STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455560	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McAllen Nursing Center	600 N Cynthia St McAllen, TX 78501

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Some	**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 (Resident #1) of 3 residents reviewed for accuracy of records, in that:LVN A failed to document the administration of clonazepam and insulin on 10/11/25 and 10/17/25.LVN B failed to document the administration of clonazepam and insulin on 10/27/25 and 10/28/25. This failure could affect residents whose records are maintained by the facility and could place them at risk for errors in care.The findings included:Record review of Resident #1's face sheet dated 11/21/25 reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: Parkinson's disease (movement disorder of the nervous system), type 2 diabetes (high levels of sugar in blood), unspecified intellectual disabilities, autistic disorder (developmental condition that affects communication, social interaction, and behavior), anxiety disorder, and depression. Record review of Resident #1's order summary dated 11/21/25 reflected Resident #1 had orders for clonazepam oral tablet 2 mg, give 1 tablet by mouth three times a day for anxiety with start date of 07/31/25, and insulin pen 100 unit/ml solution pen injector, inject as per sliding scale, subcutaneously before meals and at bedtime related to type 2 diabetes with start date of 08/04/25.Record review of Resident #1's MAR dated October 2025 reflected clonazepam oral tablet 2 mg was not checked off as administered on 10/11/25 at 800 and 1200, on 10/17/25 at 1200, on 10/27/25 at 1200, and on 10/28/25 at 1200. Insulin pen 100 unit/ml solution pen injector was not checked off as administered on 10/11/25 at 700 and 1100, on 10/17/25 at 700 and 1100, on 10/27/25 at 700 and 1100, and on 10/28/25 at 700 and 1100. Record review of Resident #1's progress notes dated October 2025 reflected no documentation for the missing check offs on 10/11/25, 10/17/25, 10/27/25, or 10/28/25 to indicate the medication was administered, held for any reason, or refused. Record review of the facility's sign in sheets dated 10/11/25, 10/17/25, 10/27/25, and 10/28/25 reflected LVN A worked on 10/11/25 and 10/17/25 from 6 AM-2 PM, and LVN B worked on 10/27/25 and 10/28/25 from 6 AM-2 PM. On 11/21/25 at 10:15 AM, an attempted interview and observation with Resident #1, revealed he was not interviewable. Resident #1 did not answer baseline questions or questions related to the incident. Resident #1 laid in bed with the call light within reach. Resident #1 appeared with good personal hygiene, no injury, and not in distress. The bed was at its lowest position. A fall mat was in place next to the bed.On 11/21/25 at 11:30 AM, in an interview with LVN A, she said she worked on 10/11/25 and 10/17/25 with Resident #1. LVN A said Resident #1 had not been out to the hospital and did not refuse his medications. LVN A said she administered all medications, including the antianxiety medication, and followed orders for the insulin as she checked his blood sugar and administered insulin based on the sliding scale. LVN A said Resident #1 showed no indications that his medications were not administered as ordered such as episodes of hypo/hyperglycemia or significant increase in behaviors. LVN A said she administered all medications as ordered, just did not document or check off the medications on the MAR. LVN A said she did not know why, maybe she forgot to check off the MAR. LVN A said the facility instructed them in the past that it was her responsibility to ensure all the documentation was done. LVN A said it was important for documentation to be accurate to show if the resident was compliant with medications and to show the staff followed the orders. On 11/21/25 at 12:30 PM, in an interview with LVN B, she said she worked on 10/27/25 and 10/28/25 with Resident #1. LVN B said Resident #1 did not refuse his medications when she worked with him and he allowed her to do the blood sugar checks. LVN B said she did not have to notify the doctor of any abnormal findings and there were no other indications that Resident #1 had not been administered his medications as ordered. LVN B said she administered Resident #1's medications on 10/27/25 and 10/28/25, including the antianxiety medication and insulin, but possibly forgot to check off the MAR. LVN B said she was in-serviced on medication administration and documentation a few weeks ago. LVN B said she was told it was her responsibility to ensure documentation was completed before leaving for the day. LVN B said it was important for the MAR to be accurate, to ensure they gave Resident #1's medications appropriately, to not give double medications and to prevent medication errors. On 11/21/25 at 3:00 PM, in an interview with the DON, he said he reviewed the documentation and did not find the MARs to be checked off correctly for Resident #1. The DON said he spoke to the nurses and they all ensured that they administered the medication. The DON said he will be re-educating staff to ensure they check their MARs before leaving at the end of their shift. The DON said