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	01/30/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview and record review, the facility failed to ensure residents were free from verbal abuse for 1 of 6 residents (Resident #1) reviewed for abuse. The facility failed to prevent CNA A, from verbally abusing Resident #1 on 04/29/24 when she referred to her as ay mi pendejita [NAME], [NAME] estas (hello my stupid pretty, how are you). This failure could place residents at risk of emotional distress, fear, decreased quality of life and further abuse. Record review of Resident #1's admission record dated 01/29/25 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her relevant diagnoses included vascular dementia (a type of dementia caused by brain damage from impaired blood flow to the brain), Parkinson's disease (A brain disorder that causes movement problems, including shaking, difficulty walking, and rigidity in muscles), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). 2) Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected she had been coded a 2 for speech clarity which indicated Resident#1 had no speech (absence of spoken words). She had been coded a 3 for making herself understood and ability to understand others which indicated Resident #1 rarely/never understood. Resident #1 did not have a BIMS score which indicated she was rarely/never understood. Record review of Resident #1's quarterly care plan dated 12/04/24 reflected Resident #1 had a communication problem related to dementia. Resident #1 was unable to express clear thought and rarely never understood. Date initiated 09/02/23 and revised on 12/28/23. Her interventions were to monitor/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed. An observation on 01/28/25 at 1:29 p.m., Resident #1 was observed lying in bed awake. She was listening to the radio swaying side to side. She was did not respond to this surveyor's questions. She was quiet with no facial expression. An attempted telephone interview on 01/28/25 at 2:27 p.m., CNA A did not answer. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An attempted telephone interview on 01/29/25 at 8:05 a.m., CNA A did not answer. An interview on 01/28/25 at 5:04 p.m., Administrator said the cooperate hotline had received an anonymous complaint alleging CNA A was being verbally abusive towards Resident #1. She said the Assistant Administrator had completed the investigation. She said CNA A had admitted to using inappropriate language with greeting Resident #1. She said her number one priority was the safety and welfare of the residents. She said the facility took immediate action and CNA A was suspended on 04/29/24 and then later she was terminated. She said she had no knowledge of CNA 's behavior prior to 04/29/24. She said all staff were trained on ANE and how to speak to residents. The Administrator said, Resident #1 was non-verbal which to her was a concern because there was no way for her to say if she had been offended by CNA A's comment. She said CNA A's behavior was inappropriate and had been terminated to avoid any other resident being put at risk. Record review of Resident #1's admission census reflected she was housed in the 200 hall on 04/29/24. Record review of the Assistant Administrator's investigation summary completed on 05/16/24 reflected, that an anonymous report had been made to the facility's compliance line identifying CNA A had used profanity and vulgar language with residents. The facility's response included the alleged perpetrators were suspended (pending the investigation), abuse coordinator was informed, the facility reported to state, the facility-initiated an investigation which included interviews with direct and indirect care staff, residents, and family members. Head-to-toe assessments were initiated on all residents of 100 and 200 halls for any signs or symptoms of distress, and staff were in-serviced on ANE, professional communication, and resident care. The investigation summary reflected; upon interviewing [CNA A], it was identified that she acknowledged using bad words with her communication with Resident #1. CNA A stated she, on occasions, would greet Resident #1 using Spanish-language connotations of the word stupid. CNA A stated she would not use the word in an offensive manner, but instead used the word in part of her greeting [Resident #1] in a joking and loving manner. It was [CNA A] interpretation that the words were well-received by the resident because [Resident #1] would smile when she saw her. [CNA A] stated she felt her greetings and interactions cheered-up [Resident #1]. [CNA A] recognized that her communication may be offensive to [Resident #1] and others . Resident and residents' family interviews revealed no concerns of abuse or neglect. Monitoring of all residents in 100 and 200 halls did not identify any other concerns. Staff interviews revealed no concerns of abuse or neglect. No evidence of physical or emotional harm was identified. The IDT team concluded that the allegations of abuse was confirmed. Provider actions taken post-investigation included, CNA A had been terminated, the Administrator and Assistant Administrator re-educated 100 % of facility staff on the topics of ANE and professional communication. Staff were provided with the contact numbers for the administrator, ombudsman, and compliance hotline. Staff on leave were re-educated prior to the start of their next scheduled shift. The administrator/designee would conduct quarterly and as needed education to ensure facility staff remained knowledgeable on the identification and reporting of abuse, neglect, and exploitation. A media alert was sent to all employee's with the request to report any concerns without the fear of retaliation. A second media alert was sent to all employees with the contact information of the Ombudsman. A media alert was sent out to representative of the residents with the information n to report any concerns. