STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455560	A. Building B. Wing	04/24/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51216 Based on observation, interview, and record review the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriaton of resident property, and exploitation for two out of 10 residents (Resident #59 and Resident # 100) reviewed for abuse/neglect. The facility failed to ensure Resident #59 was free of abuse. Resident #59 was hit on the head twice by Resident #100 on 02/22/25. This failure could place residents at risk of serious injury or death. The findings include: 1.Record review of Resident #59's face sheet dated 04/23/2025 indicated a [AGE] year-old male who was initially admitted to the facility on [DATE]. Resident #59 had a diagnoses which included nontraumatic subdural hemorrhage (rare condition where a blood clot forms in the space between the brain and its outer lining) , dysphagia(difficulty swallowing), difficulty in walking, other lack of coordination, muscle weakness, cognitive communication deficit (problems in communicating in conversations) , dementia (loss in cognitive functioning) and muscle wasting and atrophy (wasting and shrinking of the muscles). Record review of Resident #59's Admission MDS Assessment, dated 02/20/2025, revealed Resident #59 had a BIMS Score of 09, which indicated-Moderate cognitive impairment needed some assistance with all ADLs. Record review of Resident #59's Care Plan, date initiated 01/04/2025, indicated Resident #59 had impaired cognition and was at risk for a further decline in cognitive and functional abilities related to dementia and pain. The resident had an ADL self-care performance deficit. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Record review of Resident #100's face sheet, dated 04/23/25, indicated a [AGE] year-old female who was initially admitted to the facility on [DATE]. Resident #100 had diagnoses which included Rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood), muscle weakness (generalized) unsteadiness on feet, lack of coordination, need for assistance with personal care. Major depressive disorder(a mental disorder characterized by persistent feelings of sadness, loss of interest or pleasure in activities, and other symptoms that interfere with daily life), anxiety(a natural human emotion characterized by feelings of worry tension and apprehension about the future), cerebral palsy (congenital disorder of movement muscle tone or posture) . Record review of Resident #100's Admission MDS Assessment, dated 02/23/2025, indicated a BIMS score of 00 which indicated -severe cognitive impairment. Resident #100 needed extensive assistance with all ADLs. The assessment indicated Resident #100 had hallucinations and delusions. Resident #100 had physical and verbal behavioral symptoms directed toward others within 1 to 3 days. Record review of Resident #100's Care Plan, dated 02/19/25, indicated Resident #100 had impaired cognition and was at risk for a further decline in cognitive and functional abilities related to cerebral palsy, insomnia, depression, and violence. Resident#100 had a behavior problem as evidenced created an emotional attachment towards male staff. The resident preferred male staff to give care and refused care from female staff (on occasion). Resident #100 had a behavior problem as evidenced by aggressive behavior such as yelling, screaming, and throwing herself on floor. Intervention included monitoring behavior episodes and attempted to determine the underlying cause. Consider location, time of day, persons involved, and situations. Document behaviors and interventions in behavior log. Approach the resident in a calm manner, call by name, speak slowly, and maintain eye contact. Talk to the resident while providing care, allow time for a response, and do not rush. Record review of Resident #100's progress notes indicated: -02/21/25 at 7:56 PM Resident received 1:1 monitoring until a bed becomes available at psychiatric behavior hospital in the morning 2-22-25. Will continue to monitor resident. -On 02/22/25 at 4:25 PM Resident #100 was in the front lobby being verbally abusive to residents, residents' family members, and staff shouting curse words. -02/22/25 at 6:42 PM Haloperidol Lactate injection Solution (an antipsychotic used to treat mental disorders) 5 MG/ML injection 2 mg intramuscularly as needed for psychosis delusions 03/05/2025 daily as needed was effective. -02/22/25 at 8:13 PM Resident continues to be verbally and physically abusive to staff and resident she is banging on other residents' doors, also put an object into a female resident's lap nudging the resident. resident is very non redirectable at this point. This nurse notified [local] police and ambulance resident is being sectioned to a psychiatric behavior hospital DON is aware. 02/22/2025 at 8:13 pm Resident #100 refused all medication she stated F K off. 02/22/2025 at 8:50 PM Resident transported to psychiatric hospital via ambulance escorted by [local] police department. Resident to be sectioned to psychiatric hospital. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Provider Investigation Report Indicated: Date reported to HHSC: 02/24/25 8:45 PM. Incident date:02/22/25 7:00PM in the dining room. Description of allegation: During morning round, alleged witness notified me of incident where female resident [Resident #100] hit male [Resident #59] twice on the head. Male resident interview stated was not hit . Assessment: 02/24/25 11:05 AM-no injuries noted upon skin assessment. Investigation summary . resident initially denied being hit, but during our investigation admitted being hit but did not want to report it. Investigation findings: confirmed. No witness statement was observed to have been taken from any residents. Record review of Resident #59's Progress Notes dated 02/25/2025 indicated Resident #59 was Hit by a female resident twice. Resident stated it did not occur. No complaints of pain or discomforts, able to move all extremities with no difficulty. Able to voice needs. All due care rendered, call light within reach. Record Review of the facility's incident and accident log, dated January 2025 - April 22, 2025, indicated there were no prior incidents involving Resident #59 and Resident #100. In an observation and interview on 04/23/25 at 09:14 AM with Resident #59 revealed he was alert, verbal, and appropriately engaged in conversation. Resident #59 stated Resident #100 was verbally abusing him for some time but never reported it to staff because he did not want the situation to get worse between them. Resident #59 said he also did not want to report any incident because he did not want police involved because he was afraid his probation would be revoked. Resident #59 stated on the day of the incident the verbal abuse escalated to Resident #100 assaulting him in the dining room. Resident #59 stated as Resident #100 was wheeled past him in her wheelchair Resident #100 started swinging her arms towards him and hit him twice on the head. Resident #59 stated HA K who was wheeling Resident #100 asked him if he was ok and if she had hit him. Resident #59 told HA K was ok and she did not touch him, but she had made contact and hit him twice. Resident #59 stated he also told CNA H during the head-to-toe assessment he stated to her he had not pain or discomfort. Resident #59 stated the physical abuse was a one-time incident, but arguments would occur frequently between Resident #100 and him. Resident #59 stated he had no fear of retaliation from staff or other residents, just from Resident #100. Resident #100 was no longer a resident at the facility at the time of the investigation. On 2/24/25 Resident #100 left against medical advice and has not been readmitted . In an interview on 04/23/25 at 03:46 PM with the DON revealed the administrator was conducting rounds on 02/24/25 when she was told by former Resident #101 the witnessed Resident #59 got hit by Resident #100. The DON said it was reported Resident #59 was hit by Resident #100 twice on the head as the residents were walking past each other in the dining room. The DON said Resident #59 and Resident #100 had not had any previous altercations with each other or other residents. The [NAME] Stated Resident #100 was put on a one to one monitoring and was awaiting placement at a psychiatric hospital. All Staff were notified to redirect Resident #100 if she was being disruptive, verbally abusive or trying to enter the rooms of the other residents. