

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455560	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER McAllen Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. On 06/22/26, the facility failed to ensure bread and fresh vegetables were properly labeled and dated. This failure placed all residents who ate food served by the kitchen at risk of cross contamination and food-borne illness. Findings include: Observation of the dry pantry room on 06/22/26 at 8:26 AM revealed an open bag of bread was not labeled or dated when opened. Observation of the dry pantry room on 06/22/26 at 8:26 AM revealed approximately 5 trays of unopened loaves of bread not labeled or dated when received. Observation of the refrigerator on 06/22/26 at 8:29 AM revealed an open box of fresh vegetables not labeled or dated when received. In an interview on 06/22/26 at 8:34 AM, the [NAME] stated he did not know why the food items had not been labeled. He stated it was important to label food with dates because it could prevent residents from being severed with old food, which could cause them to get sick. In an interview on 06/24/26 at 10:26 AM, the DON stated that the SOM would make rounds of the kitchen whenever there were food deliveries. The DON stated that anytime new merchandise arrived, the kitchen staff knew it had to be labeled and dated. He stated that he didn't know why the food items got missed, but they should have been labeled and dated. In an interview on 06/24/26 at 1:05 PM, the SOM stated that all staff were responsible for ensuring items were stored, labeled, and dated. The SOM stated that when there was a food delivery, whoever was on shift, was responsible for labeling the food. The SOM stated that every item open should have an open date in the refrigerator, freezer, and dry storage. The SOM stated that if food items were not properly labeled and dated, staff may be unaware of when the items were opened, increasing the risk of food spoilage and potential illness for residents. The SOM stated dates should have been legible to read to make it easy for staff to discard when needed. The SOM stated that if food items were not properly labeled, it would have increased the risk of food getting spoiled, or it would cause potential illness for the residents. In an interview on 06/24/26 at 7:25 PM, the Administrator stated that she did weekly rounds in the kitchen. She stated she had not seen any issues with labeling. The administrator stated it was important to label and date food because it was a way to monitor the quality of food and ensure the food was appropriate for consumption. Record review of the Dry Food and Supplies Storage Policy with a review date of 07/22/22 revealed the following: 9. All opened products must be resealed effectively and properly labeled, dated and rotated for use. Record review of the Frozen and Refrigerated Foods Storage with a review date of 07/22/22 revealed the following: 9. Items stored in the refrigerator must be dated upon receipt. 11. All refrigerated and frozen items in storage will contain a minimum label of common name of product and dated as noted above.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident had a right to a dignified existence and to treat each resident with respect and dignity for 1 of 16 residents (Resident #19) reviewed for resident rights. The facility failed to ensure Resident #19's foley catheter bag (a drainage bag that collects urine) had a privacy cover on it to provide respect and dignity. This failure could lead to residents at risk of experiencing feelings of shame and/or embarrassment as well as having their right to privacy violated. Findings include: Record review of Resident #19's face sheet dated 06/23/26 revealed a [AGE] year-old female originally admitted to the facility on [DATE] and then a re-admission date of 06/17/26. Her diagnoses included but not limited to, acute panmyelosis with myelofibrosis (a very rare and aggressive type of leukemia), malignant melanoma of skin (the most serious type of skin cancer), neutropenia (having low levels of white blood cells), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), generalized anxiety (a group of mental illnesses that cause constant fear and worry), and schizophrenia (mental health condition that affects how people think, feel and behave). Record review of Resident #19's care plan dated 04/17/26 revealed the foley catheter (a device that drains urine from your urinary bladder into a collection bag outside of your body) was not added as part of the care plan. Record review of Resident #19's Order Summary of active orders dated 06/22/26 revealed an order with a date of 06/17/26: Flush foley catheter (sending a liquid gently through the tube to clear out any blockages) with 60ml of sterile water or normal saline as needed for non-patency (blockage). During an observation on 06/22/26 at 10:21 AM, Resident #19 was lying in her bed. Resident #19's foley catheter bag was hung from the side of the bed with no privacy cover over it. The foley catheter bag had urine in it that was visible to anyone in the room. In an interview on 06/22/26 at 10:21 AM, Resident #19 stated the foley catheter had been placed during a recent hospital stay. She stated she returned to the facility with the foley catheter in place. Resident #19 stated she could not remember the exact date the foley had been placed, but it was a few days ago. She stated she did not realize there was not a cover on the foley bag because since her return to the facility, she had been just in bed due to her health restrictions. Resident #19 stated she could not see the foley drainage bag from the position she was in. She stated she didn't know it had to be covered but knowing that