor was the catheter wouldn't drain well and pick up bacteria from floor. During an interview with the ADON on 04/14/26 at 8:45 AM, she stated, for catheters, they should be on the side of the bed, not the on part that went up and down, so it didn't fall, but on frame. ADON stated, no, it should not be touching the floor. If on the floor, residents could be at risk of infection. ADON stated that the DON was not available. Record Review of facility's Nursing Pocedure 8th edition Titled Indwelling Urinary Catheter Care and Removal, revealed: Make sure the catheter is properly secured.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 8 residents (Resident #20) reviewed for respiratory care. 1. The facility failed to ensure Resident #20's oxygen tubing was not touching the floor on 4/12/2026. 2. The facility failed to post an Oxygen sign indicating Resident #20 received oxygen on 4/12/2026. These deficient practices could place residents who receive respiratory care at an increased risk of developing respiratory complications, a decreased quality of care, and at risk of fire hazards by not posting oxygen signs outside the residents' rooms.The findings included: Record review of Resident #20's face sheet, dated 04/12/2026, revealed a [AGE] year-old male with an admission date of 4/8/2026. Pertinent diagnoses included Acute Respiratory Failure with Hypercapnia (a sudden, life-threatening inability of the respiratory system to eliminate carbon dioxide from the blood), and Heart Failure. Record review of Resident #20's Comprehensive MDS assessment, dated 4/2/2026, revealed he was on Oxygen Therapy while a resident. Record review of Resident #20's Care Plan, dated 01/22/2019, revealed Resident #20 has oxygen therapy PRN r/t SOB with an intervention of oxygen settings:O2 via nasal Cannula, as per MD order. Record review of Resident #20's physician orders, started 4/12/2026, revealed an order for Oxygen at 2 liters per minute every shift for hypoxia (a dangerous condition where tissues receive inadequate oxygen, leading to symptoms like confusion, shortness of breath, rapid heart rate, and bluish skin). An observation on 4/12/2026 at 2:10 p.m. revealed Resident #20 was in his room lying on his bed. He was wearing a nasal canula and was receiving oxygen at 2 liters per minute. The oxygen tubing was touching the floor without a protective sleeve. There was no oxygen sign posted outside of his room. During an interview on 04/12/2026 at 2:15 p.m., LVN D stated that she was the nurse for Resident #20. She stated all staff were responsible for posting the oxygen sign outside the residents' rooms. LVN D verified Resident #20 did not have an oxygen sign posted outside his room. She stated all residents who were on oxygen, regardless of needing it continuously or prn, all needed a sign. LVN D stated it was important for the oxygen tubing not to touch the floor because it could get contaminated and Resident #20 could get an infection. LVN D stated that it was important for posting an oxygen sign outside the resident's rooms, so no one should [NAME], and everyone who went into the facility would be aware that there was oxygen in use inside the room, for safety. During an interview on 04/14/2026 at 8:45 a.m., the ADON stated the floor nurses were responsible for verifying the oxygen tubing was not touching the floor every shift because it's a risk for infection for the resident. She stated that anybody could post the oxygen sign on the outside of the residents' room, but it was the responsibility of the admitting nurse. The ADON stated that it was important for the oxygen sign to be posted for everyone to know that there was oxygen in use in that room. She stated that she does random compliance rounds. Record review of the facility's General Procedures and Treatment Modalities 1. Post a NO SMOKING sign on the outside of door to the residents room before starting use of oxygen.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to ensure all drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 of 7 (100/200-hall and 300/400-halls) medication carts reviewed for pharmacy services. 1. The facility failed to store 5 loose tablets in their appropriate blister packs in the medication cart for halls 100 and 200 at 2:37 PM on 04/13/26. 