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CNA A's statement written by the Assistant Administrator on 04/29/24 reflected, she had worked the 200 hall on said day. CNA A acknowledged she had used some words that could be interpreted as offensive to the recipient or others. CNA A acknowledged that on several occasions, she had greeting Resident #1 with a phrase of ay mi pendejita [NAME], [NAME] estas (hello my stupid pretty, how are you). CNA A said she had used that phrase in a joking and loving manner and not to offend the resident. CNA A said she believed her words were well received by Resident #1 as she would smile when she would see her. CNA A said she would sing the phrase to Resident #1, and it would cheer her up. Record review of CNA A's employee counseling report dated 05/06/24 reflected an other offence of a violation of any other policy or procedure contained in Employee Manual: Allegation of abuse. Record review of CNA A's NAR search dated 04/08/24 reflected she had an active status (certification was current) and was not listed on the EMR. Record review of facility's Resident abuse interview and observation sheets conducted between 04/29/24 through 05/01/24 reflected all residents in the 100 and 200 hall had been interviewed and observed with no concerns of abuse voiced. Record review of the facility's in-service training report dated 04/29/24 reflected staff were in-serviced on the topics of ANE and professional communication. An interview on 01/29/25 at 1:15 p.m. The DON said CNA A was re-hired on 04/07/2024 and terminated on 05/06/24. An interview on 01/29/25 at 4:40 p.m., LVN B said she had conducted resident assessments on all residents in the 100 and 200 halls on 04/29/24 through 05/01/24. She said no concerns of abuse or neglect had been voiced and no residents had been observed to be in emotional distress. LVN B said Resident #1expressed herself by using facial expressions (smiling or grimacing). She said on 04/29/24, when Resident #1 was observed she had not shown any signs of being in distress. Record review of CNA A's Student and Group Transcript Report reflected she had last been in-serviced on the topic of effective communication, reporting abuse, abuse, and neglect on 04/08/24. Record review of the facility's Abuse, Neglect and Exploitation policy dated 08/15/22 reflected: Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Definitions: Verbal Abuse: means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV. Identification of Abuse, Neglect and Exploitation B. Possible indicators of abuse include, but are not limited to: 1. Resident, staff, or family report of abuse 5. Verbal abuse of a resident overheard VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting oa all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: .

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301 Based on observation, interview and record review, the facility failed to ensure residents were free from verbal abuse for 1 of 6 residents (Resident #5) reviewed for abuse. 1)The facility failed to ensure CNA F communicated Resident #5's allegation of abuse on 11/17/24. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 11/20/24 and ended on 11/20/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of emotional distress, fear, decreased quality of life and further abuse. The findings included: Record review of Resident #5's admission record dated 1/29/25 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of cerebral infarction (when blood flow to the brain is disrupted, which can lead to brain cell death), aphasia (a neurological disorder that impairs a person ' s ability to communicate), and mild intellectual disabilities. Resident #5 was discharged home with home health on 01/14/2025. Record review of Resident #5's quarterly MDS assessment dated [DATE] reflected she had short-term memory problem and cognitive skills for daily decision making were severely impaired. Record review of intake investigation worksheet, for Resident #5 revealed On 11/17/24 at about 8-9 am CNA F when into resident's room to pick up breakfast tray and saw that resident seemed sad. Asked her how it went when she went out on pass with her sister. Resident began to cry and stated that she was hit while out on pass by her nephews. Did not go into detail about incident. When asked if she wanted to speak with someone, she stated no. During the rest of the shift resident remained sad. During incontinent care and care CNA did not see any visible injuries. Facility made aware of allegation on 11/20/24 and resident is currently out on pass with sister. Family to be called to have resident return to facility. Upon arrival, police will be called, head to toe assessment will be conducted, interview to be done with resident. In an interview on 1/29/25 at 11:30 am with the police officer, he said no crime was discovered. He said they spoke to the resident, resident's family and staff and found that the resident may have referred to an incident that happened years ago, nothing recent. