STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676495	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Starr County Nursing and Transitional Care	5260 Brand St Rio Grande City, TX 78582

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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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 observation, interview and record review the facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, for 1 of 5 residents (Resident#1) reviewed for oxygen in that:The facility failed to ensure Residents #1 oxygen therapy was being properly administered.This deficient practice could place residents who receive oxygen therapy at an increased risk of developing respiratory complications and a decreased quality of care. Findings Included: Record review of Resident #1's electronic face sheet dated 10/14/2025 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses which included the following: Chronic Obstructive Pulmonary Disease (lung condition that damages the airways making it difficult to breathe), Muscle Wasting and Atrophy (muscles shrinking and getting weaker), Dysphagia (difficulty swallowing), Hypertension (high blood pressure), Peripheral Vascular Disease (a circulation problem that affects blood vessels outside your heart and brain, most commonly in the legs and arms), Gout (inflammatory arthritis in the joints). Record review of Resident #1's Comprehensive MDS assessment, dated 09/29/2025, reflected a BIMS score of 03, indicated her cognition was severely impaired. Special treatments, procedures, and programs reflected resident received oxygen therapy. Record review of the Physician's Order Summary dated 10/14/2025 reflected Resident #1 was prescribed Oxygen at 2LPM via nasal cannula as needed for SOB related to Chronic Obstructive Pulmonary Disease (lung condition that damages the airways making it difficult to breathe) start date 09/29/2025. Record review of Resident #1 care plan, dated 10/14/2025, reflected the resident had oxygen therapy related to COPD. Interventions reflected: administer oxygen per physician's orders, monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, Increased heart rate, Restlessness, Diaphoresis (excessive sweating that was not caused by typical triggers like heat or exercise), Headaches, Lethargy, Confusion, Atelectasis (partial or complete collapse of a lung or a section of a lung), Hemoptysis (coughing up blood or bloody mucus from the lungs or respiratory tract), Cough, Pleuritic pain, Accessory muscle usage, Skin color. Observation on 10/14/2025 at 10:51 a.m. Resident #1 observed in room lying in bed with her eyes closed and the head of the bed was slightly elevated. Oxygen concentrator was on and set on 2LPM. Resident #1 had oxygen tubing properly placed on her face via nasal cannula, but the oxygen tube was not connected to the concentrator. Resident #1 did not have symptoms of respiratory distress. ADON A along with RN B checked Resident #1 O2 saturation with different devices at the same time. ADON A checked it on finger, read 93% and RN B checked it on the earlobe, read 96%. During an interview on 10/14/2025 at 10:53 a.m. ADON A stated that the nurses were responsible for checking the oxygen in the morning or once per shift. She stated that Resident #1 tends to move around a lot and that was probably how it got disconnected. ADON A stated that the negative outcome was that Resident #1 oxygen can desaturate (drop in oxygen levels in the blood) and as a result can become hypoxia (condition where the body tissues don't get enough oxygen). During an interview on 10/14/2025 at 10:57 a.m. RN B stated that she was the nurse for Resident #1. She stated that Resident #1 had been on oxygen since she was admitted . RN B stated that she was in Resident #1's room around 10:15 a.m. and that at the time the tubing was connected to the oxygen concentrator. She stated that she checks Resident #1 oxygen several times during her shift due to Resident #1 getting up to use the restroom and gets SOB. RN B stated the negative outcome was that Resident #1 oxygen can desaturate (drop in oxygen levels in the blood). During an interview on 10/14/2025 at 2:56 p.m. with the DON stated that the nurses were responsible for checking oxygen and O2 saturation levels every shift and as needed throughout the day. The DON stated that the negative outcome was that Resident #1 can go into respiratory distress. Record review of the facility's Lippincott Manual of Nursing Practice 11th edition Administering Oxygen Therapy, revealed 1.Assess need for oxygen by observing for symptoms of hypoxia: . Assess the patient's current oxygenation 3.Administer oxygen in the appropriate concentration and device.c. Ensure proper use and fit of oxygen delivery device., with oxygen flow rate according to instructions.