| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761<br><br>Based on observation, interview, and record review, the facility failed to provide services in the facility with reasonable accommodation of resident needs and preferences, for 1 resident (Resident #177) of 12 residents reviewed for accommodation of needs.<br><br>The facility staff did not provide Resident #177 with a call light that was within reach.<br><br>This failure could place residents at risk for not having his/her needs met.<br><br>Findings included:<br><br>Review of Resident #177's Admission Record dated 02/26/24 documented a [AGE] year-old female, on hospice, initially admitted on [DATE], readmitted on [DATE], with the diagnoses that included cerebral infarction (stroke), dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), aphasia (a language disorder that affects a person's ability to communicate), tracheostomy (an incision in the windpipe made to relieve an obstruction to breathing), gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), functional quadriplegia (the complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the spinal cord), contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) to right knee, left knee, right hand, and left hand, and osteoarthritis (degeneration of joint cartilage and the underlying bone that causes pain and stiffness).<br><br>Review of Resident #177's Admission Minimum Data Set, dated dated dated [DATE] revealed Resident #177 had no speech, BIMS was blank indicating severe cognitive impairment, and was always incontinent of bowel and bladder.<br><br>Review of Resident #177's comprehensive care plan dated 01/31/24 documented: Resident has the potential for falls. Interventions included: Place the resident's call light is within reach and encourage the resident to use it for assistance as needed.<br><br>Observation on 02/26/24 at 12:40 p.m., Resident #177 was lying in bed with the head of bed inclined. Touch call light was on upper left hand side of pillow not within reach of Resident #177.<br><br>(continued on next page) |



| 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 |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 02/29/24 at 11:30 a.m., Resident #177's touch call light was on her pillow in the upper left hand corner. Call light was not within reach of resident.<br><br>In an interview on 02/29/24 at 04:19 p.m., LVN D stated everybody was responsible for answering call lights. He said call lights had to be in reach of the resident. LVN D said if he goes in a room, he always checks call light placement. LVN stated if the call light was not within reach of the resident, the resident would not be able to get the assistance they need.<br><br>In an interview on 02/29/24 at 04:35 p.m., CNA A stated CNAs are responsible for the call lights and their placement. She said the call light had to be where the resident can reach it. CNA A stated for a resident who uses a touch call light, she would place the call light next to their face so the resident could use the call light by turning their head slightly. CNA A stated if the call light was not within reach, the resident would not be able to use it if there were an emergency and they needed assistance.<br><br>In an interview on 02/29/24 at 05:38 p.m., ADON E stated all staff are responsible for call lights. ADON E stated he tells everyone if they see a call light not in reach of a resident to put it within reach of the resident. ADON E stated it was the same (procedure) with the touch call light. ADON E agreed Resident #177 would not be able to use the call light if it were on the left upper corner of the pillow. ADON E stated if the resident could not use the call light, it could result in them falling or injury, or they could not call for assistance in an emergency.<br><br>In an interview on 02/29/24 at 06:07 p.m., the DON stated everybody was responsible for the call lights. The DON stated the call lights were to be placed within reach (of the resident). the DON stated the touch call light needs to be placed where the resident, if they turn their head, will turn their light on. The DON stated if the resident cannot reach their call light, they would not be able to get the attention of staff when they need someone.<br><br>The facility's policy for Call Light Response dated 02/10/21 documented:<br><br>Anticipated Outcome<br><br>The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance.<br><br>Process<br><br>5. With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26920<br><br>Based on interview, and record review, the facility failed to ensure the residents' right to a safe, clean, comfortable, and homelike environment for (Resident #5, Resident #279, Resident #3, and Resident # 275) of 15 rooms reviewed for water temperatures in that:<br><br>The facility failed to ensure resident room hand sink's hot water was maintained at a comfortable temperature which was at least 100 degrees F.<br><br>These failures could place residents at risk for living in an uncomfortable, and unhomelike environment which could cause a diminished quality of life.<br><br>The findings included:<br><br>Observations on 02/28/24 begining at 8:45 am accompanied by the Maintenance Supervisor revealed hand sinks in rooms had temperatures below 98 degrees.<br><br>Room # 45 79.8 degrees F<br><br>room [ROOM NUMBER] 78.4 degrees F<br><br>room [ROOM NUMBER] 74.6 degrees F<br><br>Room # 49 77.1 degrees F<br><br>Room # 50 85.9 degrees F<br><br>room [ROOM NUMBER] 69.0 degrees F<br><br>Room # 58 70.3 degrees F<br><br>Room # 54 67.6 degrees F<br><br>room [ROOM NUMBER] 86.5 degrees F<br><br>room [ROOM NUMBER] 86.5 degrees F<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 02/28/24 at 9:15 am with the Maintenance Supervisor revealed the facility was only using two halls for their census of 39 residents. The Maintenance Supervisor said the back end of the halls would have the lowest water temperatures because the heater that was used for both halls E and F (39 residents) would take some time to flow the hot water to the back rooms. The Maintenance Supervisor said the staff would let the water run for approximately 15 to 20 minutes to allow the hot water to flow into the resident rooms when they needed to use warm or hot water for resident care. The Maintenance Supervisor said he did not know if any residents who used their hand sinks allowed the water to flow for 15 or 20 minutes. He said none of the residents had voiced any complaints to him that the water temperature in the hand sinks in their rooms only had cold water. The Maintenance Supervisor said he would let the water in the hand sinks flow for about 15 to 20 minutes and then take the temperatures for his weekly maintenance log.<br><br>Interviews on 02/28/24 at 10:00 am during a group meeting with Resident #5 in room [ROOM NUMBER], Resident #279 in room [ROOM NUMBER], Resident #3 in room [ROOM NUMBER], and Resident # 275 in room [ROOM NUMBER] voiced they did not have warm or hot water when they used their hand sinks. They voiced they always got cold water. None of the residents had voiced any complaints to staff.<br><br>Record review of the Logbook Documentation completed by the Maintenance Supervisor reflected:<br><br>Room # 49 tested 107.9 degrees on 02/2/24.<br><br>room [ROOM NUMBER] tested 107.5 degrees on 02/02/24.<br><br>room [ROOM NUMBER] tested 107.6 degrees on 02/22/24.<br><br>room [ROOM NUMBER] tested 108.7 degrees on 02/15/24.<br><br>room [ROOM NUMBER] tested 108.7 degrees on 02/15/24.<br><br>Interview on 2/28/24 at 2:21 pm with CNA H revealed when the hand sinks in the resident rooms did not have hot water, they would let the water run until the water ran hot to use for resident care.<br><br>Interview on 02/29/24 at 10:39 am with the Maintenance Supervisor revealed he tested random rooms on the water temperature tests he conducted. He said the temperatures were taken after he let the water run for about minutes. The maintenance supervisor said he would have to install circulating pumps at the ends of each hall to draw the hot water faster to the hall rooms, especially to the end of hall rooms. The Maintenance Supervisor said the facility did not have a policy on water temperatures, but he knew they needed to be between 100 degrees F and 110 degrees F.<br><br>Interview on 02/29/24 at 1:25 pm with the Administrator revealed when the water temperatures in the resident rooms were not between 100 degrees F and 110 degrees F, the staff would notify Maintenance Supervisor and he would adjust the water heater valves. The failure to provide warm or hot water to resident rooms placed the residents at risk of not having access to warm or hot water when they were ready to use the hot water in their rooms. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26920<br><br>Based on interview and record review, the facility failed to complete an initial comprehensive resident-centered assessment of each resident's cognitive, medical, and functional capacity for 2 of 4 resident (Resident#14 and Resident # 275 ) reviewed for comprehensive MDS assessment timing.<br><br>The facility failed to complete the Admission MDS assessment within 14 days of admission for Resident #14 and Resident #275.