

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455586	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/19/2025
NAME OF PROVIDER OR SUPPLIER  Grand Terrace Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  812 W Houston Ave 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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observations interview, and record review the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles for 1 (1 and 2 hallway cart) of 5 medication carts. The facility failed to ensure that the nurses medication cart for 1 and 2 hallway was secured by a lock when it was left unattended by LVN A. The failure could place residents at risk of injury to other residents if medication left unsecured were consumed. Findings included: During an observation on 11/17/2025 from 02:51 PM revealed the 1 and 2 nurse's medication cart was left unlocked and unattended against the nurse's station. During the observation LVN A was called by surveyor and informed her that the medication cart was unlocked. LVN A secured the cart by locking it. During an interview on 11/17/2025 at 02:52 PM with LVN A revealed she was responsible for the nurse's medication cart that was left unlocked. She stated she was expected to lock the nurse's medication cart when she walked away from it. She stated if it was left unlocked then a resident could open a drawer and take a medication that was not for them. She stated she had left the cart unlocked because she just went to answer a call. During an interview on 11/18/2025 at 05:20 PM with the DON revealed numerous staff, including he and the ADON, were responsible for ensuring medications carts were locked. The DON stated his expectation of staff when they walked away from the medication cart was to lock it. The DON stated that the negative outcome for leaving the cart unlocked was that a resident or visitor could grab the medication from the cart, and it could harm them. He stated he had provided in-services to the staff, and he visually monitored daily. Record review of undated facility policy Storing and Controlling Medications dated 7/2017, revealed: Medications of those residents who do not self-administer, will be stored in a locked cabinet, (such as a medication cart). Only authorized personnel will have a key/access to the locked cabinet.</p>

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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