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from any significant medication errors for one of five residents (Resident #2) reviewed for medication errors. The facility failed to administer Resident #2's clonidine (blood pressure medication) when Resident #2's blood pressure was within parameters 12 days in the months of September and October 2025. This failure could place residents at risk for complications such as increased blood pressure, exacerbation of symptoms, and potential hospitalization. The findings include:Record review of Resident #2's face sheet, dated 10/14/25, reflected a [AGE] year-old male with an admission date of 05/15/24. Resident #2's pertinent diagnosis included hypertensive heart disease with heart failure (condition in which long-term high blood pressure leads to heart failure). Record review of Resident #2's Quarterly MDS assessment, dated 09/02/25, reflected a BIMS score of 10 which indicated moderate impairment. Record review of Resident #2's comprehensive care plan, dated 10/14/25, reflected the problem [Resident #2] has hypertension. last revised on 12/26/24. An intervention listed for the problem included Give anti-hypertensive medications as ordered. initiated on 05/16/24. Record review of Resident #2's order summary reflected an active order for clonidine HCl Oral Tablet 0.1 MG. Give 1 tablet by mouth every 6 hours as needed for HTN. May administer if SBP greater than 150mmhg or DBP greater than 100mmhg initiated on 10/14/24. Resident #2 also had an active order for amlodipine besylate oral tablet 10 MG (blood pressure medication). Give 1 tablet by mouth one time a related to hypertensive heart disease with heart failure. May hold if SBP 100 or below DBP 60 or below initiated on 08/05/24. Record review of Resident #2's blood pressure log, on 10/14/25, from September and October of 2025 reflected the following blood pressures:- 10/09/25 at 09:43 AM - 152/68 mmhg- 10/07/25 at 09:50 AM - 156/84 mmhg- 10/05/25 at 09:38 AM - 158/84 mmhg- 09/25/25 at 09:07 AM - 158/88 mmhg- 09/24/25 at 09:27 AM - 168/78 mmhg- 09/20/25 at 09:35 AM - 164/92 mmhg- 09/14/25 at 09:10 AM - 153/84 mmhg- 09/13/25 at 09:44 AM - 164/86 mmhg- 09/11/25 at 09:11 AM - 164/72 mmhg- 09/08/25 at 09:45 AM - 162/96 mmhg- 09/06/25 at 09:59 AM - 152/80 mmhg- 09/04/25 at 11:03 AM - 154/86 mmhgFurther Record review of the blood pressure logs revealed Resident #2's blood pressure was only checked twice on 09/30/25 and 09/16/25. Neither of the two dates it was checked twice recorded a blood pressure above 150/100 mmhg. Record review of Resident #2's MAR for September and October 2025 reflected clonidine 0.1 mg had not been administered during those two months. Further review revealed Resident #2 had been administered amlodipine 10 mg every morning during those two months. In an interview with LVN C at 9:48 AM on 10/14/25, LVN C stated he measured Resident #2's blood pressure earlier that day. LVN C stated Resident #2's systolic blood pressure was usually in the 140's. LVN C stated Resident #2 gets his blood pressure checked in the morning when he is scheduled to receive a daily blood pressure medication. LVN C stated if he measured Resident #2's blood pressure to be above 150/100, he would wait for around one hour and recheck to see if it was still elevated, and if so, administer the clonidine. LVN C stated he did not know if Resident # 2's blood pressure was rechecked on the days it was measured to be above 150/100. LVN C stated if the blood pressure was rechecked it should have been recorded in the blood pressure log. LVN C stated it was important to administer blood pressure lowering medications as ordered to prevent the resident from having a stroke. In an interview with ADON A at 10:07 AM on 10/14/25, ADON A stated Resident #2's blood pressure should have been checked at least twice per day to know if he needed the clonidine or not. ADON A stated Resident #2's blood pressure was only being checked once per day on most days. ADON A stated if Resident #2's blood pressure was checked in the evening, and it was over 150/100 she would administer the clonidine. ADON A stated it was important to maintain a resident's blood pressure to prevent strokes. In an interview with the DON at 10:27 AM on 10/14/25, the DON stated the facility should have measured Resident #1's blood pressure every 6 hours to determine if he needed the clonidine. The DON stated if Resident #2's blood pressure was measured in the morning to be over 150/100, nurses should have administered Resident #2's other blood pressure medication, wait an hour or so, and recheck the blood pressure to see if it was still over the threshold. The DON stated she was unable to find any documentation showing Resident #2's blood pressure was rechecked on the days it was over 150/100 in the morning. The DON stated it was important to ensure Resident #2's blood pressure did not rise too high otherwise he could have a stroke. Record review of the facility's policy Medication Administration, dated 10/24/22, reflected the following policies: .8. Obtain and record vitals signs, when applicable or per physician orders. When applicable, hold medication for those