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/23/25 at 04:49 PM with the Administrator she stated she was made aware of Resident #100 hitting Resident #59 after the incident occurred, and not until 02/24/25, two days later, was when she made aware of the incident. The Administrator said she immediately initiated an investigation and had both residents assessed for injuries, which no injuries were found on either resident. The Administrator said Resident #59 initially denied being hit by Resident #100 but then confirmed he was hit on the head, twice. The Administrator said Resident #100 was already on one-to-one supervision due to her behaviors and was awaiting a bed at the psychiatric hospital for evaluation and treatment. The Administrator said she reported this abuse incident to state officials but did not report it to law enforcement because Resident #59 did not want to involve law enforcement due to him being on probation and did not want to risk getting arrested for being involved in an altercation. The administrator stated it was policy and procedure to inform state and local law enforcement for abuse and neglect allegations. In an interview on 04/24/25 at 09:48 AM HA K said he was escorting Resident #100 to her room when they passed by Resident #59 and Resident #100 began swinging her arms to hit Resident #59. HA K said Resident #100 hit Resident #59 on the head twice. HA K stated Resident #100 proceeded to swing her arms while he was escorting her to her room. HA K said Resident #100 continued to display aggressive behavior in her room. HA K said he could not recall if he reported Resident #100 hitting Resident #59 since he was dealing with Resident #100 during her behavior. Record review of the facility's Abuse and Neglect and Exploitation Policy and Procedure dated 09/06/2024 indicated Policy: it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing a d implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident properties. 1. The facility provides resident protection that includes: Prevention/ prohibit resident abuse, neglect, and exploitation and misappropriation of resident property; Investigation of all allegations listed above and Training for new and existing staff on activities that constitute abuse, neglect and exploitation and misappropriate of resident property, reporting procedures, and dementia management and resident abuse prevention; .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51216 Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries or unknown source and misappropriation of residents property, were reported immediately, but not later than two hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials, including to the State Agency, in accordance with State Law through established procedures for 1 out of 10 residents (Resident #59 that occurred on 02/24/25 to the local law enforcement agency, for 1 of 10 residents (Resident #59) reviewed for reporting of abuse/neglect. The facility failed to report an incident involving Resident #100 and Resident #59 that occurred on 02/24/25 to the local law enforcement agency. This failure could place residents at risk for potential abuse. The findings include: 1.Record review of Resident #59's face sheet dated 04/23/2025 indicated a [AGE] year-old male who was initially admitted to the facility on [DATE]. Resident #59 had diagnoses which included nontraumatic subdural hemorrhage (rare condition where a blood clot forms in the space between the brain and its outer lining) , dysphagia(difficulty swallowing), difficulty in walking, other lack of coordination, muscle weakness, cognitive communication deficit (problems in communicating in conversations) , dementia (loss in cognitive functioning) and muscle wasting and atrophy (wasting and shrinking of the muscles) . Record review of Resident #59's Admission MDS assessment dated [DATE] revealed Resident #59's had a BIMS Score of 09 which indicated -Moderate cognitive impairment Resident #59 needed some assistance with all ADLs. Record review of Resident #59's Care Plan initiated date 01/04/2025 indicated Resident #59 had impaired cognition and was at risk for a further decline in cognitive and functional abilities related to dementia and pain. The resident had an ADL self-care performance deficit. 2. Record review of Resident #100's face sheet dated 04/23/25 indicated a [AGE] year-old female who was initially admitted to the facility on [DATE]. Resident #100 had diagnoses which included Rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood), muscle weakness (generalized) unsteadiness on feet, lack of coordination, need for assistance with personal care. Major depressive disorder Major depressive disorder(a mental disorder characterized by persistent feelings of sadness, loss of interest or pleasure in activities, and other symptoms that interfere with daily life), anxiety(a natural human emotion characterized by feelings of worry tension and apprehension about the future), cerebral palsy (congenital disorder of movement muscle tone or posture). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #100's Admission MDS assessment dated [DATE] indicated a BIMS score of 00-severe cognitive impairment and needed extensive assistance with all ADLs. The assessment revealed Resident #100 had hallucinations and delusions. Resident #100 had physical and verbal behavioral symptoms directed toward others within 1 to 3 days. Record review of Resident #100's Care Plan dated 02/19/25 indicated Resident #100 had impaired cognition and was at risk for a further decline in cognitive and functional abilities related to cerebral palsy, insomnia (a sleep disorder characterized by difficulty falling asleep, or experiencing non-restorative sleep), depression, and violence. Resident#100 had a behavior problem as evidenced created an emotional attachment towards male staff. The resident preferred male staff to give care and refused care from female staff (on occasion). Resident #100 had a behavior problem as evidenced by aggressive behavior such as yelling, screaming, and throwing herself on floor. Intervention included monitoring behavior episodes and attempted to determine the underlying cause. Consider location, time of day, persons involved, and situations. Document behaviors and interventions in behavior log. Approach the resident in a calm manner, call by name, speak slowly, and maintain eye contact. Talk to the resident while providing care, allow time for a response, and do not rush. Record review of Resident #100's progress notes indicated: -02/21/25 at 7:56 PM Resident received 1:1 monitoring until a bed becomes available at psychiatric behavior hospital in the morning 2-22-25. Will continue to monitor resident. -On 02/22/25at 4:25 PM Resident#100 was in front lobby being verbally abusive to residents, residents' family members, and staff shouting curse words. -02/22/2025 at 6:42PM Haloperidol Lactate injection Solution (an antipsychotic used to treat mental disorders) 5 MG/ML injection 2 mg intramuscularly as needed for psychosis delusions 03/05/2025 daily as needed was effective. -02/22/25 8:13 at PM Resident continues to be verbally and physically abusive to staff and resident she is banging on other residents' doors, also put an object into a female resident's lap nudging the resident. resident is very non redirectable at this point. This nurse notified [local] police and ambulance resident is being sectioned to a psychiatric behavior hospital DON is aware. 