<br><br>This failure could place residents at risk for not having their needs met.<br><br>The findings included:<br><br>Record review of Resident #14's admission record dated 02/27/24 reflected she was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #14's diagnoses included alzheimer's disease (a common cause of dementia), mood disorder due to known physiological condition, delusional disorders (paranoia), major depressive disorder (feeling of sadness), anxiety disorder (symptoms of anxiety), insomnia (sleep disorder), and cognitive communication deficit.<br><br>Record review of Resident #14's admission MDS assessment, dated 02/13/2024, reflected it had not been completed as documented.<br><br>Record review of Resident #275's admission record dated 02/29/24 reflected she was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #275's diagnoses included diabetes (high blood sugars), insomnia (sleeplessness), schizophrenia (severe psychiatric condition that affects the brain), major depressive disorder, dementia (impaired ability to remember), and cognitive communication deficit.<br><br>Record review of Resident #275's admission MDS assessment, dated 02/14/24, reflected it had not been completed as documented.<br><br>Interview on 02/27/24 at 1:10 pm with the DON revealed the facility did not have a permanent MDS Coordinator since January 2024. The DON said she thought a PRN (RN F) staff member was responsible to complete the MDS assessments. RN F should have completed the MDS assessments for Resident #14 and Resident #275. The DON said the MDS assessments should be completed within the required time to ensure the necessary information was accurate to help develop the plan of care. The DON said she was responsible to ensure the MDS assessments were completed and in the required timeframes.<br><br>Interview on 02/27/24 at 1:37 pm RN F revealed she was responsible to develop, update and revise care plans as needed. The DON and ADON were also responsible to update care plans. RN F said she had not completed the admission MDS assessment for Resident #14 and Resident #275 because she had not had time to complete the assessments. RN F said failure to complete the assessement did not give staff the information needed to develop care plans to address focus areas.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 02/29/24 at 1:25 pm with the administrator revealed the DON was responsible to ensure the MDS assessments were completed in the required timeframes.<br><br>Record review of the facility policy and procedure titled MDS Completion revised 02/21/21 reflected Residents are assessed, using a comprehensive assessment process, to identify care needs and to develop an interdisciplinary care plan. Process Admission Assessment-completed within 14 days of admission counting the day of admission as day one. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26920<br><br>Based on observation, interviews, 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 objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #14) of 4 residents reviewed for care plans.<br><br>Resident #14's care plans did not reflect she was administered the medication Keppra (anti-convulsant) for behaviors.<br><br>This failure placed residents at risk of not having their needs met.<br><br>The findings included:<br><br>Record review of Resident #14's admission record dated 02/27/24 reflected she was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #14's diagnoses included alzheimer's disease (a common cause of dementia), mood disorder due to known physiological condition, delusional disorders (paranoia), major depressive disorder (feeling of sadness), anxiety disorder (symptoms of anxiety), insomnia (sleep disorder), and cognitive communication deficit.<br><br>Record review of Resident #14's incomplete admission MARs dated 02/13/24 reflected Resident #14 had severe cognitive impairment, alzheimer's disease and psychotic disorder.<br><br>Record review of Resident #14's physician orders dated 02/27/24 reflected an order for Keppra oral tablet 500mg (Levetiracetam),give one tablet by mouth in the morning related to mood disorder due to known physiological condition, start date 02/15/24. Resident's target behavior is anger, yelling, delusions, resident takes Keppra to decrease the frequency and severity of this behavior. Monitor resident for episodes, interventions, and outcomes of interventions, every shift for behavior monitoring d/t use of psychotic medication, start date 02/03/24.<br><br>Record review of the MARs dated February 2024 for Resident #14 reflected.<br><br>Antipsychotic medication monitoring -Keppra. Monitor for the following indications of an adverse drug event (ADE):<br><br>0=no indications of ADE<br><br>1=orthostatic hypotension (blood pressure drops when standing up or sitting down)<br><br>2=tachycardia (heart rate that exceeds the normal resting rate)<br><br>3=tardive dyskinesia (involuntary repetitive body movements)<br><br>4=restlessness (feeling of needing to constantly move or being unable to calm your mind)<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 5=drowsiness (feeling more sleepy than normal)<br><br>6=spasms (sudden involuntary and forceful contraction of a muscle)<br><br>Every shift for antipsychotic therapy if any of the above indications are notes, document in nurse's notes and notify MD immediately, start date 02/03/24.<br><br>Resident's target behavior is anger, yelling, delusions. Resident takes Keppra to decrease the frequency and severity of this behavior. Monitor resident for episodes of this behavior and record number of episodes, interventions, and outcomes of interventions, every shift for behavior monitoring d/t use of psychoactive medication.<br><br>Record review of Resident #14's comprehensive care plan revised 02/21/24 reflected no evidence of a care plan for Resident #14's use of the medication Keppra for anti-psychotic behaviors. Resident #14's care plan reflected resident had a behavior problem, start date 02/03/24 and interventions included monitor behavior episodes and attempt to determine underlying cause.<br><br>Observation on 02/26/24 at 12:25 pm revealed Resident #14 lying in her bed, alert to self. Resident #14 did not respond to surveyor.<br><br>Interview on 02/27/24 at 1:10 pm with the DON revealed the facility did not have a permanent MDS Coordinator since January 2024. The DON said she thought a PRN (RN F) staff member was responsible to develop, update and revise the care plans. RN F should have developed a care plan for Resident #14's use of Keppra medication.<br><br>Interview on 02/27/24 at 1:15 pm with LVN G revealed she would get information from Resident #14's care plans to review the interventions developed for each focus care area and share the information with the direct care staff.<br><br>Interview on 02/27/24 at 1:37 pm RN F revealed she was responsible to develop, update and revise care plans as needed. The DON and ADON were also responsible to update care plans. RN F said she had overlooked developing a care plan for Resident #14's use of Keppra medication. RN F said failure to develope a care plan to address Resident #14's use of the anti-psychotic medication did not provide interventions for the care area.<br><br>Interview on 02/29/24 at 10:47 am with the DON revealed she was responsible for ensuring care plans were developed. The DON said if a care plan is not developed for the medication Keppra, the care is not individualized to provide care to the resident.<br><br>Interview on 02/29/24 at 1:25 pm with the facility Administrator revealed care plans were developed for individualized resident focus area care. The Administrator said the DON was responsible to ensure the care plans were developed, updated, and revised.<br><br>Record review of the facility policy and procedure titled Care Plan and CAA's (Care Area Assessments) revised 05/06/2016 revealed It is the intent of this facility to meet and abide by all State and Federal regulations that pertain to resident care plans and subsequent Care Area Assessments to completion. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>26920<br><br>Based on observation, interview, and record review the facility failed to ensure the environment remained as free of accident hazards as is possible for one (women's shower room) of two shower rooms reviewed for accidents.<br><br>The facility failed to maintain water temperatures at a safe temperature level in the women's shower room.<br><br>This failure could place residents at risk of injuries and burns.<br><br>Findings include:<br><br>Observation on 02/28/24 at 9:00 am with Maintenance Supervisor and using the supervisor's thermometer revealed the women's shower in the B hall had hot water temperature that was 121.4 degrees F.