| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455586 | A. Building<br>B. Wing | 12/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Grand Terrace Rehabilitation and Healthcare | 812 W Houston Ave<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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(continued on next page) |

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

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

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received care in accordance with professional standards of practice for 1 (Resident #1) of 2 residents observed for Quality of Care. The facility failed to ensure that CNA A asked for help when she performed incontinent care and dressed a resident who required 2-person assistance for these tasks. This failure could place residents at risk for potential harm or injury during tasks that require 2-person assistance.The findings included:Record review of Resident #1's admission record dated 10/13/25 reflected a [AGE] year-old man who was admitted to the facility on [DATE]. The resident's diagnosis included non-traumatic intracerebral hemorrhage in hemisphere (a stroke caused by bleeding within the brain's cerebral hemispheres, most commonly due to chronic high blood pressure), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a condition where blood flow to the brain is interrupted, leading to brain tissue damage) affecting the left non-dominant side, need for assistance with personal care, and muscle weakness.Record review of Resident #1's MDS dated [DATE] indicated a BIMS score 06 reflected severe cognitive impairment. The MDS indicated that Resident #1 was totally dependent on two or more staff for toileting hygiene, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and eating. Record review of Resident #1's care plan reflected that Resident #1 had ADL Self Care Performance Deficit related to generalized weakness with interventions of TOILET USE (toilet transfer, toilet hygiene): requires assistance x2 and DRESSING (lower and upper body dressing) requires x2 to dress. On 10/13/25 at 11:00pm observation revealed CNA A performed incontinent care and re-dressed Resident #1 with no assistance from another staff member. It was observed that CNA A did not request assistance from another staff member for this task. On 10/13/25 at 11:10pm, CNA A was interviewed. CNA A stated that she was ok with providing incontinent care alone on Resident #1. CNA A admitted she did not request assistance for this task. CNA A stated that Resident #1's RP, who was present today, usually assisted with incontinent care and dressing. CNA A stated that during the night shift, at times, it was difficult to find another staff member to assist with tasks that required 2-person assistance. CNA A stated that other staff members had their own tasks to perform. CNA A stated that she was aware that Resident #1 had the intervention for 2 persons assist but felt confident in her ability to change the resident on her own. CNA A stated that a negative outcome for not having another staff member assist her could have resulted in the resident being positioned incorrectly or maybe even being injured with a wrong movement. On 10/13/25 at 11:18pm, Resident #1's RP was interviewed. The RP stated that he usually assists the CNAs when they have performed incontinent care or dressed the resident. The RP stated that this was the second time he had seen CNA A perform incontinent care on Resident #1 The RP stated CNA A was not often assigned to Resident #1.On 10/13/25 at 11: 22pm, an attempt was made to interview Resident #1 however resident was too sleepy to answer any questions. When asked a question, Resident #1 kept his eyes closed and did not respond. Resident #1's RP stated that once resident falls asleep, it is difficult to wake him up.On 10/13/25 at 11:41pm CNA B was interviewed. CNA B stated that generally when a new resident arrived at the facility, she looked into the facility's computer system called Kardex which informed her whether a resident required 1- or 2-person assistance on tasks. CNA B stated if she needed assistance from another staff member, she did not rely solely on another, CNA. CNA B stated that nurses have assisted her with resident tasks such as incontinent care or dressing a resident. CNA B stated that CNA A did not ask her to assist her with incontinent care on Resident #1. On 10/13/25 at 11:56pm RN C was interviewed. RN C stated that nurses have the responsibility to inform the CNAs about specific interventions such as whether the residents required 1- or 2-person assistance for tasks. RN C stated that care plans were written by the ADON or the DON and not by the floor nurses. RN C stated that RNs were responsible for overseeing that CNAs followed interventions according to the care plan. RN C stated that CNAs could not access the care plans therefore it was important to communicate with the CNAs on any changes. RN C stated that she was not approached by CNA A to assist with incontinent care for Resident #1. RN C stated she was not aware CNA A had performed incontinent care on Resident #1 alone. On 10/14/25 at 12:04 am RN D was interviewed. RN D stated that she did not write care plans. RN D stated that the DON or the ADON were responsible for implementing care plans and then letting nurses know of any changes. RN D stated that floor nurses were to oversee CNAs and to make sure interventions were performed as written. RN D stated she was not aware CNA A had performed |