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	02/03/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the comprehensive care plans were periodically reviewed and revised by a team of qualified persons after each assessment, including both the comprehensive and quarterly review assessments for 2 of 3 residents (Resident #1 and Resident #2) reviewed for care plans, in that:1. The facility failed to ensure Resident #1's care plan reflected an unwitnessed fall on 11/27/2025.2. The facility failed to ensure Resident #2's care plan reflected witnessed falls on 11/14/2025, 12/16/2025, and 12/30/2025.This failure could place residents at risk of not being provided the necessary care or services and not having personalized care plans updated to address their specific needs. The Findings included:1. Record review of Resident #1's face sheet dated 2/3/26 reflected Resident #1 was admitted on [DATE] with an original admission date of 7/3/24. Resident # 1 was an [AGE] year old with diagnosis of muscle weakness, reduced mobility, stiffness of unspecified joint, disorder of bone density (measurement of amount of minerals contained within a certain volume of bone) and structure, dementia (severe loss of cognitive functions including memory, language, reasoning, and behavior that was significant enough to interfere with a person's daily life and functional independence) and Alzheimer's disease (progressive, irreversible brain disorder characterized by the gradual destruction of brain cells leading to severe impairment in memory, thinking, language, judgment, and behavior). Record review of Resident #1's Quarterly MDS dated [DATE] reflected a BIMS score of 03 which indicated Resident #1's cognition was severely impaired. Resident #1 required substantial/maximal assistance for self-care of toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear. Resident #1 required supervision or touching assistance for self-care of eating and oral hygiene and required setup or clean-up assistance for personal hygiene. Record review of Resident #1's comprehensive care plan reflected Resident #1 had the potential for falls related to Alzheimer's Disease. Date Initiated: 07/04/2024 Revision on: 12/16/2025. Interventions: Floor mat to side of the bed. Date Initiated: 12/16/2025 May be up to high back wheelchair with bilateral leg rests and anti-tippers as tolerated.Date Initiated: 12/16/2025 Anticipate and meet the resident's needs. Place items frequently used by the resident within easy reach when in the room. Date Initiated: 01/14/2026 Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 07/04/2024 Fall Risk Screening upon admission and quarterly to identify risk factors. Date Initiated: 07/04/2024 Floor Mat Date Initiated: 01/14/2026 Low bed Date Initiated: 01/14/2026 Place the resident's call light was within reach and encourage the resident to use it for assistance as needed. Date Initiated: 07/04/2024Record review of the facility's incident/accident report from dates 11/2/2025 to 1/22/2026 revealed Resident #1 had an unwitnessed fall on 11/27/25 that was not reflected on Resident #1's care plan. 2. Record review of Resident #2's face sheet dated 2/3/26 indicated Resident #2 was admitted on [DATE]. Resident #2 was an [AGE] year old with diagnoses of hemiplegia (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(paralysis affecting one side of the body) and hemiparesis (weakness or reduced motor function on one side of the body) following cerebral infarction (occurs because of disrupted blood flow to the brain due to problems with the blood vessels that supply it) affecting the right dominant side, contracture (permanent tightening and shortening of muscles, tendons, skin, or other tissues that restricts normal movement of a body part), muscle weakness, lack of coordination, dementia (severe loss of cognitive functions including memory, language, reasoning, and behavior that was significant enough to interfere with a person's daily life and functional independence), and mood disorder. Record review of Resident #2's Quarterly MDS dated [DATE] reflected a BIMS score of 14 which indicated Resident #2's cognition was intact. Resident #2 required substantial/maximal assistance for self-care of lower body dressing and putting on/taking off footwear. Resident #2 required partial/moderate assistance for toileting hygiene, shower/bathe self, and upper body dressing and required setup or clean-up assistance with eating and oral hygiene. Record review of Resident #2's comprehensive care plan reflected Resident #2 had the potential for falls related to CVA, dementia, and R sided weakness in UE/[NAME] Date Initiated: 08/12/2025 Revision on: 08/25/2025. Interventions: Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs.Date Initiated: 08/12/2025 Encourage socialization and activity attendance as tolerated. Date Initiated: 08/12/2025 Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Date Initiated: 08/12/2025 Fall Risk Screening upon admission and quarterly to identify risk factors. Date Initiated: 08/12/2025 Place the resident's call light was within reach and encourage the resident to use it forassistance as needed. Date Initiated: 08/12/2025Record review of the facility's incident/accident report from dates 11/2/2025 to 1/22/2026 revealed Resident #2 had witnessed falls on 11/14/2025, 12/16/2025, and 12/30/2025 that were not reflected on Resident #2's care plan. During an interview on 2/3/26 at 4:55 p.m., the MDS/RN said per the corporate consultant they no longer update care plans with dated interventions. The MDS/RN said staff used the information located on the incident reports, progress notes, post-fall evaluations, and neuro check forms to provide information on interventions done and any updates to interventions. The MDS/RN said after hearing the Fall Management System Policy, she feels the work was done but the facility just did not complete the dates in the care plan. The MDS/RN said she did care plan reviews quarterly, annually and when there was a significant change in condition. The MDS/RN said dated interventions were not added after each fall, especially if there was no injury or significant change in condition. The MDS/RN said she did not feel that not having the fall dates reflected in the residents' care plan would cause any adverse outcomes because staff had access to the care plans, but they choose to use the information they receive from the 24-hour report and previous progress notes.During an interview on 2/3/26 at 5:05 p.m., the DON said staff learn of changes to interventions during in-services provided after a fall or with the incident report. The DON said care plans were updated when an incident occurs or as needed by any IDT staff. He said after a resident had a fall, the MDS, ADON, or DON would usually updated the care plans. He said if new interventions were implemented, they would update the care plan. He said if care plans were reviewed and no updates were needed, the care plan was updated to reflect that. He said falls without injuries would be updated in the care plans if they needed interventions. The DON said after hearing the Fall Management System Policy, it meant each fall must be documented, reviewed, and interventions updated in the care plan. The DON said they should place a fall date on the care plan, it was in the policy that staff were supposed to. The DON said he did not recall the regional consultant ever mention the fall dates were not supposed to be documented on the care plans. Record review of facility's Fall Management System policy with revised date of (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/19/2021 reflected: Policy:It is the policy of this facility that each resident will be assessed to determine his/her risk for falls, and a plan of care implemented based on the resident's assessed needs.Procedure: .A. Identifying residents at risk for falls.3. A care plan is implemented for residents at risk for falls.5. Preventive interventions are reviewed, evaluated and implemented to reduce the reoccurrence of falls. D. Documentation requirements for residents sustaining a fall.4. Documentation in the nurse's notes and/or care plan will reflect interventions attempted.8. An Administrative nurse will ensure that the resident's plan of care is revised to reflect each fall and interventions that were implemented.