the bag had urine, she did not want other people to see it. In an interview on 06/22/2026 at 10:27 AM, LVN A stated Resident #19 had returned from the hospital a week ago. LVN A stated Resident #19 already had the foley in place when she returned. LVN A stated the foley catheter bag had to be covered for dignity purposes and so Resident #19 would not feel embarrassed. LVN A stated that the foley catheter bag should also be covered for infection control. In an interview on 06/24/26 at 10:26 AM, the DON stated Resident #19 had returned from the hospital with a foley. The DON stated that a foley catheter bag cover should have been placed right away upon her return. He stated ultimately the admitting nurse should have placed the privacy bag, but all nurses were responsible too. It was important to have the privacy cover on the foley catheter bag because it maintained Resident #19's dignity. In an interview on 06/24/26 at 7:25 PM, the Administrator stated that as soon as the nurse realized Resident #19 did not have a cover on the foley catheter bag, one was placed and everyone received an in-service (teaching) on placing privacy bags over foley catheter bags. Record review of the facility's Resident Rights policy reviewed on 02/20/21, revealed, Resident Rights. The resident has the right to a dignified existence. 4. Respect and dignity. The resident has a right to be treated with respect and dignity.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 1 of 16 residents' rooms (Resident #17's room) reviewed for food safety. The facility failed to place a thermometer in the refrigerator located in Resident #17's room; therefore, the staff did not monitor the internal temperature and expiration/used by dates of food items. These failures could place residents at risk of foodborne illnesses. Findings include: Record review of Resident #17's face sheet dated 06/24/26 revealed an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Alzheimer's' disease (a brain disorder that slowly destroys a person's memory and thinking skills), Type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), protein-calorie malnutrition (a condition resulting from inadequate intake of protein and calories, often due to decreased oral intake), diverticulosis of intestine (small, bulging pouches (diverticula) form in the walls of the large intestine), age related physical debility, and need for assistance with personal care. During an observation on 06/22/26 at 11:22 AM, Resident #17's room was noted to have a personal refrigerator. The refrigerator contained perishable food items such as bottled water and canned drinks. The refrigerator did not contain a thermometer inside. There was not a log present indicating the refrigerator's daily temperatures. During an interview on 06/22/26 at 11:23 AM, Resident #17 stated no one had ever placed a thermometer in the refrigerator. He stated that no one would review the items in the refrigerator either. Resident #17 stated he assumed that since the refrigerator was his personal item, the facility staff did not have to maintain it. He stated that in the time he had the refrigerator, no staff member had checked the temperature of the refrigerator or cleaned it. During an interview on 06/22/26 at 3:57 PM, the MM stated he was not in charge of checking the refrigerator temperature. He stated that housekeeping oversaw that task. During an interview on 06/22/26 at 4:02 PM, the SOM stated that the refrigerator temperatures were checked by the CNAs. The SOM stated that resident refrigerators should have a paper on the side of the refrigerator where the temperatures were logged. She stated that if there was no paper on the refrigerator, then nursing should be questioned because it was a duty for the CNAs. During an interview on 06/22/26 at 4:27 PM, LVN B stated she was the nurse for Resident #17. LVN B stated she was unaware that personal refrigerators had to be checked. She stated she would have to speak to a CNA to confirm that. LVN B stated that it was important to check the temperature of the refrigerators because food could be spoiled and could have caused the residents to get sick. During an interview on 06/22/26 at 4:30 PM, CNA C stated he had not checked Resident #17's fridge. He stated that if it was a personal fridge, the resident's family would oversee its upkeep. CNA C stated it was important to check the fridge daily because if the refrigerator did not work properly, the food could go bad, and the resident could get sick. During an interview on 06/22/26 at 4:33 PM, the Administrator stated that because of the facility's transition into a different company, she was waiting on the new forms to log in Resident #17's refrigerator temperatures. The administrator stated she could not confirm that staff were not checking the refrigerator's temperatures. The Administrator stated she did not have the old forms with Resident #17's refrigerator temperature logs. The Administrator stated it was important to do temperature checks on Resident #17's refrigerator because it was a way to monitor the quality of the food and ensure the food was appropriate for consumption. Record review of the facility's Resident Refrigerators policy revised 08/28/23 revealed: 1. Dormitory-sized refrigerators are allowed in a resident's room under the following conditions: The refrigerator is inspected by maintenance personnel and deemed safe prior to (continued on next page)		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	use. The refrigerator maintains proper temperatures. 2. Staff shall record refrigerator temperatures weekly on a temperature log attached to the refrigerator. a. A thermometer shall remain in the refrigerator. 3. Staff shall inspect the refrigerator weekly.		