02/22/2025 at 8:13 pm Resident #100 refused all medication she stated F K off. 02/22/2025 at 8:50 PM Resident transported to psychiatric hospital via ambulance escorted by [local] police department. Resident to be sectioned to psychiatric hospital. Record review of the facility's Provider Investigation Report Indicated: Date reported to HHSC: 02/24/25 8:45 PM. Incident date:02/22/25 7:00PM in the dining room. Description of allegation: During morning round, alleged witness notified me of incident where female resident [Resident #100] hit male [Resident #59] twice on the head. Male resident interview stated was not hit Assessment: 02/24/25 11:05 AM-no injuries noted upon skin assessment. Investigation summary resident initially denied being hit, but during our investigation admitted being hit but did not want to report it. Investigation findings: confirmed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #59's Progress Notes dated 02/25/2025 indicated Resident #59 was Hit by a female resident twice. Resident stated it did not occur. No complaints of pain or discomforts, able to move all extremities with no difficulty. Able to voice needs. All due care rendered, call light within reach. Record review of the facility's incident and accident log date January 2025 - April 22, 2025, indicated there were no prior incidents involving Resident #59 and Resident #100. In an observation and interview on 04/23/25 at 09:14 AM Resident #59 revealed he was alert, verbal, and appropriately engaged in conversation. Resident #59 stated he did not want to report the altercation between himself and #100 because he felt sorry for her and he did not want to get her in trouble. Resident #59 was afraid to get in trouble himself for arguing with resident #100 said he also did not want the incident reported to police because he was afraid that his probation would be revoked. Resident #59 stated he did not want to go back to jail and was afraid that the situation would be turned around and he would somehow be blamed of assault too and this would have revoked his probation and he ' d go back to jail. In an interview on 04/23/25 at 03:46 PM with the DON revealed she stated the administrator was responsible for reporting all incidents to the local authorities after she reports them to the state. The administrator was initially made aware of the incident two day after the altercation took place with resident #59 and Resident #100 in the dining room. As soon as she was made aware she began to investigate why it had not been reported to staff and what actually happened n 02/22/25 . the [NAME] stated that the resident was fearful of going back to jail and that was the reason local authorities were not notified of the abuse to Resident #59. In an interview on 04/23/25 at 04:49 PM with the Administrator she stated she was made aware of Resident #100 hitting Resident #59 two days after the time the incident occurred on 02/24/25. The Administrator said she immediately initiated an investigation and had both residents assessed for injuries, which no injuries were found on either resident. The Administrator said Resident #59 initially denied being hit on 02/22/25 by Resident #100 but then confirmed he was hit on the head twice. On 02/24/25. The Administrator said Resident #100 was already on one-to-one supervision due to previous behaviors and was awaiting a bed at the psychiatric hospital for evaluation and treatment. The Administrator said she reported this abuse incident to state officials but did not report it to law enforcement because Resident #59 did not want to involve law enforcement due to him being on probation and did not want to risk getting arrested for being involved in an altercation. The administrator stated it was policy and procedure to inform state and local law enforcement for abuse and neglect allegations. The administrator wrote in a letter dated 02/24/25 stating the reason she did not report to local police was because I explained that was not my protocol but since it was resident request/ family request I would honor. I still need to report to state. They understood. This administrator explained that he would be free of any abuse or harm in our facility and that if any Future incidents happen please call or text me. Both understood. DON present. In an interview on 04/24/25 at 09:48 AM with HA K said he was escorting resident#100 to her room when the incident occurred, and he did ask Resident# 59 if Resident #100 hit him and he said no. HA K could not remember if he reported it to anyone as he was trying to redirect Resident #100 to her room so that she could not hurt anyone while she was acting up as he took her to her room. He knew if he witnessed any abuse or neglect, he would report it to a nurse, DON, or Administrator. HA K also stated the facility had abuse and neglect training at least once a month if not more. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Abuse and Neglect and Exploitation Policy and Procedure dated 09/06/2024 indicated Policy: it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing a d implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident properties. 1. The facility's Abuse Prevention Coordinator is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50039 Based on interview and record review, the facility failed to develop a comprehensive care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs, as well as describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 6 (Residents #42 and #53) residents reviewed for care plans. 1) The facility failed to ensure Resident #42 was weighed weekly as ordered by the physician. 2) The facility failed to ensure Resident #53 was weighed weekly as ordered by the physician. These failures could place residents at risk of unnoticed weight loss or weight gain resulting in exacerbation of symptoms and increased morbidity. The findings included: 1. Record review of Resident #42's face sheet, dated 04/22/25, revealed a [AGE] year-old male with an initial admitted [DATE] and a current admitted [DATE]. Resident #42's pertinent diagnoses included morbid obesity due to excess calories and chronic systolic heart failure (condition where the heart's left ventricle weakens and cannot pump blood effectively). Record review of Resident #42's Quarterly MDS assessment, dated 04/10/25, section C revealed a BIMS score of 15, which indicated the resident's cognition was intact. Record review of Resident #42's comprehensive care plan, dated 04/22/25, revealed the focus Nutritional Status: Resident is on a renal, regular, regular and at nutritional & hydration risk [sic] initiated on 09/10/24. The goal of the focus stated Resident will maintain adequate nutritional and hydration status as evidenced by weight being stable with no signs or symptoms of malnutrition or dehydration being present through the next review date initiated on 09/10/24. The intervention listed stated Provide and serve diet as ordered- renal, regular, regular initiated on 09/10/24. Record review of Resident #42's physician orders revealed an active order initiated on 02/28/25 for weekly weights: if has 5lb wt gain/loss report to MD for further orders. Every day shift every Thu. Record review of Resident #42's weight revealed Resident #42 was weighed on 04/17/25 with a result of 234.3lbs, and he was weighed on 03/14/25 with a result of 245.0lbs. No weights were documented between 04/17/25 and 03/14/25. In an interview with Resident #42 at 2:45 PM on 04/22/25, Resident #42 stated he was not sure if he was supposed to be weighed weekly or monthly. Resident #42 stated he knew they weighed him but was not sure exactly how often. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #53's face sheet, dated 04/22/25, revealed a [AGE] year-old male with an initial admitted [DATE] and a current admitted [DATE]. Resident #53's pertinent diagnoses included mild protein-calorie malnutrition (body does not receive enough protein or calories), and dementia (loss of cognitive function including memory, thinking, and reasoning severe enough to interfere with daily life). Record review of Resident #53's Quarterly MDS assessment, dated 03/22/25, section C revealed a BIMS score was not gathered for this resident. Resident #53 was rarely/never understood. Record review of Resident #53's comprehensive care plan, dated 04/22/25, revealed the focus [Resident #53] has, unplanned/unexpected weight loss. 10/17/24 wt 125 has 10% wt loss since 04/24/24 initiated on 05/10/24 and revised on 10/17/24. Interventions listed included: - 10/17/24 weekly weights, speech therapy, diet testing for po intake initiated on 10/17/24. - Monitor and evaluate any weight loss. Determine percentage lose and follow facility protocol for weight loss initiated on 05/10/24 and revised on 05/10/24. Record review of Resident #53's physician orders revealed an active order initiated on 02/13/25 for weekly weights every day shift every Thu. Record review of Resident #53's weight revealed Resident #53 was weighed on 04/17/25 with a result of 154. 3 lbs. He was weighed on 03/13/25 with a result of 159.1lbs. No weights were documented between 04/17/25 and 03/13/25. An interview was attempted with Resident #53 at 2:40 PM on 04/22/25, but Resident #53 was not interviewable. In an interview with CNA B at 2:08 PM on 04/23/25, CNA B stated she weighed residents before. CNA B stated the nurses gave the CNAs a list at the beginning of the shift with the residents who needed to be weighed that day. CNA B stated she always weighed all residents who needed to be weighed on her shifts. CNA B stated she had not heard of any CNAs not weighing their residents. CNA B stated they monitored the weight of residents to ensure they were not losing or gaining weight, and they were eating well. In an interview with CNA E at 2:16 PM on 04/23/25, CNA E stated they weigh residents on the first of every month. CNA E stated she had a list of residents who needed weekly weights. CNA E stated she had never missed weighing a resident when they needed it. CNA E stated if she did not get to a resident on a specific day, she informed the nurse so they could have the next CNA on shift weigh the resident. CNA E stated it was important to monitor the resident's weight to know if they were losing or gaining weight, which could lead to other problems. (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 B. Wing	04/24/2025

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN A at 2:34 PM on 04/23/25, LVN A stated the nurses gave a list of residents who needed to be weighed to the CNAs at the beginning of the shift. LVN A stated the list was pre-filled by the MAR. LVN A stated sometimes CNAs were not able to weigh all residents on the list every shift, so they passed the information to a nurse who then told the oncoming shift to weigh the necessary residents. LVN A stated it was important to monitor a resident's weight depending on what conditions they had. LVN A stated if a resident's weight was not monitored as frequently as ordered they might have underlying symptoms of diseases go unnoticed for extended periods of time. In an interview with the ADON at 2:49 PM on 04/23/25, the ADON stated at the beginning of the shift, the nurses gave the CNAs a list of all residents who needed to be weighed that day. The ADON stated the CNAs weighed the residents, recorded it on paper, and then handed the results to the nurse. The ADON stated the nurses pulled the list of residents who needed to be weighed from the MAR. The ADON stated if residents were not weighed as ordered they could experience exacerbations of their problems, ultimately causing them harm. In an interview with the DON at 7:51 AM on 4/24/25, the DON stated they discovered residents were not being weighed as ordered recently. The DON stated they implemented a new policy involving a weight team that would come in on Thursdays to weigh all residents who needed to be weighed on a weekly basis. The DON stated residents received orders for weekly weights if they had heart failure, a G-tube, severe weight loss, or they were a new resident. The DON stated those residents were more prone to weight changes. The DON stated if they did not weigh residents as ordered there was potential to miss a change in the resident's condition. Record review of the facility's policy titled Weight Management, written on 01/05 and last reviewed on 09/13/24 revealed the following: Resident weights will be recorded in each resident's medical record monthly, unless specifically ordered otherwise . All weights (admission, readmission, weekly and monthly) are to be entered into the Point Click Care (PCC) weight system . All residents should be weighed on admission, readmission and monthly unless more frequent weights are deemed necessary by the clinical team.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50039 Based on observation, interview and record review the facility failed to ensure all drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 of 4 (B-hall and D/E-halls) medication carts reviewed for medication storage. 1. The facility failed to store 17 loose tablets/capsules in their appropriate blister packs in the medication cart for B-hall. 2. The facility failed to store 17 loose tablets/capsules in their appropriate blister packs in the medication cart for D/E-halls. These deficient practices could place residents at risk of losing medications leading to medication shortage. The findings included: An observation of the B-hall medication cart on 04/23/25 at 12:25 PM revealed 17 assorted tablets and capsules loose in the 2nd drawer from the top. The drawer contained blister packs of medications for residents living on the B-hall along with the loose medications. An observation of the D/E-hall medication cart on 04/23/25 at 12:35 PM revealed 17 assorted tablets and capsules loose in the 2nd drawer from the top. The drawer contained blister packs of medications for residents living on the D/E-hall along with the loose medications. In an interview with LVN A at 1:34 PM on 04/23/25, LVN A stated she was the current charge nurse for B hall and E hall. LVN A stated she had never seen loose medications in any of the medication carts. LVN A stated she would dispose of any loose medications properly if she saw any inside the carts. LVN A stated the proper way to dispose of medications was to crush it and put it in the biohazard box on the medication cart or a sharps container. LVN A stated she cleaned out her carts at the end of each month and as needed if she had free time during the day. LVN A stated she was not aware of any official policy on cleaning out medication carts. LVN A stated wasting pills unnecessarily was not good because they were the residents' property. LVN A stated if they ran out of medications on a resident early, they would have to order more before they could administer them to the resident. LVN A stated medications should not be loose in the cart because it meant residents were losing some of their medications unnecessarily. LVN A stated she did not think the medications were loose in the cart for over a month. LVN A stated she did not know what medications they were and there was no way of determining who the medications belonged to. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the ADON at 2:49 PM on 04/23/25, the ADON stated nurses went through medication carts weekly to clean them out. The ADON stated he did not believe there was a policy that covered how to properly clean out a medication cart. The ADON stated each nurse was responsible for cleaning out their own cart. The ADON stated he could not determine how long the medications had been loose in the medication carts or which resident they belonged to. The ADON stated if a nurse found a loose tablet or capsule in a cart, they were to notify a supervisor and destroy the medication appropriately. The ADON stated it was important to keep medication carts free of loose medications to prevent cross contamination and from medications potentially falling out of the cart as drawers were opened and closed. In an interview with the DON at 7:51 AM on 04/24/25, the DON stated loose medications should not be in the medication carts, and they should be properly disposed of whenever spotted. The DON stated nurses were responsible for keeping their medication carts clean. The DON stated there was not an official policy on how often medication carts were to be cleaned, but it was to be done whenever necessary. The DON stated the loss of medications resulted in residents losing their property. The DON stated there was no way to determine how long the loose medications had been in the cart or which resident they belonged to. The DON stated the facility would pay for new medications if they ran out of them before they were due for a refill. Record review of the facility's policy titled Medication Storage, dated 01/20/21, revealed the following: .8. Medication Carts are routinely inspected for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are removed and destroyed in accordance with the facility policy.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on interviews and record reviews, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 2 (Resident #2 and Resident #11) of 6 residents reviewed for accuracy and completeness of clinical records. 1. The facility failed to ensure LVN A correctly documented Resident #2's blood pressure 59 times when she administered blood pressure altering medications (amiodarone, hydralazine, metoprolol, and midodrine) between 04/01/25 and 04/23/25. 2. The facility failed to ensure LVN I correctly documented Resident #2's blood pressure 10 times when she administered blood pressure altering medications (amiodarone, hydralazine, metoprolol, and midodrine) between 04/01/25 and 04/23/25. 3. The facility failed to ensure LVN D correctly documented Resident #2's blood pressure 4 times when she administered blood pressure altering medications (amiodarone, hydralazine, metoprolol, and midodrine) between 04/01/25 and 04/23/25. 4. The facility failed to ensure LVN A correctly documented Resident #11's blood pressure 16 times when she administered blood pressure altering medications (amlodipine) between 04/01/25 and 04/23/25. These deficient practices could affect residents whose records are maintained by the facility and could place them at risk for errors in care and treatment due to documentation of inaccurate information. The findings included: 1. Record review of Resident #2's admission record reflected an [AGE] year-old female originally admitted to the facility on [DATE] with most recent admission on 04/10/24. Resident #2's diagnoses included chronic combined systolic and diastolic heart failure (aka congestive heart failure- a condition in which the heart does not pump blood as well as it should and can cause fluid to build up in the lungs), essential hypertension (high blood pressure), hypotension (low blood pressure), end stage renal disease (a condition in which the kidneys have permanently lost the ability to function effectively), and dependence on renal dialysis (a process that replaces the function of the kidneys by removing blood from the body, filtering it through a machine, then returning the blood to the body). Record review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS score of 15 which indicated Resident #2 was cognitively intact. Record review of Resident #2's order summary report dated 04/22/25 reflected the following orders dated 04/10/24: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Amiodarone HCl tablet 200mg. Give 1 tablet by mouth two times a day (8:00am and 4:00pm) related to paroxysmal atrial fibrillation (when the top part of the heart does not contract correctly sometimes). Hold if SBP less than 110 or HR under 60. (This medication did not require the blood pressure to be documented on the eMAR when it was administered, however it did have hold parameters). Hydralazine HCl oral tablet 50mg. Give 1 tablet my mouth four times a day (8:00am, 12:00pm, 4:00pm, and 8:00pm) related to essential hypertension. Hold if SBP less than 110 or HR under 60. (This medication required the blood pressure to be documented on the eMAR when it was administered.) Metoprolol Succinate ER tablet Extend Release 24 Hour 25mg. Give 1 tablet by mouth at bedtime (8:00pm) related to essential hypertension. Hold if SBP less than 110 or HR under 60. (This medication required the blood pressure to be documented on the eMAR when it was administered.) Midodrine HCl tablet 10mg. Give 1 tablet by mouth three times a day 8:00am, 12:00pm, 4:00pm) related to hypotension. (This medication required the blood pressure to be documented on the eMAR when it was administered.) Record review of Resident #2's eMAR and blood pressure summary both dated 04/01/25 to 04/23/25 reflected the following: On 04/01/25 at 8:18pm, Resident #2's blood pressure was documented as 102/56 on the blood pressure summary by LVN J. On 04/02/25, LVN A documented she administered Resident #2's 8:00am dose of Amiodarone, Resident #2's 8:00am and 12:00pm doses of Hydralazine (BP documented on the eMAR as 102/56 for both administrations), and Resident #2's 8:00am and 12:00pm doses of Midodrine (BP documented on the eMAR as 102/56 for both administrations). On 04/02/25, LVN I documented she administered Resident #2's 8:00pm doses of Hydralazine (BP documented on the eMAR as 122/66) and Metoprolol (BP documented on the eMAR as 122/66). On 04/02/25, the only blood pressure documented on Resident #2's blood pressure summary was 122/66 which was done at 5:57pm by LVN I. On 04/03/25, LVN A documented she administered Resident #2's 8:00am dose of Amiodarone, Resident #2's 8:00am and 12:00pm doses of Hydralazine (BP documented on the eMAR as 122/66 for both administrations) and Resident #2's 8:00am and 12:00pm doses of Midodrine (BP documented on the eMAR as 122/66 for both administrations). On 04/03/25, LVN I documented she administered Resident #2's 8:00pm doses of Hydralazine (BP documented on the eMAR as 114/67) and Metoprolol (BP documented on the eMAR as 114/67). On 04/03/25, the only blood pressure documented on Resident #2's blood pressure summary was 114/67 which was done at 5:53pm by LVN I. On 04/04/25, LVN A documented she administered Resident #2's 8:00am doses of Amiodarone, Hydralazine (BP documented on the eMAR as 114/67) and Midodrine (BP documented on the eMAR as 114/67). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/04/25, the only blood pressures documented on Resident #2's blood pressure summary were 106/48 at 4:19pm and 114/56 at 8:21pm, both documented by LVN J. On 04/07/25 at 8:59pm, Resident #2's blood pressure was documented as 114/46 on the blood pressure summary by LVN J. On 04/08/25, LVN A documented she administered Resident #2's 8:00am dose of Amiodarone, Resident #2's 8:00am and 12:00pm doses of Hydralazine (BP documented on the eMAR as 114/46 for both administrations) and Resident #2's 8:00am and 12:00pm doses of Midodrine (BP documented on the eMAR as 114/46 for both administrations). On 04/08/25, LVN I documented she administered Resident #2's 8:00pm doses of Hydralazine (BP documented on the eMAR as 115/62) and Metoprolol (BP documented on the eMAR as 115/62). On 04/08/25, the only blood pressure documented on Resident #2's blood pressure summary was 115/62 at 6:13pm by LVN I. On 04/09/25, LVN A documented she administered Resident #2's 8:00am dose of Amiodarone, Resident #2's 8:00am and 12:00pm doses of Hydralazine (BP documented on the eMAR as 115/62 for both administrations) and Resident #2's 8:00am and 12:00pm doses of Midodrine (BP documented on the eMAR as 115/62 for both administrations). On 04/09/25, LVN I documented she administered Resident #2's 4:00pm dose of Amiodarone, Resident #2's 4:00pm and 8:00pm doses of Hydralazine (BP documented on the eMAR as 115/62 for both administrations), Resident #2's 4:00pm dose of Midodrine (BP documented on the eMAR as 115/62), and Resident #2's 8:00pm dose of Metoprolol (BP documented on the eMAR as 115/62). On 04/09/25, there were no blood pressures documented on Resident #2's blood pressure summary. On 04/10/25, LVN A documented she administered Resident #2's 8:00am dose of Amiodarone, Resident #2's 8:00am and 12:00pm doses of Hydralazine (BP documented on the eMAR as 115/62 for both administrations) and Resident #2's 8:00am and 12:00pm doses of Midodrine (BP documented on the eMAR as 115/62 for both administrations). On 04/10/25, the only blood pressures documented on Resident #2's blood pressure summary were 132/68 at 4:33pm and 96/54 at 8:40pm, both documented by LVN J. On 04/11/25, LVN A documented she administered Resident #2's 8:00am dose of Amiodarone, Resident #2's 8:00am and 12:00pm doses of Hydralazine (BP documented on the eMAR as 96/54 for both administrations), and Resident #2's 8:00am and 12:00pm doses of Midodrine (BP documented on the eMAR as 96/54 for both administrations). On 04/11/25, the only blood pressures documented on Resident #2's blood pressure summary were 100/56 at 4:33pm and 108/56 at 8:10pm, both documented by LVN J. On 04/13/25, at 7:53pm, Resident #2's blood pressure was documented as 108/56 on the blood pressure summary by LVN J. (continued on next page)

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	455560	A. Building B. Wing	04/24/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/14/25, LVN A documented she administered Resident #2's 8:00am and 4:00pm doses of Amiodarone, Resident #2's 8:00am, 12:00pm, 4:00pm, and 8:00pm doses of Hydralazine (BP documented on the eMAR as 108/56 for all 4 administrations), Resident #2's 8:00am, 12:00pm, and 4:00pm doses of Midodrine (BP documented on the eMAR as 108/56 for all 3 administrations), and Resident #2's 8:00pm dose of Metoprolol (BP documented on the eMAR as 108/56). On 04/14/25, there were no blood pressures documented on Resident #2's blood pressure summary. On 04/15/25, LVN A documented she administered Resident #2's 8:00am dose of Amiodarone, Resident #2's 8:00am and 12:00pm doses of Hydralazine (BP documented on the eMAR as 108/56 for both administrations) and Resident #2's 8:00am ad 12:00pm doses of Midodrine (BP documented on the eMAR as 108/56 for both administrations). On 04/15/25, LVN D documented she administered Resident #2's 4:00pm dose of Amiodarone and Resident #2's 4:00pm dose of Hydralazine (BP documented on the eMAR as 108/56). On 04/15/25, the only blood pressure documented on Resident #2's blood pressure summary was 124/60 at 7:29pm by LVN D. On 04/16/25, LVN A documented she administered Resident #2's 8:00am dose of Amiodarone, Resident #2's 8:00am and 12:00pm doses of Hydralazine (BP documented on the eMAR as 124/60 for both administrations), and Resident #2's 8:00am and 12:00pm doses of Midodrine (BP documented on the eMAR as 124/60 for both administrations). On 04/16/25, the only blood pressures documented on Resident #2's blood pressure summary were 98/62 at 4:06pm and 108/56 at 8:50pm, both by LVN J. On 04/17/25, LVN A documented she administered Resident #2's 8:00am dose of Amiodarone, Resident #2's 8:00am and 12:00pm doses of Hydralazine (BP documented on the eMAR as 108/56 for both administrations) and Resident #2's 8:00am and 12:00pm doses of Midodrine (BP documented on the eMAR as 108/56 for both administrations). On 04/17/25, the only blood pressures documented on Resident #2's blood pressure summary were 132/76 at 4:10pm and 128/76 at 8:50pm, both by LVN J. On 04/19/25, LVN A documented she administered Resident #2's 12:00pm doses of Hydralazine and Midodrine (BP documented on the eMAR as 102/62 for both administrations). On 04/19/25, the only blood pressures documented on Resident #2's blood pressure summary were 102/62 at 9:46am by LVN C, 98/56 at 4:44pm by LVN J, and 108/52 at 7:58pm, also by LVN J. On 04/20/25, LVN A documented she administered Resident #2's 8:00am dose of Amiodarone, Resident #2's 8:00am and 12:00pm doses of Hydralazine (BP documented on the eMAR as 108/52 for both administrations), and Resident #2's 8:00am and 12:00pm doses of Midodrine (BP documented on the eMAR as 108/52 for both administrations). On 04/20/25, the only blood pressures documented on Resident #2's blood pressure summary were 124/74 at 4:48pm and 136/70 at 7:24pm by LVN K. (continued on next page)

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	455560	A. Building B. Wing	04/24/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/21/25, LVN A documented she administered Resident #2's 8:00am dose of Amiodarone, Resident #2's 8:00am and 12:00pm doses of Hydralazine (BP documented on the eMAR as 136/70 for both administrations), and Resident #2's 8:00am and 12:00pm doses of Midodrine (BP documented on the eMAR as 136/70 for both administrations). On 04/21/25, LVN D documented she administered Resident #2's 4:00pm doses of Hydralazine and Midodrine (BP documented on the eMAR as 136/70 for both administrations). On 04/21/25, the only blood pressure documented on Resident #2's blood pressure summary was 128/76 at 7:55pm by LVN D. On 04/22/25 at 11:11pm, LVN K documented Resident #2's blood pressure as 122/66 on the blood pressure summary. On 04/23/25, LVN A documented she administered Resident #2's 8:00am dose of Amiodarone and Resident #2's 12:00pm doses of Hydralazine and Midodrine (BP documented as 122/66 for both administrations). On 04/23/25, there were no blood pressures documented on Resident #2's blood pressure summary. 2. Record review of Resident #11's admission record reflected a [AGE] year-old male admitted to the facility on [DATE]. Resident #11's diagnoses included essential hypertension (high blood pressure) and chronic kidney disease (a condition where the kidneys do not function as they should). Record review of Resident #11's quarterly MDS dated [DATE] reflected a BIMS of 15 which indicated Resident #11 was cognitively intact. Record review of Resident #11's order summary report reflected an order for Amlodipine Besylate oral tablet 5mg. Give 1 tablet by mouth in the morning related to essential hypertension. Hold if SBP <100 dated 02/14/25. Record review of Resident #11's eMAR and blood pressure summary both dated 04/01/25 to 04/23/25 reflected the following: On 04/01/25, LVN C documented Resident #11's blood pressure as 112/65 at 12:07pm on the blood pressure summary. On 04/02/25, LVN A documented she administered Resident #11's 8:00am dose of Amlodipine (BP documented as 112/65 on the eMAR). On 04/02/25, there were no blood pressures documented on Resident #11's blood pressure summary. On 04/03/25, LVN A documented she administered Resident #11's 8:00am dose of Amlodipine (BP documented as 112/65 on the eMAR). On 04/03/25, the only blood pressure documented on Resident #11's blood pressure summary was 123/72 at 3:23pm by LVN I. (continued on next page)