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 1/29/25 at 12:30 pm with the facility's Social Services, she said she recalls CNA F reported to a nurse when CNA F returned to work on 11/20/24 and the nurse told her to talk to me. CNA F said she did not tell anyone because she was doing work and while she was off, she thought about it, and she told the nurse when she returned. Social Services said she called the administrator, and she took over from there. She said Resident #5 was out on pass so could not interview her. Social Services said she called the family member to bring the resident back so they could assess her. Social Services said she asked the family member if any males were around the resident and the family member denied. The family member said Resident #5 was never alone, she was always with the family member. Social Services said they called the PD, and they took a statement from Resident #5. Social Services said the resident denied allegations of abuse to police and the family also denied. Social Services said Resident #5 also denied allegations to her. Social Services said the police talked to the family, RP, resident, and staff. Social Services said she completed the one-to-one with CNA F. In an interview on 1/29/25 at 5:54 pm with CNA F she said Resident #5 had gone on pass with a family member on 11/17/24. When Resident #5 returned, CNA F said she asked how it went, and Resident #5 began to cry. CNA F said Resident #5 said someone hit her while out on pass. She said it was the sobrinos (nephews). CNA F said after Resident #5 reported that to her, she never commented on it again. CNA F said Resident #5 went out on pass again on 11/20/24 with family and everything was normal. CNA F said she did not report to anyone at the time because it was a Sunday, and no one was there except a new nurse. CNA F said she got busy after she came out of the resident ' s room, so she forgot to report. She said after work that day she was off. CNA F said when she returned to work, she reported it to the nurse and then it was reported to the administrator. CNA F said she completed an Abuse, Neglect and Exploitation in-service after the incident, and they also completed a one-on-one. She said they ask them about the types of abuse and tell them who to report to. She said she should first report to the administrator. She said they tell them to report immediately. She said they tell them if the administrator is not there, they must report to Social Services or a nurse. She said allegations of abuse were not reported; she could lose her certification. She said residents could also continue to get abused. In an interview on 1/30/25 at 11:05 am with LVN H, said she worked with resident the night shift of 11/17/24 to 11/18/24. She said Resident #5 did not voice complaints or show distress. She said Resident #5 was in good spirits and while she was awake, there were no concerns, reports of abuse, or any emotional distress noted LVN H said when an incident happens on the day shift, they pass on report to her and she follows up or monitors the resident. LVN H said during in-services, they were informed they must report physical, verbal, or sexual abuse. She said they must report any abnormalites or suspiciouns they of staff or family. She said they must report these examples to the Administrator as soon as they suspect. She said they are informed of alternative people to report to if the Administrator is not available such as the ADON or DON. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 1/30/25 at 1:56 with the DON, she said that prior to the incident they drilled staff on abuse, neglect and exploitation and the importance of reporting timely, so for her to have voiced it was because she was off after or whatever reason she gave made no sense. The DON said staff know the phone numbers for who they need to report to. The DON said they use alert media to inform staff of the importance of reporting abuse, how to report abuse, who to report it to and the importance of reporting immediately. The DON said they sent the staff the Ombudsman ' s number, and they provided staff the 1-800 number in case they wanted to report anonymously. DON said they also have people from outside the facility to come and do random interviews and ask questions about who the abuse coordinator was and how do they make a report, and they get back to the administration if anyone needs any intervention. The DON said they come in twice a week. The DON said they even printed out and laminated cards to place behind the staff ' s ID with all the information, along with the Recognize, Remove and Report card as well. The DON said on those cards it even says to report immediately. The DON said right after the incident, they in-serviced on abuse, neglect, and exploitation. In an interview on 1/30/25 at 3:10 pm with the Administrator, she said all she remembered was that there was no excuse for that, especially since Resident #5 went out on pass again and they weren't aware. The Administrator could recall the exact date she went on pass again. The administrator said they did a one-to-one with CNA F. When this was brought to their attention, the family was interviewed and they insisted Resident #5 was not around any males at the home. The Administrator was notified on 02/10/2025 at 11:15 am, that a past noncompliance Immediate Jeopardy situation had been identified due to the above failures. It was determined these failures placed Resident #5 in an Immediate Jeopardy situation on 11/17/24. The facility had corrected the noncompliance before survey began. Record review of continuing education transcript for CNA F revealed completion of Abuse and Neglect training and Incident Reporting on 6/20/24 and 7/24/24 and training on Reporting Abuse Attestation on 6/20/24. Record