STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455586	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Terrace Rehabilitation and Healthcare	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)
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** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #1) of 3 residents reviewed for care plans. The facility failed to ensure Resident #1's care plan reflected an aggressive behavior he displayed towards a CNA on 5/30/26.This deficient practice could place residents in the facility at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs. The findings include:Record review of Resident #1's face sheet dated 6/17/26 reflected Resident #1 was admitted on [DATE] with an initial admission date of 5/19/24. Resident #1 was a [AGE] year-old male with diagnoses of hemiplegia (paralysis affecting only one side of the body caused by brain or spinal cord injury) and hemiparesis (partial weakness, numbness, or reduced motor control affecting only one entire side of the body) of left non-dominant side, alcoholic cirrhosis (late stage of progressive liver scarring caused by long-term liver diseases or injuries) of liver, depression (common, serious mood disorder that causes persistent sadness, loss of interest and physical or emotional fatigue), and cognitive communication disorder.Record review of Resident #1's Quarterly MDS dated [DATE] reflected the resident:had a BIMS score of 7 which indicated his cognition was severely impaired.Resident #1 required partial/moderate assistance with oral hygiene and was dependent on staff for all other self-care. Resident #1 had no behaviors. Record review of Resident #1's undated comprehensive care plan did not reflect an update of Resident #1's aggressive behavior towards a CNA on 5/30/26. In an interview on 6/17/26 at 2:00 p.m. MDS A said Resident #1's aggressive behavior in a previously reported incident on 5/30/26 which was investigated should have been care planned. MDS A said usually resident behaviors were care planned by SSS, so she assumed it had been care planned. MDS A said usually Monday mornings she printed out orders, discussed them during morning meetings and then care planned needed items. MDS A said she recalled being off the Monday after Resident #1 displayed the aggressive behavior. MDS A said if aggressive behaviors were not care planned nurses and staff would still have received the information during morning meetings, or they usually reviewed documentation of the previous day to get informed. MDS A said if staff were not informed, they would not know interventions needed, such as to be more patient or look out for aggressive behaviors from the residents.In an interview on 6/17/26 at 2:10 p.m. SSS said the facility normally updated care plans when a resident displayed aggressive behavior. SSS said the MDS department usually updated the care plans. SSS said it was her understanding the facility was going to further investigate and were pending MD orders for possible nursing interventions. In an interview on 6/17/26 at 2:15 p.m. the DON said he looked through the resident's care plan and Resident #1's aggressive behavior on 5/30/26 was not care planned. The DON said the aggressive behavior should have been care planned. The DON said even isolated events of aggressive behaviors should be care planned. The DON said they held a care plan meeting with IDT and family, but they missed it probably due to the nature of the (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident which was aggressive behavior towards staff and not towards a resident. The DON said during morning meetings they reviewed progress notes and care planned due to documentation and it was documented on the progress notes. The DON said the care plan could have been edited by any of us. The DON said in the future, they must assign one member of staff to be responsible for ensuring care plans were completed. The DON said CNAs go based off on what the nurses report to them. The DON said an adverse outcome of not care planning aggressive behaviors would be employee safety. Record review of facility's Comprehensive Person-Centered Care Planning reflected, Policy:It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.5. The resident has the right to refuse or discontinue treatment. In the event that a resident refuses certain services posing a risk to resident's health and safety, the comprehensive care plan will identify care or service declined, the associated risks, IDT's effort to educate the resident and resident representative and any alternate means to address risk. 6. The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment including both the comprehensive and quarterly review assessments.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interviews, and record review, the facility failed to ensure nurse staffing data was posted and readily accessible to residents and visitors with all required information for 1 (6/16/26) of 2 days reviewed for nurse staffing information. The facility failed to ensure the current daily staffing information was posted on 6/16/26. This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts. The findings include:Record Review on 6/16/26 of the facility's daily staffing information form revealed the form was dated 6/15/26. In an interview on 6/16/26 at 4:00 p.m. HR said she was in charge of updating and posting their daily staffing information. HR said she obtains the information she needs from the actual schedules. HR said she was informed by the facility that daily staffing should be updated and posted daily. HR said she was never informed by the facility, daily staffing must be posted by a specific time. HR said she normally posted daily staffing between 10:00 a.m. and her lunch time. HR said her lunch was at different times every day. HR said she left for lunch today at 11:30 a.m. and when she returned, she began assisting giving out plates for CNA Week activities. HR said the reason for posting daily staffing information was so the facility and family of residents would know how many staff members were on floor per shift. HR said daily staffing postings were important information in case a family stated there were not enough staff on the floors, so they could show them the staffing information and/or the schedule. HR said if daily staffing were not posted, there would be no negative outcomes that she was aware of other than it was a required posting and it was not done. In an interview on 6/17/26 at 12:24 p.m. the Administrator said there was no answer to justify why the updated daily staffing was not posted on 6/16/26. The Administrator said he did not know what happened because daily staffing was usually posted daily and must be posted at the beginning of the shift. The Administrator said medical records worked on the information for daily staffing and HR was responsible for ensuring accurate information was posted daily. The Administrator said daily staffing information must be posted to inform staff, visitors, and family about census and staffing information and they were able to refer to it if they felt there were not enough staff.In an interview on 6/17/26 at 1:08 p.m. the DON said HR was responsible for updating and posting the daily staffing information. The DON said daily staffing information should be updated and posted daily as soon as possible in the morning. The DON said HR's practice was posting daily staffing information as soon as she got into work in the morning. The DON said they reviewed the information first thing in the morning due to census. The DON said the importance of reviewing and posting daily staffing information was to make everyone aware census and staffing were appropriate. The DON said they were looking into designating a secondary staff member to ensure the information was posted. Record review of facility's Nursing Administration policy dated 5/2024 reflected, Policy:It is the policy of this facility to provide adequate staffing to meet the needs of the resident population.4. Staffing PostingThe facility shall post daily nurse staffing information in a visible location including staff type, shifts, and hours worked. Required postings per Texas HHSC shall be maintained.