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	455560	A. Building B. Wing	04/24/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/04/25, LVN A documented she administered Resident #11's 8:00am dose of Amlodipine (BP documented as 123/72 on the eMAR). On 04/04/25, there were no blood pressures documented on Resident #11's blood pressure summary. On 04/07/25, LVN C documented Resident #11's blood pressure as 128/72 at 11:54am on the blood pressure summary. On 04/08/25, 04/09/25, and 04/10/25, LVN A documented she administered Resident #11's 8:00am dose of Amlodipine (BP documented as 128/72 on the eMAR for all 3 days). On 04/08/25 and 04/09/25, there were no blood pressures documented on Resident #11's blood pressure summary. On 04/10/25, the only blood pressure documented on Resident #11's blood pressure summary was 126/74 at 5:12pm by LVN J. On 04/11/25, LVN A documented she administered Resident #11's 8:00am dose of Amlodipine (BP documented as 126/74 on the eMAR). On 04/11/25, there were no blood pressures documented on Resident #11's blood pressure summary. On 04/13/25, LVN C documented Resident #11's blood pressure as 124/72 at 8:19am on the blood pressure summary. On 04/14/25, LVN A documented she administered Resident #11's 8:00am dose of Amlodipine (BP documented as 124/72 on the eMAR). On 04/14/25, the only blood pressure documented on Resident #11's blood pressure summary was 120/66 at 10:53pm by LVN L. On 04/15/25, LVN A documented she administered Resident #11's 8:00am dose of Amlodipine (BP documented as 120/66 on the eMAR). On 04/15/25, there were no blood pressures documented on Resident #11's blood pressure summary. On 04/16/25, LVN A documented she administered Resident #11's 8:00am dose of Amlodipine (BP documented as 133/72 on the eMAR). On 04/16/25, the only blood pressures documented on Resident #11's blood pressure summary were 133/72 at 3:16am by LVN L and 126/74 at 4:59pm by LVN J. On 04/17/25, LVN A documented she administered Resident #11's 8:00am dose of Amlodipine (BP documented as 120/66 on the eMAR). On 04/17/25, the only blood pressures documented on Resident #11's blood pressure summary were 120/66 at 1:24am by LVN K, 118/78 at 4:12pm by the ADON, and 112/62 at 9:48pm by LVN J. (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 B. Wing	04/24/2025

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/19/25, LVN A documented she administered Resident #11's 8:00am dose of Amlodipine (BP documented as 110/66 on the eMAR). On 04/19/25, the only blood pressures documented on Resident #11's blood pressure summary were 110/66 at 12:03am by LVN K, 114/62 at 4:43pm by LVN J, and 126/76 at 10:29pm by LVN K. On 04/20/25, 04/21/25, 04/22/25, and 04/23/25, LVN A documented she administered Resident #11's 8:00am dose of Amlodipine (BP documented as 126/76 on the eMAR on all 4 days). On 04/20/25, 04/21/25, 04/22/25, and 04/23/25, there were no blood pressures documented on Resident #11's blood pressure summary. In an interview on 04/23/25 at 3:04pm, LVN A stated when a resident got medications that affected blood pressure, she checked vital signs 5-10 minutes prior to administration of the medications. LVN A stated there were not any times she did not check vital signs prior to medication administration. LVN A stated the blood pressure was documented on the eMAR when the medication was administered because it would not let you click that it was administered without that documentation. LVN A stated the windows that came up for vital sign documentation were new, view prior, and n/a. LVN A stated she always put in new vital signs with medication administration. LVN A stated if a resident did not have much activity or did not move around much, they could have the same blood pressure 2 times in a row, but a resident having the same blood pressure 4 times in a row would not be normal. LVN A stated if a medication that altered blood pressure was given without checking vital signs, it could lower or raise the blood pressure to a dangerous level. LVN A stated if the blood pressure went too low, it could put the resident into cardiac arrest and they could pass away and if the blood pressure was raised too high, it could cause a stroke and cause hospitalization or death. LVN A stated when Resident #2 got back from dialysis at about 10:30am or 11:00am on 04/23/25 she checked Resident #2's blood pressure, and she did not know why the blood pressure did not show up on the blood pressure documentation page. LVN A stated she did not know why the blood pressure when she got back from dialysis was the same as the blood pressure from 11:11pm on 04/22/25. When asked about Resident #2's Midodrine administration on 04/14/25 and 04/15/25, (6 administrations) and how Resident #2's BP was exactly the same for all 6 medication administrations, LVN A stated it was not documented properly. LVN A stated she checked the blood pressure each time but if she misplaced the paper she wrote it on, she would go back and use the blood pressure she had previously documented. LVN A stated if vital signs were not documented correctly, the provider could increase or decrease a medication unnecessarily which could cause the resident's blood pressure to be unstable. LVN A stated she had not seen or heard of anyone else not checking a resident's blood pressure before blood pressure altering medications were given. LVN A stated they were in-serviced on mediation administration/documentation anytime there was a problem or a change in staff and the last one was about a month ago. (continued on next page)

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McAllen Nursing Center	600 N Cynthia St McAllen, TX 78501

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/23/25 at 5:48pm, the ADON stated when medications that could affect blood pressure were administered, the nurse checked the blood pressure right before giving the medication and documented in the eMAR right after administration. The ADON stated it was not acceptable to write it down on a piece of paper to document later, it was not acceptable for the nurse to not check a blood pressure prior to administration/documentation nor was it acceptable for the nurse to use prior blood pressure documentation. The ADON stated it was not normal for a resident to have the same blood pressure 2 or more times in a row. When asked about Resident #11's blood pressure documentation on the eMAR on 04/20/25, 04/21/25, 04/22/25, and 04/23/25, the ADON stated that it did not look right for his blood pressure to be the same 4 days in a row when there were no blood pressures documented on the blood pressure summary page. The ADON stated if blood pressures were not checked prior to administration of blood pressure altering medications, it could cause a dangerous drop or elevation in the resident's blood pressure which could lead to hospitalization . The ADON stated if a provider was to look at inaccurately documented vital signs, they could stop, decrease, or increase a medication unnecessarily. The ADON stated in-services on medication administration and documentation were done annually and as needed, however he did not recall when the last in- service was completed. The ADON stated his expectation was for the nurses to document accurately and timely. In an interview on 04/24/25 at 10:35am the DON stated when nurses were giving medications that could affect blood pressure, they were to check the resident's blood pressure within 5-10 minutes prior to administration of the medication. The DON stated the nurses were to document the blood pressure on the eMAR at the time the medication was given or held, and it was important to check the blood pressure before medication administration to ensure the medication did not adversely affect the resident. The DON stated it was important to document vital signs on the eMAR so the provider did not make any unnecessary adjustments to the medication. The DON stated if a resident had a low blood pressure and a medication was given that further lowered it, or if a resident had a high blood