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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 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. (continued on next page)

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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 0842 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 observation, interviews, and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for medication administration. The facility failed to accurately document Resident #1's Medication Administration Record for Oxygen Therapy that was administered from 10/10/2025 through 10/14/2025. This deficient practice could place residents at risk of having inaccurate medical records. Findings Included:Record review of Resident #1's electronic face sheet dated 10/14/2025 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses which included the following: Chronic Obstructive Pulmonary Disease (lung condition that damages the airways making it difficult to breathe), Muscle Wasting and Atrophy (muscles shrinking and getting weaker), Dysphagia (difficulty swallowing), Hypertension (high blood pressure), Peripheral Vascular Disease (a circulation problem that affects blood vessels outside your heart and brain, most commonly in the legs and arms), Gout (inflammatory arthritis in the joints). Record review of Resident #1's Comprehensive MDS assessment, dated 09/29/2025, reflected a BIMS score of 03, indicated her cognition was severely impaired. Special treatments, procedures, and programs reflected resident received oxygen therapy. Record review of the Physician's Order Summary dated 10/14/2025 reflected Resident #1 was prescribed Oxygen at 2LPM via nasal cannula as needed for SOB related to Chronic Obstructive Pulmonary Disease (lung condition that damages the airways making it difficult to breathe) start date 09/29/2025. Record review Resident #1 care plan, dated 10/14/2025, reflected that the resident had oxygen therapy related to COPD. Interventions reflected: administer oxygen per physician's orders, monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, Increased heart rate, Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. Record review of Resident #1's Medication Administration Record (MAR) reflected Oxygen at 2LPM via nasal PRN, had no administration entries from 10/10/2025 through 10/14/2025. Record review of Resident #1's Skilled Nurse Notes dated 10/10/2025, 10/11/2025, 10,12/2025, 10/13/2025, and 10/14/2025 reflected Resident #1 was on Oxygen @2LPM via NC. During an interview on 10/14/2025 at 10:57 a.m. RN B stated that she was the nurse for Resident #1. She stated that Resident #1 had been on oxygen since she was admitted .Follow up interview on 10/14/2025 at 3:20 p.m. RN B stated that she would document Resident #1's Oxygen saturation once a shift in the MAR. She would then document that the resident was on oxygen in the skilled nurse note. RN B was not aware that she needed to document this information in the MAR. She then stated that she would reach out to the doctor to get a continuous oxygen order. During an interview on 10/14/2025 at 2:56 p.m. with the DON stated Resident #1 oxygen therapy was ordered as needed. She stated that the oxygen should had been signed off in the MAR that it was being administered. The DON stated that it was important for the oxygen to be documented to follow doctors' orders. During an interview on 10/14/2025 at 3:25 p.m. ADON A stated the nurse who administered the oxygen was to document that it was administered in the MAR. She then confirmed that the nurse did not document in the MAR that oxygen was being administered. ADON A stated that it was important to document so that it was verified that Resident #1 was currently on oxygen. She stated that the DON and herself check the MAR's for completion and accuracy. ADON A stated that Resident #1's MAR's slipped and therefore she did not notice that it had not been documented. Record review of the facility's policy titled Medication Administration, dated 10/24/2022 revealed, Policy Explanation and Compliance Guidelines:10. Review MAR to identify medication to be administered.17. Sign MAR after administered. For those medications requiring vital signs, record vital signs on the Medication Administration Record (MAR). Record review of the facility's policy titled Documentation in Medical Record, dated 10/24/2022, revealed: Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the residents progress through complete, accurate, and timely documentation.