review of Staff Individual Inservice Record One to One (1:1) Procedure dated 11/20/24 revealed, Subject: Abuse, Neglect and Ex;loitation How to Correct Employee re-educated on ANE and the importance of reporting any allegations of abuse immediately to facilites abuse coordinator. Record review of In-Service Training Report dated 11/22/24 - ongoing for General Staff revealed, Topic Abuse, Neglect and Exploitation (ANE) training Contents or summary of training session . (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Re-educated staff on Abuse, Neglect and Exploitation (ANE training acts that constitute abuse, neglect, and exploitation, signs and symptoms of abuse, neglect, and exploitation, methods to prevent abuse, neglect, and exploitation, and how to report. Abuse Coordinator Three Rs: Recognize, Remove, Report. It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Definitions: Verbal Abuse: means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. IV. Identification of Abuse, Neglect and Exploitation B. Possible indicators of abuse include, but are not limited to: 1. Resident, staff, or family report of abuse 5. Verbal abuse of a resident overheard VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting oa all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26141 49301 Based on interview, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 2 (Resident #4 and Resident #6) of 11 residents reviewed for accuracy of assessments. 1.The facility failed to ensure Resident #4 was coded in the MDS for a fall on 2/28/24. 2.The facility failed to accurately identify Resident #6's unstageable pressure ulcer on her Discharge Return Anticipated MDS Assessment on 01/30/24. This failure could place residents at risk of receiving inadequate care and services based on inaccurate assessments. The findings included: 1. Record review of Resident #4's admission record dated 1/29/2025 reflected Resident #4 was an [AGE] year-old male originally admitted on [DATE] with diagnoses of Intervertebral Disc Disorders (the breakdown and degeneration of the cushions between the vertebrae in the spine), Alzheimer ' s disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), muscle wasting and atrophy (the shrinking or wasting away of muscle), and age-related osteoporosis (a skeletal disorder characterized by a decrease in bone mass and density, leading to increased bone fragility and an elevated risk of fractures). Record review of Resident #4's comprehensive care plan dated 4/26/24 reflected: Resident #4 had an actual fall Date Initiated: 02/28/2024 Interventions included: Continue interventions on the at-risk plan. 2-28-24: Resident s/p fall, sustained small, raised area to back of head, OT may evaluate and treat, safety inspection to restroom area. 3/1 PT will eval and treat instead of OT. Date Initiated: 02/29/2024 Revision on: 03/01/2024 CT scan as ordered. Date Initiated: 02/29/2024 Monitor/document /report PRN x 72h to MD for s/sx: Pain, bruises, Change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. Date Initiated: 02/29/2024 Neuro-checks as ordered Date Initiated: 02/29/2024 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4 ' s Quarterly MDS dated [DATE] revealed: BIMS Score of 15 indicating mental status cognitively intact. Required supervision or touching assistance for lower body dressing. Required partial/moderate assistance for eating, oral hygiene, toileting hygiene, shower/bathe self, and upper body dressing. Required substantial/maximal assistance for putting on/taking off footwear and personal hygiene. Section J1800 - Number of falls since Admission/Entry or Reentry or Prior MDS Assessment. The facility entered 0. Record review of the facility's incident log not dated revealed that on 2/28/24, Resident #4 had a witnessed fall. No other information is noted on the facility log. During an interview on 1/29/25 at 4:30 pm with MDS E, she said the fall would have been entered on the Quarterly MDS Resident #4 had done after the fall on 4/26/24. She said, the question for J 1800 said, has the resident had any falls since admission, entry or reentry or the prior assessment. She said that the answer shows no, and that she was responsible for doing that MDS. She said the answer should be marked yes. She said she cannot recall why yes was not marked. She said an annual or an admission MDS would trigger for them to do a care plan. She said it did not affect the quarterlies. She said, yes, I should have coded it. She said since it was a quarterly assessment for level of payment, it did not affect the patient. During an interview on 1/30/25 at 2:20 pm with DON, she said she gets an email anytime an RMS is completed. She said they review information on falls and other items in the morning meetings with MDS. The DON said MDS should document at the meetings so they could update the MDS. The DON said they also have a weekly meeting where MDS must attend, and they get information on the falls that have happened within the week, as well as other occurrences. The DON said the MDS was not the driver for the care plans. She said it was their MD orders and care plan updates from the nurses. The DON said a fall not on the MDS might have an effect if a resident was transferred to another location as the form of communication of resident 's information from SNF to SNF. Record review of CMS's RAI Version 3.0 Manual dated April 2012, reflected section: J1800: Any falls since admission/entry or Reentry or Prior to Assessment. Has the resident had any falls since admission/entry or reentry or the prior assessment .? 