pressure and a medication was given that would further increase it, it could lead to hospitalization or possibly death. The DON stated she expected the nurses to check vital signs within 5-10 minutes before medication administration and to document accurately at the time the medication was given. The DON stated in-services on medication administration and documentation were done at least annually and as needed and nurse skills check offs, and an in-services were done either late February or early March. The DON stated the ADON did the check offs. The DON stated this would become part of the QAPI plan and a PIP was put into place. In an interview on 04/24/25 at 11:05am, Resident #2 stated the nurses sometimes only checked her blood pressure once a day and sometimes checked it a lot. Resident #2 stated she sometimes felt tired after dialysis, but in general she felt ok. In an interview on 04/24/25 at 11:27am, the MD stated he expected the nurses to follow physician orders and check blood pressures prior to administering medications that had an effect on blood pressures. The MD stated if a resident had a low blood pressure and a medication was given that could lower it more, it could cause a precipitous drop and lead to hospitalization and if a medication to raise the blood pressure was given to a resident who already had a high blood pressure, it could lead to a hypertensive emergency, a stroke, hospitalization , or death. Record review of LVN A's Medication Pass Validation Checklist, dated 01/06/25 and signed by the ADON, reflected the following procedures were observed and no corrective actions were required: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.3. Obtained necessary information to administer medications safely (BP, pulse, glucose, lab values). 9. Documented medications administered on MAR. Record review of the facility's Medication-Treatment Administration and Documentation Guidelines, dated 01/09/14 and revised 04/06/23, reflected in part: Anticipated Outcome: To provide a process for accurate, timely administration and documentation of medication and treatments. Fundamental Information: The Medication-Treatment Administration Documentation Guideline applies to licensed nurses and certified medication aides according to licensure or certification scope of practice. Process: 3. Verify and provide medication or treatment focused assessment i.e. BP . as indicated by manufacturers guidelines or physician orders. 4. Administer the medication according to the physician order. 5. Document e-signature for medications and treatments administered on the EMAR or ETAR immediately following administration. 12. Review the EMAR after each medication and treatment administration is completed and prior to end of the shift to validate documentation is completed and supports services provided according to physician orders.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038 Based on observation, interview, and record review, the facility failed to establish and maintain 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 for one of 16 residents (Resident #40) reviewed for infection control practices. 1. The facility failed to ensure the WCN wore proper PPE (gown) during wound care for Resident #40 who required enhanced barrier precautions. 2. The facility failed to ensure CNA E wore proper PPE (gown) during wound care for Resident #40 who required enhanced barrier precautions. 3. The facility failed to ensure the WCN performed hand hygiene after removing a glove during wound care for Resident #40. 4. The facility failed to ensure CNA E performed hand hygiene after removing a glove while assisting during wound care for Resident #40. These failures could place residents at risk for healthcare associated cross-contamination and infections . The findings include: Record review of Resident #40's face sheet dated 04/23/25 reflected a [AGE] year-old-male who had an original admitted [DATE]. Resident #40 had diagnoses which included pressure ulcer (open wound on the skin caused by prolonged pressure to specific area of the body) of sacral (a bone in the lower back) region stage 4 (full thickness tissue loss extending below the subcutaneous fat into deep tissue, muscle, tendons and ligaments), hypertension (high blood pressure), and type 2 diabetes (insufficient insulin production in the body). Record Review of Resident #40's physician orders reflected the following: Dated 4/05/25: Enhanced barrier precautions: Must wear gloves and gown for the following high-contact resident care activities: Dressing, bathing/showering, transferring, changing linens, providing hygiene, assisting with toileting, wound care, feeding tube, trach care, central line care, urinary catheter care, every day for wounds and foley. Dated 04/09/25: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cleanse sacrum with NS wound cleanser, pat dry with 4x4 gauze, apply skin prep to peri (region of the body located between the thighs marking the lower boundary of the pelvis) wound, apply collagen sheet (promotes healing by stimulating new tissue growth) , apply calcium alginate sheet (highly absorbent wound dressing), cover with 4x4 gauze (bleached white cloth or fabric used in bandages and dressings) secure with tape every day. Record review of Resident #40 's care plan dated 03/27/2024 and revised on 02/11/2025 reflected: Resident requires enhanced barrier precautions related to catheter and wound. Enhanced barrier precautions: Must wear gloves and gown for the following high-contact resident care activities: Dressing, bathing/showering, transferring, changing linens, providing hygiene, assisting with toileting, wound care, feeding tube, trach care, central line care, urinary catheter care. During an observation of wound care on 04/23/25 at 08:57 AM revealed CNA E and the WCN did not put on the correct PPE (a gown) to perform wound care. An EBP sign was observed above Resident #40's bed which indicated a gown must be worn. During wound care, both CNA E and the WCN were observed removing a glove and placed another glove on without washing or sanitizing their hands. In an interview on 04/23/25 at 09:21 AM, the WCN stated when her glove tore, she should have taken off both gloves, washed or sanitized her hands, but instead, she took off only the torn glove and forgot. The WCN said it was important to wash or sanitize hands after removing gloves as it was a part of infection control practice and could cause cross contamination. The WCN stated infection control in-services happened frequently but could not recall the last in-service. The WCN nurse stated she should have worn a gown to prevent cross contamination since Resident #40 had a wound but just forgot. In an interview on 04/23/25 at 09:26 AM, CNA E stated she forgot to wash or sanitize her hands after removing gloves while helping during wound care. CNA E stated it was important to wash or sanitize hands to prevent resident cross contamination and infection. CNA E stated she should have worn a gown to prevent cross contamination. CNA E stated she usually did not work Resident #40's hall and just forgot. In an interview on 04/23/25 at 02:37 PM, the DON stated the WCN and CNA E should have washed or sanitized their hands to prevent infection and because it was good hygiene practice. The DON stated EBP should have been worn to prevent cross contamination since Resident #40 had a wound. The DON stated the last infection control in-service was about 3 weeks ago. Record Review of facility's Hand Hygiene policy dated 02/20/20 and revised on 02/11/22, reflected: Policy: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. 6. Additional considerations: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The use of gloves does not replace hand hygiene. If your tasks requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.