2. The facility failed to store 8 loose tablets/capsules in their appropriate blister packs in the medication cart for halls 300 and 400 at 2:54 PM on 04/13/26. This deficient practice could place residents at risk of losing medications leading to medication shortage.The findings included:During an observation of the 100/200 hall medication cart at 2:37 PM on 04/13/26 five assorted tablets were found loose in the 2nd drawer from the top. The drawer contained blister packs of medications for residents living on the 100 and 200 halls along with the loose medications. During an observation of the 300/400 hall medication cart at 2:54 PM on 04/13/26 eight assorted tablets were found loose in the 2nd drawer from the top. The drawer contained blister packs of medications for residents living on the 300 and 400 halls along with the loose medications. In an interview with MA A at 3:43 PM on 04/13/26, MA A stated she was in charge of the 100/200 hall medication cart when the loose pills were found. MA A stated she always cleaned out her cart at the end of her shift. MA A stated she looked for expired medications and loose tablets when she cleaned out her cart. MA A stated she found loose tablets in her cart before when she cleaned it. MA A stated it was important to keep the cart clean and organized to help prevent contamination and to protect residents' property. In an interview with the ADON at 3:56 PM on 04/13/26, the ADON stated it was nursing best practice for whoever was responsible for the medication cart to ensure it was cleaned appropriately. The ADON stated each cart should be cleaned once per shift. The ADON stated when cleaning a cart, the staff member should ensure there were no loose pills, liquids were sealed properly, nothing was expired, the wheels, drawers and brakes on the cart all functioned appropriately, and it was generally clean and organized. The ADON stated this was important to prevent any contamination and to avoid possible administration errors. Record review of the facility's policy titled Medication Carts and Supplies for Administering Meds last revised 10/01/19, revealed the following: .10. The licensed nurse or medication aide should maintain a clean top surface on the medication cart while passing medications and clean and replenish the medication cart after each use. Equipment and supplies relating to medication administration are clean and orderly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #20) reviewed for infection control. CNA B and CNA C failed to follow Enhanced Barrier Precautions for an indwelling catheter for Resident #20 on 4/12/26. This failure could place residents at risk for cross contamination and the spread of infection. Finding included: Record review of Resident #20's face sheet, dated 04/12/2026, revealed a [AGE] year-old male with an admission date of 4/8/2026. Pertinent diagnoses included Neuromuscular dysfunction of bladder (nerve damage from conditions like spinal cord injury, or Parkinson's that disrupts signals between the brain and bladder) and Heart Failure. Record review of Resident #20's Comprehensive MDS assessment, dated 4/2/2026, revealed Section H-Bladder and Bowel indicated Resident had an indwelling catheter while a resident. Record review of Resident #20's Care Plan, dated 01/22/2019, revealed Resident #20 has the need for Enhanced Barrier Precautions due to Foley Catheter. During an incontinent care observation on 4/12/26 at 4:05 p.m., CNA B and CNA C commenced incontinent care and indwelling catheter care of Resident #20. CNA B and CNA C entered Resident #19's room after knocking. CNA B and CNA C began with washing their hands for 30 seconds, gloved up, and prepared the table of needed supplies. CNA B and CNA C continued by raising bed and then discarded gloves. After discarding the gloves, CNA B and CNA C continued with applying hand sanitizer, and she applied new gloves. CNA B proceeded with catheter care and proceeded to clean the back area, removed brief, and applied new brief. CNA B and CNA C did not use gowns during incontinent care. During an interview on 04/12/26 at 4:15 p.m., CNA B stated any resident with an indwelling catheter was required for enhanced barrier precautions. She stated she should have worn a gown, and just overlooked it when she entered the room. She stated the risk of not following Enhanced Barrier Precautions was the spread of infection. During an interview on 4/12/26 at 4:20 p.m., CNA C said she forgot to use the gown. CNA C said it was important to use the EBP to protect residents from whatever microorganisms that she could carry and to protect other residents. CNA C said residents could be at risk of infection. During an interview on 4/14/26 at 8:45 a.m., the ADON stated EBP was staff needing to wear a gown and gloves for individuals with a catheter, feeding tube, or wounds. ADON said it was important to use PPE to prevent introducing any kind of infection to residents. ADON said not using EBP could put residents at a higher risk for infection. Record review of the facility's Enhanced Barrier Precautions policy dated 11/24/25 reflected: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definition: enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and gloves to use during high contact resident care activities. Policy Explanation and Compliance Guidelines:.2. Initiation of Enhance Barrier Precautions:.b. An order for an enhanced barrier precautions will be obtained for residents with any of the following: .i. wounds (e.g., chronic wounds such as urinary catheters.)