STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675162	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliff Nursing and Rehabilitation Center	3201 N Ware Rd 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 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** 51760 Based on observations, interviews, and record review, 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 1 (Resident #1) of 4 Residents reviewed for accuracy and completeness of clinical records. 1. The facility failed to ensure LVN A accurately documented that Resident #1 was currently on an anti-coagulant. 2. The facility failed to ensure LVN A accurately documented neurological check findings for Resident #1 post fall. These failures could place residents at risk of not receiving appropriate care resulting in deterioration in condition, exacerbation of disease process, overmedication, and increased risk of harm or injury. Findings included: Record review of Resident #1's Admission Record, dated 02/14/24, revealed an [AGE] year-old female with diagnoses of vascular dementia (a type of dementia that occurs when blood vessels in the brain are damaged, reducing blood flow and oxygen supply), hypertension (a chronic condition where the force of blood in your arteries is consistently too high), muscle wasting and atrophy (referring to the loss of muscle mass and strength, often occurring due to lack of physical activity, injury, malnutrition, or certain medical conditions, resulting in a decrease in muscle size and function), and unspecified atrial fibrillation (a heart condition where the upper chambers of the heart beat irregularly and out of sync with the lower chambers). Record review of Resident #1's care plan, dated 02/14/24, revealed Resident #1 was on anticoagulant medication therapy Xarelto (drugs that prevent blood clots or slow down the process of clotting) related to disease process of atrial fibrillation with interventions of monitor patient frequently for signs and symptoms of neurological impairment. If neurological compromise was noted, urgent treatment was necessary. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's order summary, dated 02/14/24, revealed an order for: anticoagulant medication (Xarelto) - monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath, and nose bleeds. Record review of Resident #1's MAR, dated 02/14/24, revealed the resident had an anticoagulant medication (Xarelto) ordered and was being administered such medication once daily since upon admission to facility on 02/14/24. Record review of Resident #1's medication administration audit report, effective date 02/14/24 revealed the resident was being administered anticoagulant medication (Xarelto) daily since upon admission and the resident continued with anticoagulant medication therapy daily. Record review of Resident #1's quarterly change MDS assessment, dated 05/02/24, revealed the Resident was on high-risk drugs class of anti-coagulants (Xarelto). Resident #1 had a BIMS score of 6, which indicated her cognition was severely impaired. Record review of Resident #1's neurological checks dated 07/28/24 at 4:15pm, revealed Resident #1's pupils were not reactive to light after the first 15 minutes following the fall. On the next 15 minutes and thereafter, documentation reflected that Resident #1's pupils were reactive to light. Record review of Resident's #1 progress notes entered by LVN A dated 07/28/24at 3:45pm, revealed the resident sustained an un-witnessed fall in her bedroom with immediate findings of left clavicle appearing swollen and hematoma-like to left side of forehead. LVN A also documented that resident #1 was not on an anti-coagulant. During observation and interview on 01/23/25 at 3:12pm Resident #1 stated she remembered her shoulder was broken. She stated no further pain to the area. Resident #1 was unable to recall accurately how she fell . During an interview on 01/23/25 at 3:41pm LVN A stated she recalled when Resident #1 sustained a fall on 07/28/24. Stated upon visual inspection, she noted Resident #1's shoulder was bulged out (swollen) and there was a hematoma to the left side of her forehead. LVN A stated she called the nurse practitioner on call and continued with fall protocol. Stated protocol included head to toe assessment, start neurological checks, and follow orders given by the doctor. LVN A stated she remembered NP C gave her orders for x-rays to the left shoulder, to continue with neurological checks, and order medication for pain. LVN A recalled NP C did not give orders to have Resident #1 taken to the hospital. LVN A stated that when residents were on an anti-coagulant, residents get sent to the hospital for CT scans. She stated that the doctor or nurse practitioners were the ones who determine if a resident was to be sent to the ER. LVN A stated she did not remember if she checked if the resident was on an anti-coagulant. LVN A stated that negative outcomes for not have documented correctly could have resulted in that Resident #1 could have had a slow brain bleed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/23/25 at 5:20pm NP C stated as per their own protocol, when a nurse called to report a resident fall, they were to always ask the nurse if the resident sustained a head injury and if the resident was on anti-coagulant. NP C stated that in her notes for the day of 07/28/24 when Resident #1 sustained the fall, she was informed of the injury to left shoulder and the hematoma to the left side of Resident #1's head. NP C stated her notes had no documentation having been informed if Resident #1 was on an anti-coagulant, however stated had she been informed, she would have sent Resident #1 to the emergency room for further evaluation. NP C stated that as part of her order for neurological checks, she informed LVN A to monitor and report back with any abnormal findings. During an interview on 01/24/25 at 11:03am LVN A stated she did not remember having documented that Resident #1's pupils were not reactive to light in the first 15-minute neurological check. Stated it was a typo because had it been a true finding, she would have notified NP C of abnormal findings. She stated abnormal findings need to be reported right away. During an interview on 01/24/25 at 1:30pm the DON said NP C had remote access to Resident #1's medical chart where NP C could have also verified Resident #1's medication record. The DON read LVN A's progress note for Resident #1's fall and stated she did not know why LVN A documented that Resident #1 was not on an anti-coagulant when Resident #1's medication record, order summary, and plan of care indicated Resident #1 was on an anti-coagulant. The DON stated any change of condition, such as an abnormal neurological check findings should have been reported to the nurse practitioner or doctor immediately. The DON stated she was responsible to follow up on documentation regarding abnormal findings however admitted she did not. The DON stated there could have been many negative outcomes for Resident #1 due to poor documentation. She stated Resident #1 could have suffered neurological damage. She stated continued neurological checks were part of the fall protocol and were ordered by NP C to continue so that any abnormal findings could be reported immediately. Record review of the facility's policy titled Documentation in the Medical Record, dated 10/24/22, stated Each Resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. Principles of documentation include but are not limited to: Documentation shall be factual, objective, and resident centered. False information shall not be documented.