<br><br>Interview on 02/28/24 at 9:10 am with the Maintenance Supervisor revealed the women's shower was in the B hall. All the residents in the facility were housed in the E and F halls. The water heater in the B hall was also used by the C hall. Both B and C hall were currently empty and had no residents. The Maintenance Supervisor said since the B and C hall did not have any residents using the rooms or the hot water, the hot water in the women's shower room would not circulate and caused the shower room water temperature to stay hot, over 110 degrees F. The Maintenance Supervisor said he would have to drain all the hot water and adjust the water temperature in the women's shower to stay between 100 degrees F and 110 degrees F maximum. The Maintenance Supervisor said he checked the women's shower room monthly and documented in the Logbook Documentation.<br><br>Record review of the Logbook Documentation dated 02/15/24 reflected the women's shower room water temperature was 107.6 degrees F.<br><br>Interview on 02/28/24 at 9:30 am with the Administrator revealed the direct care staff assisted the residents with their showers. The Administrator said she would tell the direct care staff to wait for the water temperature in the women's shower room to get adjusted. The Administrator said the temperature in the shower room should not be over 110 degrees F because it would place the residents at risk of getting burned. She said the Maintenance Supervisor was responsible to ensure the water temperatures were at the safe temperatures of 100 degrees F and 110 degrees F. The Administrator said there was no policy for water temperatures.<br><br>Interview on 02/28/24 at 2:21 pm with CNA H revealed that the women's shower hot water would be instantly hot when opened, but the cold water was used to bring the water to a comfortable temperature to shower residents. CNA H said some residents did not want assistance to shower but she would stay in the shower room with the resident.<br><br>Interview on 02/29/24 at 9:17 am with the DON revealed the women's shower room water temperature should not be over 110 degrees F because this might place the residents at risk for skin burns.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 02/28/24 at 1:45 pm with the Maintenance Supervisor and using the supervisor's digital thermometer revealed the hot water temperature in the woman's shower room had been adjusted and tested 101.0 degrees F. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761<br><br>Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care was provided with professional standards of practice for 2 of 3 residents (Resident #299 and Resident #177) reviewed for oxygen in that:<br><br>1. Resident #299 oxygen concentrator displayed a red warning light indicating oxygen flow rate <0.5L/min, or concentration <73 %.<br><br>2. Resident #177's oxygen was administered at 4.5 Lpm instead of 5 Lpm via trach mask as ordered by physician.<br><br>This failure could place residents who receive respiratory care at risk of developing respiratory complications and a decreased qualify of care.<br><br>The findings included:<br><br>Record review of Resident #299's face sheet dated 02/29/2024 reflected he was admitted on [DATE] with an original admitted [DATE]. Resident #299's relevant diagnoses were chronic respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily function), dementia, atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), congestive heart failure, hypoxemia (abnormally low concentration of oxygen), and weakness.<br><br>Record review of Resident #299's initial MDS assessment dated [DATE] reflected he had a BIMS score of 4 which indicated he was severely impaired.<br><br>Record review of Resident #299's comprehensive care plan dated 02/02/2024 reflected a focus for oxygen, the goal was to keep him free of signs and symptoms of hypoxia, the intervention was to administer oxygen therapy per physician's orders.<br><br>Record review of Resident #299's oxygen order dated 02/19/2024 reflected 02 @ 2 Lpm via N/C. Monitor O2 saturation. Notify physician if SpO2 falls below 90%.<br><br>An observation on 02/26/2024 at 12:20 p.m., revealed Resident #299 lying in bed watching television. He was dressed in his own personal clothing, call light within reach, and bed set to lowest position. Room had a homelike environment, and oxygen sign by the door. Oxygen concentrator was set at 2.0 Lpm via N/C and the oxygen concentrator displayed a red warning light. Resident #299 was observed with the nasal cannula not in place. He was not showing any signs or symptoms of distress.<br><br>In an interview on 02/26/2024 at 12:25 p.m., Resident #299 said he sometimes removed his nasal cannula because he gets tired of it. Resident #299 said he required continuous oxygen.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An observation and interview on 02/26/2024 at 3:00 p.m., revealed this surveyor escorted LVN D to Resident #299's room. LVN D kneeled down and assessed the oxygen concentrator setting and stated it was at 2.0 LPH and said stated the red warning light indicated a decreased flow. LVN D turned off and on the oxygen concentrator and it continued to display a red-light warning light. He immediately checked Resident #299's oxygen using an oximeter, it read 94 % at room air. LVN D re-adjusted Resident 299's nasal cannula in place and rechecked his oxygen level and it read 99 %. LVN D proceeded to check the filter and stated there were no issues with the filter. LVN D said he was going replace Resident #299's oxygen concentrator. LVN D said if Resident #299 had shown signs and symptoms of respiratory distress he would have immediately replaced the oxygen concentrator with an oxygen cylinder. LVN D said he was not sure how long the oxygen concentrator had displayed a red warning light, but that was the first time he had seen it. LVN D said he would round his residents every 2 hours and he had not noticed Resident #299's oxygen concentrator displayed a red warning light. LVN D said Resident #299 had not been negatively impacted because he was not in respiratory distress. LVN D said all nursing staff receive training in oxygen safety when hired.<br><br>An interview on 02/26/2024 at 3:27 p.m., ADON E said Resident #299 required continuous oxygen. ADON E said the red warning light meant a low flow. He said he would go to Resident #299's room and check the oxygen concentrator and if it needed to be changed, he would have the charge nurse change it. ADON E said he did not know what negative effects the red-light warning had on Resident #299 because he wanted to check the oxygen concentrator first.<br><br>An interview on 02/26/2024 at 3:47 p.m., the DON said Resident #299 required continuous oxygen. The DON said she was not sure what a red-light warning light on the oxygen concentrator meant. The DON said she would have to check the oxygen concentrator to say what the red-light warning meant. This surveyor escorted the DON to Resident #299's room where she checked the oxygen concentrator. She said the red-light warning light meant a low flow, I don't know if it means it is giving less oxygen or I don't know. The DON visually observed Resident #299 and said he did not show signs of being is respiratory distress. The DON said she would make sure Resident #299's oxygen concentrator was changed. The DON said there were no negative effects on Resident #299 because he was not showing any signs or symptoms of respiratory distress.<br><br>2) Review of Resident #177's Admission Record dated 02/26/24 documented a [AGE] year-old female, on hospice, initially admitted on [DATE], readmitted on [DATE], with the diagnoses that included cerebral infarction (stroke), dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), aphasia (a language disorder that affects a person's ability to communicate), tracheostomy (an incision in the windpipe made to relieve an obstruction to breathing), gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), functional quadriplegia (the complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the spinal cord), contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) to right knee, left knee, right hand, and left hand, and osteoarthritis (degeneration of joint cartilage and the underlying bone that causes pain and stiffness).<br><br>Review of Resident #177's Admission Minimum Data Set, dated dated dated [DATE] revealed Resident #177 had no speech, BIMS was blank indicating severe cognitive impairment, and was always incontinent of bowel and bladder.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #177's comprehensive care plan dated 01/31/24 revealed:<br><br>Focus: Oxygen: Resident uses oxygen therapy routinely or as needed and is at risk for ineffective gas exchange.<br><br>Interventions: Administer oxygen therapy per physician's orders.<br><br>Focus: Tracheostomy: Resident has a tracheostomy and is at risk for potential complications such as weight loss, increased secretions, congestion, infection, and respiratory distress.<br><br>Interventions: Provide oxygen, humidity, tracheostomy care, and tubing changes as indicated by physician's order.<br><br>Record review of Resident #177's physician order summary, dated 02/12/24, reflected Cool mist aerosol at _25_% or adjust for secretions management via trach mask with O2 bleed in at 5 L/m.<br><br>In an observation on 02/26/24 at 12:40 p.m., O2 in Use signage on door. O2 for tracheostomy set on 4.5 Lpm. Filters clean. Suctioning equipment at bedside. Trach mask dated. Dressing clean.