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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. (continued on next page)

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F 0880 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 observation, interview, 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 disease and infection for one (Resident #3) of five residents reviewed for infection control, in that:On 10/18/2025, the facility failed to ensure CNA A removed her contaminated gloves and performed hand hygiene after touching multiple surfaces prior to initiating Resident #3's perineal incontinent care These failures could place residents at risk of contamination and infection. FindingsRecord review of Resident #3's Admissions Record dated 10/18/2025 revealed Resident #3 was a [AGE] year-old-female who was initially admitted [DATE]. Resident #3 was admitted with several diagnoses including: dementia (cognitive impairment), hemiplegia (paralysis) and hemiparesis (partial weakness), and unspecified psychosis (severe mental condition in which thought and emotions are so affected that contact is lost with external reality). Record review of Resident #3's Quarterly MDS dated [DATE] revealed Resident #3 had a BIMS score of 8 which meant severe cognitive impairment and was dependent on staff for most of her ADLs. Additionally Resident #3 was coded for always urine/bowel incontinence. Record review of Resident #3's Care Plan revealed date initiated 07/24/2023 [Resident #3] has bladder incontinence r/t limited mobility. Goal: The resident will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions: Clean peri-area with each incontinence episode. Monitor/document for s/sx UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. During an observation on 10/18/2025 at 2:04PM CNA A and CNA B knocked and entered Resident #3' s room. They both then notified Resident #3 of their desire to perform incontinent care, to which Resident #3 agreed to. CNA A closed Resident #3's entry door, walked into the bathroom and commenced hand hygiene utilizing soap and water for roughly 32seconds. CNA A then applied clean gloves. CNA A then retrieved Resident #3's call light remote and placed it on the side of Resident #3, then withdrew Resident #3's blankets and sheets, followed by removing Resident #3's brief and proceeded to retrieve clean wipes, and commenced incontinent care without removing the potentially contaminated gloves nor performed hand hygiene prior to commencement of incontinent care. During an interview on 10/18/2025 at 2:29PM, CNA A stated she should have removed her contaminated gloves once she touched Resident #3's call light remote and removed Resident #3's sheet and blanket. CNA A stated the reason she should have taken off the contaminated gloves and utilized ABHR, after she touched Resident #3's surroundings, was a precautionary infection control measure to ensure that any unknown microorganisms would not be introduced to Resident #3 during incontinent care. CNA A stated by not removing her contaminated gloves after she touched Resident #3's call light and linen, she may have compromised Resident #3's well-being and continued to state if the microorganisms were introduced to Resident #3, the resident could become at risk for contracting a UTI. CNA A stated she was nervous during the observation and that she had recently completed her incontinent care skills check off. During an interview on 10/19/2025 at 9:56AM, the DON stated the facility follows CDC Guidelines regarding hand hygiene. The DON stated CNA A should have removed her contaminated gloves and performed hand hygiene after touching Resident #3's surroundings. The DON stated that CNA A should have completed the glove removal and hand hygiene was to promote infection control. The DON stated by CNA A not completing the two tasks, Resident #3 could have potentially contracted an infection that could lead to a urinary tract infection which could negatively affect Resident #3's well-being. The DON stated her managerial staff facilitate random skill check offs for all CNAs and conduct monthly in-services regarding hand hygiene and infection control. Record review of the facility's CNA A's Skill Checklist dated 10/07/2025 revealed CNA A adequately was educated and completed the infection prevention portion of training regarding hand washing and stand precautions. Record review of the facility's Infection Control and Handwashing in-service on 10/01/2025 was reviewed and CNA A was in attendance. Record review of the facility's Perineal Care policy date implemented 10/24/2022 revealed it is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible and to prevent and assess for skin breakdown.Record review of the facility's Infection Control Policy did not specifically detail when to perform hand hygiene during incontinent care. Record review of the CDC guidelines Clinical Safety: Hand Hygiene