<br><br>In an interview on 02/29/24 at 04:19 p.m., LVN D, working on Resident #177's hall, stated the nurse sets the O2 on the oxygen machines. LVN D stated he rechecks the order and the (O2) machine when he comes in. LVN D stated the ball on the meter is set to the top of the ball for the measurement line. LVN D stated the resident could lose O2, desat (insufficient blood oxygen, low levels, during sleep), or be confused, if the oxygen is not set per the order.<br><br>In an interview on 02/29/24 at 04:35 p.m., CNA A stated only nurses set the O2 levels. She said CNAs are not allowed.<br><br>In an interview on 02/29/24 at 05:38 p.m., ADON E stated the nurses, at the beginning of their shift, were to check to make sure O2 settings are correct for residents. ADON E stated the ball on the meter is set at the middle of the ball. ADON E agreed that if the top of the ball is set on the mark of the meter, the O2 is not set right. ADON E stated the patient would desaturate, have shortness of breath, and possible respiratory distress, if the O2 was not set correctly and they were getting too little oxygen.<br><br>In an interview on 02/29/24 at 06:07 p.m., DON stated nurses were responsible for the O2 machines. The DON stated the nurses are to check them (O2 settings) when they round. The DON stated the ball meter was the type of O2 machines they have and the ball is set in the middle to measure the O2 level. The DON stated if the O2 was not set correctly, the resident was not receiving the correct oxygen they needed and their oxygen level can go low.<br><br>Record review of the facility's Oxygen Administration policy dated 09/12/14 revealed Policy: To describe methods for delivering oxygen to improve tissue oxygenation .Procedure: 1. Verify physician order .<br><br>Record review of facility's Oxygen Safety policy dated 02/11/2022 reflected:<br><br>Policy:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | It is the policy of this facility to provide a safe environment for residents, staff, and the public. This policy addresses the use and storage of oxygen equipment.<br><br>Oxygen Use:<br><br>b. Defective cylinders and equipment shall be removed from use.<br><br>47828 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761<br><br>Based on observation, interview, and record review, the facility failed to establish a pain management program designed to help a resident attain or maintain his or her highest practicable level of well-being and to prevent or manage pain, to the extent possible, for 1 resident of 4 (Resident #9) observed for pain management issues in that:<br><br>1. LVN B did not assess the pain level for Resident #9, prior to administering the resident her PRN pain medication.<br><br>2. The facility failed to adequately treat and assess Resident #9's pain.<br><br>This failure could place residents at risk for unnecessary pain, discomfort, and decreased quality of life.<br><br>Findings included:<br><br>Review of Resident #9's Admission Record dated 02/27/24 documented a [AGE] year-old female, initially admitted on [DATE], readmitted on [DATE], with the diagnoses that included dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), type 2 diabetes mellitus (the pancreas does not make enough insulin and cells respond poorly to insulin and take in less sugar to fuel muscles and other tissues), hypertension (high blood pressure), pain in unspecified joint, and pain in right knee.<br><br>Review of Resident #9's Admission Minimum Data Set, dated dated dated [DATE], revealed Resident #9 had no speech, BIMS was 15 indicating no cognitive impairment, and was always incontinent of bowel and bladder.<br><br>Review of Resident #9's comprehensive care plan dated 01/31/24 revealed:<br><br>FOCUS: Resident #9 is on a pain management regimen and takes analgesics routinely or as needed<br><br>Carpal tunnel syndrome, diabetes<br><br>INTERVENTIONS/TASKS:<br><br>-Administer medications as ordered. Monitor for side effects and effectiveness.<br><br>-Report to the physician if pain management is not effective.<br><br>FOCUS: Fracture:<br><br>Location: Displaced subcapital fracture of right femur (right hip fracture)<br><br>-has history of osteopenia (reduced bone mass of lesser severity than osteoporosis<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -has mild osteoarthrosis of right hip (another term for osteoarthritis which is when the cartilage and other tissues within the joint break down or have a change in their structure)<br><br>-osteoporosis (brittle/fragile bones) and degenerative arthritis (when the flexible, protective tissue at the ends of bones, called cartilage wears down)<br><br>(X) without surgical repair (pending ct scan - orthopedic surgeon)<br><br>And is at risk for complications with healing process<br><br>INTERVENTIONS/TASKS:<br><br>2.Monitor for pain/activity tolerance, prevent trauma, monitor for pain medication effectiveness<br><br>3.Admin pain meds as ordered and assess response and monitor for s/e and adverse reactions<br><br>4.Keep MD notified as status warrants.<br><br>Record review of Physician's Progress Note dated 02/20/24 at 11:44 a.m., written by PA N: Pending CT of chest/abd/pelvis w/o contrast to rule out metastatic disease (spread of cancer cells), multiple myeloma (cancer of the plasma cells in the bone marrow) diagnosis was also discussed with patient (Resident #9) at bedside and she agreed to proceed with interventions.<br><br>Record review of the consolidated physician's orders dated 02/27/24 indicated Resident #9 had an order for Acetaminophen-Codeine 30-300mg Give 1 tablet by mouth every 6 hours for pain related to pain right knee, pain in unspecified joint. Do not exceed 2600mg/24 hours. Order dated 01/30/24.<br><br>Review of the consolidated physician's orders dated 02/27/24 indicated Resident #9 had an order for Lyrica Oral Capsule 75mg (Pregabalin) Give 1 capsule by mouth three times a day for pain related to pain right knee, pain in unspecified joint. Order dated 01/30/24.<br><br>Review of the consolidated physician's orders dated 02/27/24 indicated Assess for pain every shift and document using: Numerical scale of 0-10 if verbal or PAINAD if nonverbal Resident's acceptable pain level is: _0_ every shift. Order dated 01/30/24.<br><br>Review of the consolidated physician's orders dated 02/27/24 indicated Resident #9 had an order for Effexor XR Oral Capsule Extended Release 24 Hour 75mg (Venlafaxine HCl) Give 1 capsule by mouth in the morning for neuropathic pain. Order dated 02/12/24.<br><br>Record review of Resident #9's pain level assessment on Weights & Vitals on PCC and MAR documentation when acetaminophen-codeine 30-300mg tablet every 6 hours or as needed for pain, was administered:<br><br>02/26/24 08:20 a.m. 03 Numerical 0/10 - MAR: acetaminophen-codeine 30-300mg tablet given<br><br>02/26/24 08:50 a.m. 01 Numerical 0/10<br><br>02/26/24 09:24 a.m. 00 Numerical 0/10<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 02/26/24 01:40 p.m. 00 Numerical 0/10<br><br>02/26/24 07:30 p.m. 08 Numerical 0/10 - MAR: acetaminophen-codeine 30-300mg tablet given<br><br>02/26/24 08:00 p.m. 00 Numerical 0/10<br><br>02/26/24 11:47 p.m. 00 Numerical 0/10<br><br>02/27/24 09:01 a.m. 00 Numerical 0/10<br><br>02/27/24 09:38 a.m. 00 Numerical 0/10<br><br>02/27/24 03:20 p.m. 08 Numerical 0/10 - MAR: acetaminophen-codeine 30-300mg tablet given<br><br>02/27/24 03:50 p.m. 00 Numerical 0/10<br><br>02/27/24 05:52 p.m. 00 Numerical 0/10<br><br>02/27/24 11:49 p.m. 00 Numerical 0/10<br><br>02/28/24 10:26 a.m. 04 Numerical 0/10<br><br>02/28/24 02:49 p.m. 01 Numerical 0/10<br><br>02/28/24 02:50 p.m. 01 Numerical 0/10<br><br>02/28/24 10:16 p.m. 00 Numerical 0/10<br><br>02/29/24 08:21 a.m. 07 Numerical 0/10<br><br>02/29/24 10:08 a.m. 01 Numerical 0/10<br><br>02/29/24 10:11 a.m. 01 Numerical 0/10<br><br>02/29/24 01:04 a.m. 08 Numerical 0/10<br><br>02/29/24 01:15 a.m. 08 Numerical 0/10<br><br>02/29/24 03:29 a.m. 00 Numerical 0/10<br><br>02/29/24 05:02 a.m. 00 Numerical 0/10<br><br>During an interview on 02/26/24 at 12:47 p.m., Resident #9 stated she fell while she was at a different nursing facility and she still had pain from it. Resident #9 stated her pain at the time was 8/10 and it took the nurses a long time to bring her pain medication. She said her hip, leg, and toes/feet on the right side hurt. Resident #9 said she was always in pain that was between 8 -10.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a Med Pass observation for Resident #9 on 2/27/24 at 3:22 pm., LVN B reviewed her medication orders prior to administering Resident #9's medications. While LVN B was lifting head of bed for resident to be in appropriate position to take her oral medications, Resident #9 complained of pain. LVN B asked Resident #9 if she was in pain and the resident answered that she was. LVN B asked Resident #9 if she wanted her pain medication and Resident #9 answered, yes. When LVN B was getting the medication, surveyor asked Resident #9 what her pain level was on a scale of 0 to 10 with 10 being the worst pain ever. Resident stated to surveyor her pain level to her right hip was 9 or 10/10. LVN B came back into Resident #9's room and administered an acetaminophen-codeine 30-300mg tablet. LVN B administered the medication without assessing Resident #9's pain level.<br><br>In an interview on 2/29/24 at 8:20 a.m., ADON E stated that he must assess pain level if a resident complains of pain and prior to administering prn medication or assess pain level per shift. If do not assess pain level, will not know if really needs the pain medication.<br><br>In an interview on 2/29/24 at 8:30 a.m., the DON M stated that staff must assess pain on a scale of 1-10 anytime a resident complains of pain. The DON stated if they do not assess pain level, they would not be able to ensure pain medication was effective.<br><br>During an observation and interview on 02/29/24 at 12:52 p.m., LVN C was in Resident #9's room giving resident regular Tylenol for pain. Resident #9 stated she just came back from an appointment, and they were moving her all over getting her back in to bed. She said she told the nurse she had a lot of pain. The nurse brought her regular Tylenol (325mg). Resident #9 stated the regular Tylenol would not help. Resident #9 stated the nurse did not ask a number for pain. Resident #9 stated she (the resident) told LVN C, Mucho mucho pain. Surveyor asked LVN what the resident's pain scale number was. The LVN replied, 8. LVN C stated it was not time for Resident #9's T3 (acetaminophen-codeine 30 - 300mg) so she was going to call and tell the doctor to see what she could give the resident. Resident #9 stated to surveyor her pain was at a 10 out of 10. Resident #9 stated her pain was always between an 8 -10. Resident #9 stated no one asks her about a number of pain, only the surveyor. Resident #9 stated before she left for her appointment, she was given a pill to relax me and that was four hours ago. Resident #9 stated earlier than that she was given a pill for pain.<br><br>In an interview on 2/29/24 at 3:50 p.m., LVN B stated that she usually asks residents their pain level prior to giving medication, but she was nervous with surveyors observing her, and she forgot to ask.<br><br>In an interview on 02/29/24 at 04:19 p.m., LVN D stated if a resident was complaining of pain, he would ask where the pain was, when did it start, and on a pain scale of 1 to 10 with 10 be extreme pain, ask the resident what number their pain was. LVN D stated he would administer pain medication if they had it ordered and he would check with the resident 30-40 minutes after administration to see if the pain was relieved. LVN D stated if the pain was not relieved, he would call the doctor and let the doctor know so he could order something that would help the pain. LVN D stated if pain was not controlled, the resident may decline further or they could be in extreme distress.<br><br>In an interview on 02/29/24 at 04:35 p.m., CNA A stated she reports any changes (pain, bruises, scratches, etc.), she noticed with a resident to the nurse immediately.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 02/29/24 at 05:38 p.m., ADON E stated if a resident was always complaining of pain, he would check with the doctor to see what could be given. ADON E would ask where the pain was and ask the Resident to rate the pain on a scale 0-10. ADON E stated if the resident had pain medication, he would give them their pain medication if he could at that time. ADON E stated he would go back and ask them if the medication were working. ADON E stated if the medication were not working, the doctor should be notified. ADON E stated if that were not done, the resident may have decreased eating, depression or be withdrawn.<br><br>In an interview on 02/29/24 at 06:07 p.m., the DON stated if she entered a resident's room and the resident was complaining of pain, she would assess the resident. The DON stated she would ask the resident where the pain was, and ask them to rate their pain on a numeric scale. The DON stated if the resident told her a pain level of 9, she would see if there were a pain medication ordered for the resident and give it to her (pain level would be documented on the MAR for the opioid pain reliever when administered). The DON stated she would go back and check on the resident, and if the pain were not relieved, she would call the doctor to let him know so maybe something else could be given. The DON stated if the resident still had severe pain and nothing was taking it (the pain) away, the resident's pain would not be managed because the medication was not effective. The DON stated the resident would be suffering and they would not be taking care of the pain. The DON stated (Resident #9 had cancer that has metastasized (Resident #9 with multiple myeloma a type of bone cancer that had spread).<br><br>Record review of facility's Pain Management reviewed 2/10/20, revealed:<br><br>Policy: Residents shall be assessed for factors that predispose to pain upon admission to the facility and subsequently thereafter according to the findings of the assessment. Residents shall receive treatment for pain relief as necessary and monitored for effectiveness.<br><br>Procedure: .<br><br>Treatment<br><br>A. Assessment and evaluation by the appropriate members of the interdisciplinary team (e.g., nurses .)<br><br>a. Asking the patient to rate the intensity of his/her pain using a numerical scale or a verbal or visual descriptor that is appropriate and preferred by the resident.<br><br>Record review of the facility's Pain Management policy dated 10/24/22 revealed:<br><br>Policy:<br><br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident' goals and preferences.<br><br>Policy Explanation and Compliance Guidelines:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility will utilize a systematic approach for recognition, evaluation, treatment and monitoring of pain. Pain evaluations are completed on admission, quarterly, with a significant change of condition and as needed.<br><br>Recognition:<br><br>1.In order to help a resident, attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will:<br><br>a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated.<br><br>b.Evaluate the resident for pain and the cause(s) upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs (e.g. after a fall, change in behavior or mental status, ;new pain or an exacerbation of pain).<br><br>c.Manage or prevent pain, consistent with the comprehensive assessment and plan of care current professional standards of practice, and the resident's goals and preferences.<br><br>Pain Evaluation:<br><br>1.The facility will use a pain evaluation tool, which is appropriate for the resident's cognitive status, to assist staff in consistent evaluation of a resident's pain.<br><br>2.Based on professional standards of practice, an assessment or evaluation of pain by the appropriate members of the interdisciplinary team (e.g., nurses, practitioner, pharmacists, and anyone else with direct contact with the resident) may necessitate gathering the following information, as applicable to the resident:<br><br>a.History of pain and its treatment (including non-pharmacological, pharmacological, and alternative medicine (CAM) treatment and whether or not each treatment has been effective;<br><br>c.Asking the patient to rate the intensity of his/her pain using a numerical scale, a verbal or visual descriptor that is appropriate and preferred by the resident.<br><br>d.Reviewing the resident's current medical conditions (e.g., pressure injuries, diabetes with neuropathic pain, immobility, infections, amputation, oral health conditions, post CVA, venous and arterial ulcers, and multiple sclerosis).<br><br>7.Pharmacological interventions will follow a systematic approach for selecting medications and doses to treat pain.<br><br>c.Consider administering medication around the clock instead of PRN (pro re nata/on demand) or combining longer acting medications with the PRN medications for breakthrough pain.<br><br>I.Facility staff will notify the practitioner, if the resident's pain is not controlled by the current treatment regimen.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 49301 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>40872<br><br>Based on observation, interview and record review, the facility failed to ensure nurse staffing data was posted and readily accessible to residents and visitors with all required information for 2 (2/27/24, 2/28/24) of 3 days reviewed for nurse staffing information.<br><br>The facility failed to ensure the daily staffing information was posted in a prominent location on 2/27/24 and 2/28/24 and failed to show the census on each form.<br><br>This failure could place residents, families and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts.<br><br>Findings include;<br><br>During a tour of the facility on 2/27/24 at 4:00 pm, Surveyor was unable to locate the daily staff form.<br><br>In an interview on 2/27/24 at 4:10 pm the DON informed the Surveyor that the Facility Staffing Disclosure form was located in the hallway by the Administrator's office. The DON then proceeded to show the Surveyor that the form was on the hallway inside a basket attached to the wall. The form was observed to be in a binder tilted sideways in a basket in a clear sleeve.<br><br>In an interview on 2/28/24 at 3:05 pm the DON said that the staffing form is completed daily by either herself, the ADON or the night staff. She said the form is supposed to be posted but she could not say if residents or visitor were able to view the form where it was located. She said that is where they place the form daily. She said the form is supposed to be filled out completely with all the information.<br><br>Record Review on 2/28/24 of the Facility Staffing Disclosure forms dated 2/27/24 and 2/28/24 revealed the forms did not have information on the daily census.<br><br>In an interview on 2/29/24 at 3:43 pm the ADON said he filled out the Facility Staffing Disclosure forms for 2/27/24 and 2/28/24 and did not know why he did not write in the census. He said the census should always be written in and the form should be filled out completely.<br><br>In an interview on on 2/29/24 at 3:54 pm the Administrator said the daily staffing sheet is supposed to be posted everyday including weekends. She said they always have it by the time clock near the administrator's office. The Administrator said they do not have a policy related to staff posting. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828<br><br>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards or food service safety for 1 of 1 kitchen reviewed for sanitation in that:<br><br>1. The facility failed to ensure all food items were labeled and dated in refrigerator #1.<br><br>2. The facility failed to keep personal drinks out of refrigerator#1<br><br>3. The facility failed to ensure expired food in refrigerator #2 was discarded.<br><br>These failures could place residents at risk of foodborne illnesses.<br><br>The findings included:<br><br>An observation of the kitchen on [DATE] beginning at 10:15 a.m., revealed there was a plastic container with beans that was not labeled in refrigerator #1, a personal 4 fl. Oz. bottle of water and an open 2-liter plastic bottle belonging to staff in refrigerator #1, and 2 gallons of milk that were expired in refrigerator #2.<br><br>In an interview on [DATE] at 10:30 a.m., the Dietary Manager said she would immediately discard the 2 gallons of milk that were expired and the beans in the plastic container that was not labeled. The Dietary Manager said kitchen staff were not going to use the milk because they knew it was expired but failed to discard it. The Dietary Manager did not say what negative effects of not labeling the food would be. She said she would in-service and counsel her staff immediately. The Dietary Manager said she conducts quarterly or as needed in-services to her staff regarding labeling/dating. She said she was responsible for making sure policy was followed.<br><br>In an interview on [DATE] at 4:00 p.m., the Administrator said the Dietary Manager had informed her of the expired milk, plastic container with bean not labeled, and personal food items in refrigerator meant for residents. She said the Dietary Manger had in-serviced and counseled her staff. The Administrator did not say what negative effects of not labeling food, expired food, and personal food in resident's refrigerator were. The Administrator said all food items had been discarded.<br><br>Record review of facility's Frozen and Refrigerated Foods Storage policy revealed:<br><br>Procedure:<br><br>7. Proper labeling of cooked foods includes the date placed in the refrigerator, and an expiration or use by date. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761<br><br>Based on interview 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 4 residents (Resident #18) reviewed for accuracy of records.<br><br>1. The facility failed to accurately document on Resident #18's MAR, post dialysis weight on 02/27/24 at 3:30 p.m.<br><br>2. The facility failed to accurately document Resident #18's PEG site care on MAR, on 02/26/2024 10-6a shift.<br><br>3. The facility failed to accurately document Resident #18's anticoagulant monitoring on [DATE]/26/24 10-6a shift, 02/27/24 6a-2 shift, 02/27/24 2-10p shift, and 02/27/24 10-6a shift.<br><br>4. The facility failed to accurately document Resident #18's SpO2 saturation on [DATE]/26/24 10-6a shift, 02/27/24 6a-2 shift, 02/27/24 2-10p shift, and 02/27/24 10-6a shift.<br><br>5. The facility failed to accurately document Resident #18's pain on [DATE]/26/24 10-6a shift, 02/27/24 6a-2 shift, 02/27/24 2-10p shift, and 02/27/24 10-6a shift.<br><br>6. The facility failed to accurately document Resident #18's [NAME] monitoring on [DATE]/26/24 10-6a shift, 02/27/24 6a-2 shift, 02/27/24 2-10p shift, and 02/27/24 10-6a shift.<br><br>These failures could place residents at risk of not receiving appropriate care resulting in deterioration in condition, exacerbation of disease process, overmedication, and increased risk of harm or injury.<br><br>The Findings included:<br><br>Review of Resident #18's Admission Record dated 02/28/24 documented a [AGE] year-old male, initially admitted on [DATE], readmitted on [DATE], with the diagnoses that included gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), type 2 diabetes mellitus (the pancreas does not make enough insulin and cells respond poorly to insulin and take in less sugar to fuel muscles and other tissues), end stage renal disease (when a person's kidneys cease functioning on a permanent basis leading to the need for regular course of long-term dialysis or kidney transplant to maintain life), myocardial infarction (heart attack), hypertension (high blood pressure), and altered mental status (a change in mental function characterized by confusion, disorientation, and disordered perceptions of sensory stimuli).<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #18's Admission Minimum Data Set, dated dated dated [DATE] revealed Resident #18 had unclear speech, was sometimes understood by others, sometimes understood others, BIMS was blank indicating cognitive impairment, and was always incontinent of bowel and bladder.<br><br>Review of Resident #18's comprehensive care plan dated 01/28/24 revealed:<br><br>FOCUS: Dialysis:<br><br>Resident #18 receives dialysis related to renal failure and is at risk for the potential complications of dialysis.<br><br>INTERVENTIONS/TASKS:<br><br>-Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations, and blood pressure to the physician.<br><br>Record review of Resident #18's Consolidated Physician's Orders dated 02/28/24 revealed:<br><br>Anticoagulant monitoring for aspirin/Plavix<br><br>Monitor resident for: Bruising, nosebleeds, bleeding gums, prolonged bleeding from wound, IV or surgical sites, blood in urine feces or vomit, petechiae, elevated PT/INR, low platelet count every shift for Anticoagulant therapy ADE (Adverse Drug Event) Y = Yes N = No If yes, document in nurse's notes and notify MD immediately Start date: 01/26/24<br><br>Review of Resident #18's Consolidated Physician's Orders dated 02/28/24 revealed:<br><br>Anticoagulant monitoring for Eliquis<br><br>Monitor resident for: Bruising, nosebleeds, bleeding gums, prolonged bleeding from wound, IV or surgical sites, blood in urine feces or vomit, petechiae, elevated PT/INR PT/INR = Prothrombin Time (PT)/ International Normalized ratio (INR) - blood test that measures how long it takes for a clot to form in a blood sample), low platelet count every shift for Anticoagulant therapy ADE (Adverse Drug Event) Y = Yes N = No If yes, document in nurse's notes and notify MD immediately Start date: 02/16/24<br><br>Record review of Resident #18's Consolidated Physician's Orders dated 02/28/24 revealed:<br><br>Monitor left chest permacath (a special catheter used for short-term dialysis treatment) q shift for s/sx of infection Start date: 01/26/24<br><br>Review of Resident #18's Consolidated Physician's Orders dated 02/28/24 revealed:<br><br>Monitor O2 saturation. Apply PRN O2 if SpO2 falls below 90%. Notify the physician if SpO2 falls below 90% Start date: 02/19/24<br><br>Record review of Resident #18's Consolidated Physician's Orders dated 02/28/24 revealed:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Monitor [NAME] (Regurgitant Aortic Valvular Area) for signs and symptoms of infection, and report to MD any abnormalities every shift Start date: 01/26/24<br><br>Record review of Resident #18's Consolidated Physician's Orders dated 02/28/24 revealed:<br><br>Assess for pain every shift and document using: Numerical scale 0-10 if verbal or PAINAD if non-verbal Resident's acceptable level of pain is: _0_ every shift Start date: 01/26/24<br><br>Record review of Resident #18's Consolidated Physician's Orders dated 02/28/24 revealed:<br><br>Enteral feed order every night shift PEG site care QD and PRN Start date: 02/09/24<br><br>Review of Resident #18's Consolidated Physician's Orders dated 02/28/24 revealed:<br><br>Obtain wt post dialysis every evening shift every Tue, Thu, Sat Order dated 01/27/24.<br><br>Record review of Resident #18's MAR revealed Resident #18's post dialysis weight on 02/27/24 at 3:30 p.m. was not placed in the MAR.<br><br>Record review of Resident #18's MAR revealed Resident #18's PEG site care was not place in MAR, on 02/26/2024 10-6a shift.<br><br>Record review of Resident #18's MAR revealed Resident #18's anticoagulant monitoring was not input in MAR, 02/26/24 10-6a shift, 02/27/24 6a-2 shift, 02/27/24 2-10p shift, and 02/27/24 10-6a shift.<br><br>Record review of Resident #18's MAR revealed Resident #18's SpO2 saturation was not input in MAR, 02/26/24 10-6a shift, 02/27/24 6a-2 shift, 02/27/24 2-10p shift, and 02/27/24 10-6a shift.<br><br>Record review of Resident #18's MAR revealed Resident #18's pain assessment was not input in MAR, 02/26/24 10-6a shift, 02/27/24 6a-2 shift, 02/27/24 2-10p shift, and 02/27/24 10-6a shift.<br><br>Record review of Resident #18's MAR revealed Resident #18's [NAME] monitoring was not input on MAR, 02/26/24 10-6a shift, 02/27/24 6a-2 shift, 02/27/24 2-10p shift, and 02/27/24 10-6a shift.<br><br>Record review of Resident #18's February 2024 MAR dated 02/28/24, order Obtain wt post dialysis every evening shift every Tue, Thu, Sat (Order dated 01/27/24), revealed no post dialysis weight input for Tuesday 01/27/24.<br><br>Record review of Resident #18's Progress Notes dated 02/27/24 at 03:30 p.m., revealed LVN B wrote, Resident back in facility from dialysis, no new skin changes noted. Dialysis site intact, dressing in place. V/S WNL. Bed in lowest position, HOB elevated. Peg tube intact. Tolerated feedings and meds well. All due care rendered.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 02/29/24 at 04:19 p.m., LVN D stated when a resident returns from dialysis the resident gets weighed either at dialysis post-dialysis or they get weighed at the facility. LVN D stated if the order is to weigh the resident at the facility, the resident would get weighed either by the nurse or the CNA. LVN D stated if the resident was not weighed post-dialysis, there would be a risk of fluid overload. LVN D stated something like anticoagulant or behavior monitoring is continuous. LVN D stated if monitoring was not done, the effects of the medication will not be documented to ensure the medication is working the way it is intended.<br><br>In an interview on 02/29/24 at 05:38 p.m., ADON E stated when a dialysis resident returns from dialysis, vitals are taken to make sure vitals are within normal limits. ADON E stated for an order for post-dialysis weight, the nurse gets the weight, and enters it in PCC as soon as possible after weight is taken. ADON E stated PCC will let them know where the weight is and should be so they know if the doctor needs to be notified. ADON E stated if weight is not taken, there could be fluid overload which is serious and the resident would be affected. The doctor would be notified. ADON E stated monitoring of behaviors, anticoagulants, antipsychotics, etc, is put in PCC immediately on notice of behaviors or adverse effect. If there is nothing to report, it is still put in PCC as a 0. ADON E stated if the monitoring and documentation were not done, they would not know if the medication was effective or not depending on what the monitoring was for.<br><br>In an interview on 02/29/24 at 06:07 p.m., the DON stated when a resident returns from dialysis, the resident is assessed and vital signs are taken, and if there was an order for weight to be taken post-dialysis, the weight from dialysis is taken and put into PCC when vitals are being put in PCC. The DON stated if the weight is not put in the computer, possible fluid overload could occur and that would not be good for the resident. The DON stated if the monitoring were not done, side effects would be missed or behaviors. The DON stated she runs a report every morning Monday through Friday that shows any missing check offs on the MAR/TARs for residents. She stated she did not see anything missing for Resident #18.<br><br>Record review of facility's policy on Medication - Treatment Administration and Documentation Guidelines dated Revision Date of 04/06/23, reflected:<br><br>Anticipated Outcome<br><br>To provide a process for accurate, timely administration and documentation of medication and treatments<br><br>Process<br><br>2. Verify and provide medication or treatment focused assessment i.e. BP, wound measurements as indicated by manufacturers guidelines or physician orders.<br><br>5. Document e-signature for medications and treatments administered on the EMAR or ETAR immediately following administration.<br><br>7. Medications or treatments that were not administered should be documented as not administered on the EMAR/ETAR with the reason for the not administration. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301<br><br>Based on observation, interview, and record review, the facility failed to establish an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, 4 residents of 5 (Resident #1, Resident #2, Resident #20, and Resident # 226) observed for infection control issues in that:<br><br>1. The LVN C did not sanitize the blood pressure cuff between resident use for Resident #1, Resident #2, and Resident #20 when taking resident's blood pressure prior to administering their medications.<br><br>2. During incontinent care for Resident #226 on 2/29/24 at 3:33 PM by CNA I failed to use appropriate incontinent care cleaning procedures.<br><br>This deficient practice could place residents at-risk for infection due to improper sanitizing of shared equipment and incontinent care practices.<br><br>The findings were:<br><br>1. Record review of Resident # 1's face sheet, dated 2/29/24, revealed a [AGE] year-old female admitted on [DATE] with diagnoses that included: Dementia, Cognitive Communication Disorder, Muscle Weakness, Morbid Severe Obesity due to excess calories, Hyperlipidemia (a condition in which there are high levels of fat particles (lipids) in the blood), Type II Diabetes, and Essential Hypertension.<br><br>Record review of Resident #1's MDS dated [DATE], revealed a BIMS of 09 suggests moderate cognitive impairment.<br><br>Record review of Resident #1's MAR dated 2/29/24, shows an order for Lisinopril Oral Tablet 2.5 MG Give 1 tablet by mouth in the morning related to Essential (Primary) Hypertension, hold if SBP (Systolic Blood Pressure) <100 and Metoprolol Tartrate Oral Tablet 25 MG Give 1 tablet by mouth two times a day related to Essential (Primary) Hypertension, hold if SBP (Systolic Blood Pressure) <100 or pulse <60.<br><br>Record review of Resident #20's face sheet, dated 2/29/24, revealed a [AGE] year-old male admitted on [DATE] with diagnoses that included: Other Frontotemporal neurocognitive disorder (a group of disorders that occur when nerve cells in the frontal and temporal lobes of the brain are lost. A common cause of dementia), Mood Disorder due to known physiological condition, Depression, Hyperlipidemia (a condition in which there are high levels of fat particles (lipids) in the blood), Dementia, Obstructive Sleep Apnea, Essential (primary) Hypertension, Muscle Weakness, Cognitive Communication Disorder<br><br>Record review of Resident #20's MDS dated [DATE], revealed a BIMS of 14 suggests cognitively intact.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #20's MAR dated 2/29/24, shows an order for Lisinopril Oral Tablet 5 MG Give 1 tablet by mouth in the morning related to Essential (Primary) Hypertension hold for SBP (Systolic Blood Pressure) < 100 and Propranolol HCl Oral Tablet 10 MG Give 1 tablet by mouth in the morning related to Essential (Primary) Hypertension hold if SBP (Systolic Blood Pressure < 100 HR (Heart Rate) < 60.<br><br>Record review of Resident # 2's face sheet, dated 2/29/24, revealed a [AGE] year-old male admitted on [DATE] with diagnoses that included: Parkinsonism, Mood Disorder, Unspecified Dementia, Muscle Weakness, Hyperlipidemia, Cognitive Communication Deficit, and Essential Primary Hypertension.<br><br>Record review of Resident #2's MDS dated [DATE], revealed a BIMS of 13 suggests cognitively intact.<br><br>Record review of Resident #2's MAR dated 2/29/24, shows an order for Carvedilol Oral Tablet 3.125 MG Give 1 tablet by mouth two times a day related to Essential (Primary) Hypertension hold if SBP (Systolic Blood Pressure) < 100 hold if pulse < 60.<br><br>During an observation of Med Pass on 2/28/24 at 8:55 am for Resident #1, LVN C reviewed her medication orders prior to administering Resident #1's medications. LVN C completed hand hygiene before and after each resident and between glove changes. There was an order for a blood pressure check prior to administering hypertensive medication. LVN C did not sanitize the blood pressure cuff prior or after use on Resident #1.<br><br>During an observation of Med Pass on 2/28/24 at 9:12 am for Resident #20, LVN C reviewed her medication orders prior to administering Resident #20's medications. LVN C completed hand hygiene before and after each resident and between glove changes. There was an order for a blood pressure check prior to administering hypertensive medication. LVN C did not sanitize the blood pressure prior cuff or after use on Resident #20.<br><br>During an observation of Med Pass on 2/28/24 at 9:30 am for Resident #2, LVN C reviewed her medication orders prior to administering Resident #20's medications. LVN C completed hand hygiene before and after each resident and between glove changes. There was an order for a blood pressure check prior to administering hypertensive medication. LVN C did not sanitize the blood pressure cuff prior or after use on Resident #2.<br><br>In an interview on 2/28/24 at 9:40 am, LVN C stated that she usually used disinfecting wipes per protocol like she used for other equipment that she reused between residents. She stated that not sanitizing equipment used on multiple residents is an infection control issue. She stated she should sanitize between every resident. LVN C stated that she usually tries to place blood pressure cuff surface to surface when the resident has long enough sleeves and not touching skin, then she doesn't need to sanitize. LVN C stated she did not remember the specific date she last took an infection control in-service, but thinks it was 1 or 2 weeks ago.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 2/28/24 at 5:19 pm, LVN D stated when he has checked a resident's blood pressure, he checked to see if they had any restrictions and will make sure he used appropriate limb or follow parameters, such as hold if blood pressure < 100/60. He stated that prior to using a blood pressure cuff on a resident, they must disinfect with disinfectant wipes. He said, That is the protocol we use. He stated that the negative consequences would be an increased risk to transfer infectious agents between residents. He did not remember when the last in-service was but stated he had taken an infection control in-service recently.<br><br>In an interview on 2/29/24 at 8:13 am, LVN K, she stated that she washes hands and disinfects all equipment before and after each resident, and that she remembers having an in-service for infection control about 1 week ago.<br><br>In an interview on 2/29/24 at 8:20 am, ADON E stated that blood pressure cuffs must be sanitized prior to and between resident use when reusing the same blood pressure cuffs on residents.<br><br>In an interview on 2/29/24 at 8:30 am, the DON M stated that all equipment, including blood pressure cuffs must be disinfected when reusing the equipment between residents. She stated that she is not aware of any protocols that state if the resident has long sleeves, there is no need to disinfect. DON M stated if staff do not sanitize blood pressure cuffs between residents, it could lead to infection control issues.<br><br>2. Record review of Resident #226's electronic face sheet dated 2/29/24 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnosis included Unspecified Sequelae of Cerebral Infarction (Psychological distress and neuropsychiatric disturbances, such as depression, anxiety or apathy as a result of a stroke), Other reduced mobility, Type 2 Diabetes Mellitus, Hyperlipidemia, Dementia, Alzheimer's Disease, Cognitive Communication disorder, and Need for Assistance with Personal Care.<br><br>Record review of Resident #226's comprehensive person-centered care plan, date initiated on 2/11/24, reflected Focus Resident #226 is incontinent of bowel/bladder. Interventions included INCONTINENT: check frequently for wetness and soiling and change as needed. Briefs or incontinence products as needed for protection. Apply barrier cream to skin after incontinent episodes. Monitor for and report to MD s/sx (signs and symptoms) of UTI (urinary tract infection): 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. Weekly skin checks to monitor for redness, circulatory problems, breakdown, or other skin concerns. Report any new skin conditions to the physician.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an incontinent care observation for Resident #226, on 2/29/24 at 3:33 pm., CNA I and CNA J knocked on the door before entering Resident #226's room. CNA J washed hands for 37 seconds and applied clean gloves. CNA I washed hands for 56 seconds and applied clean gloves prior to performing incontinent care. CNA I used one wipe per swipe while performing incontinent care to the perineal area while resident facing up in bed, wiping from clean to dirty and disposing of wipe after each use. Both CNA's removed gloves, sanitized and applied clean gloves then assisted resident to roll onto his right side to provide incontinent care to his back side. CNA I used a wipe between the resident's buttocks, folded it, and used the wipe again, scant BM noticed on wipe, then disposed of wipe. CNA I removed soiled gloves and applied clean glove. CNA I then used a wipe to clean one side of the buttocks and disposed of wipe, then used another wipe to cleanse the other side of the buttocks and disposed of wipe. CNA I removed soiled glove, sanitized, and applied clean gloves. Barrier cream applied. CNA I removed soiled glove, sanitized, and applied clean gloves. Both CNAs returned resident to lying position and re-applied clean brief and clothing. Soiled brief and supplies removed and disposed of in trash and trash removed by CNA J. CNA I removed gloves and washed hands for 35 seconds. CNA J removed gloves and washed hands for 32 seconds. CNA J lowered bed and raised head of bed to resident preference. Call light placed within reach and explained when to use.<br><br>In an interview on 2/29/24 at 3:50 pm., CNA I stated she is supposed to wipe down the center of the buttocks from clean to dirty, then on buttocks use one wipe per side, dispose of wipes. She said she used 2 wipes to cleanse the center of the buttocks and fold over, so it will not contaminate. CNA I stated she remembered that from school.<br><br>In an interview on 2/29/24 at 4:19 pm, LVN K she stated that when she performed incontinence care she must use 1 wipe per swipe and then dispose of the wipe. She stated not following that procedure will lead to infection.<br><br>In an interview on 2/29/24 at 5:08 pm, CNA L she stated when performing incontinent care, she used one wipe and throws the dirty wipe away. She stated that each pass is done with a clean wipe, then they dispose of the wipe. If they do not follow the procedure, the resident perineal area can contaminate and can get infection/UTI (Urinary Tract Infection).<br><br>In an interview on 2/29/24 at 5:20 pm, ADON E stated the procedure followed is you wipe in one direction, clean to dirty, then you dispose of the wipe immediately. You only use one wipe per swipe. He stated that if staff do not use the proper protocol, he would complete individual training, skills check off and education. Not following protocol could cause a UTI.(Urinary Tract Infection).<br><br>Record review of facility's Infection Control Guidelines Implemented 2/2007 and revised 9/22/15, revealed:<br><br>Purpose: The purpose for this policy is to reduce and prevent the spread of infections by the use of evidenced based techniques established infection control policies and procedures.<br><br>Process: .<br><br>2. Staff: .<br><br>c. Direct care staff use infection control practices in patient care procedures established to prevent spread of microorganisms<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 5. Equipment Protocol:<br><br>a. All reusable items and equipment requiring special cleansing, disinfection or shall be cleaned with appropriate cleaning agent.<br><br>Record review of facility's Incontinence Care implemented 4/17/14 and reviewed on 2/14/20, revealed:<br><br>Purpose: To outline a procedure for cleansing the perineum and buttocks after an incontinence episode.<br><br>Equipment: Toilet paper or disposable pre-moistened perineal wipes<br><br>Procedure: .<br><br>8. If feces present, remove with toilet paper or disposable wipe by wiping from front of perineum toward rectum. Discard soiled materials and gloves. Wash hands . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455560 | A. Building<br>B. Wing | 02/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Nursing Center | 600 N Cynthia St<br>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 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761<br><br>Observation and interview revealed the facility failed to provide a safe and functional environment for residents, staff and the public in 2 of 4 hallways (A Hall and E Hall) observed for environmental conditions.<br><br>1. The facility failed to ensure the bathroom ceiling on A Hall was free of dark discoloration.<br><br>2. The facility failed to ensure the ceiling in E Hall was free from dark discoloration.<br><br>These deficient practices could affect any resident's health and safety.<br><br>The findings were:<br><br>Observation on 02/26/24 at 11:43 a.m. revealed discoloration on the ceiling outside room [ROOM NUMBER]. Two circular light brownish-yellow discoloration approximately 8 12 in diameter. 8 smaller discolorations black in color were in the same area. A [NAME] smeared substance was over black discolorations on ceiling.<br><br>02/27/24 10:15 AM Observation of A Hall. Discoloration black in color on bathroom ceiling room [ROOM NUMBER].<br><br>In an interview on 02/29/24 at 05:38 p.m. ADON E stated the maintenance supervisor checks the ceilings throughout the building for stains, and discoloration. The ADON stated he checks the halls and rooms where the patients are. The ADON stated they (the facility) were shut down for quite a while due to issues, so they check. The ADON was notified of staining by room [ROOM NUMBER] hallway ceiling and room [ROOM NUMBER]'s bathroom ceiling.<br><br>In an interview on 02/29/24 at 06:07 p.m., the DON stated maintenance checks for stains or any issues with ceilings. |