0. No - Skip to K0100 1. Yes - continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Record review of Resident #6 face sheet dated 01/30/25 revealed Resident #6 was admitted to facility on 01/12/24 with diagnoses of chronic kidney disease, stage 3 (a long-term condition where the kidneys gradually lose their ability to filter waste products from the blood), acute pulmonary edema (a condition where excess fluid accumulates in the lungs), and vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain). Record review of Resident #6's comprehensive care plan revealed Resident #6 had an unstageable pressure ulcer to the sacrum initiated on 01/29/24 with interventions to monitor for healing and provide treatment as ordered. Record review of Resident #6's Discharge returned anticipated MDS dated [DATE] revealed: Resident #6 had had severe cognitive impairment, Required substantial/maximal assistance to roll left and right, sit to lying, and sit to stand. Section M0300 - Does this resident have one or more unhealed pressure ulcers/injuries? The facility entered 0. In an interview on 01/30/25 at 1:08 p.m., MDS/LVN E was observed checking Resident #6's electronic medical record and stated on 01/29/24, D/C orders for the MASD to sacrum (a triangular bone in the lower back formed from fused vertebrae and situated between the two hipbones of the pelvis) and was diagnosed with an unstageable pressure ulcer to sacrum. She said she had completed the discharge MDS for Resident #6. MDS/LVN E said she did not include resident's unstageable ulcer on the discharge MDS. She said the MDS was just a tool used for billing and the one's that would trigger the care plan were the annual, significant changes or admissions MDS. MDS/LVN E said she should have coded section M as yes on section M-100 (Determination of Pressure Ulcer/Injury Risk), M-210 (Unhealed Pressure Ulcers/Injuries) and M-300 (Current Number of Pressure Ulcers/Injuries at Each Stage)/F (Unstageable-Slough and eschar: known but not stageable due to coverage of wound bed by slough and/or eschar). She said there were no negative outcome because it was on the care plan. In an interview on 01/30/25 at 3:42 p.m., DON said Resident #6 had constant diarrhea and the constant wiping caused excoriation to her skin. The wound doctor called it an unstageable wound. The NP called it Moisture Associated Dermatitis. The DON said they have morning meetings to discuss any change of condition. The meetings were for all nursing staff including MDS so they would receive any change in conditions for residents. In an interview on 01/30/25 at approximately 5:00 p.m., the DON said the facility did not have a policy for the MDS. Record review of CMS's RAI Version 3.0 dated October 2013, revealed section: M0210: Does this resident have one or more unhealed pressure ulcers/injuries? 0. No - skip to N0415, High-Risk Drug Classes: Use and indication 1. Yes - Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries Each Stage (continued on next page)

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	01/30/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

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	01/30/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487 Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 2 of 4 residents (Resident #2 and Resident #3) reviewed for respiratory care. The facility failed to ensure Resident #2's and Resident #3's oxygen was placed on 2 liters per minute via nasal cannula as ordered by the physician. These failures could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care. Finding included: Record review of Resident #2's face sheet dated 1/29/25 indicated she was a [AGE] year-old female originally admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease also known as COPD, (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record Review of Resident #2's significant change Minimum Data Set assessment dated [DATE] indicated she received oxygen therapy while a resident. Record review of Resident #2's physician's order dated 1/29/25 indicated Oxygen at 2 liters per minute continuous via nasal cannula every shift related to respiratory failure with hypercapnia (is a condition where there is too much carbon dioxide). Record review of Resident #2's comprehensive care plan, dated 5/1/24, indicates Resident #2 required oxygen therapy related to difficulty breathing. The intervention of the care plan was OXYGEN SETTINGS: O2 as ordered. During an observation on 1/29/25 at 2:57 p.m., Resident #2 was lying in her bed with oxygen set at 3 liters per minute via nasal cannula. Record review of Resident #3's face sheet dated 1/29/25 indicated he was an [AGE] year-old male originally admitted to the facility on [DATE] with diagnoses which included Hypoxia (A condition that occurs when the body's tissues don't have enough oxygen). Record Review of Resident #3's significant change Minimum Data Set assessment dated [DATE] indicated he received oxygen therapy while a resident. Record review of Resident #3's physician's order dated 1/29/25 indicated Oxygen at 2 liters per minute continuous via nasal cannula every shift for Hypoxia (A condition that occurs when the body's tissues don't have enough oxygen). (continued on next page)

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	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliff Nursing and Rehabilitation Center	3201 N Ware Rd McAllen, TX 78501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's comprehensive care plan, dated initiated 6/27/2023, indicates Resident #3 required oxygen therapy related to Ineffective gas exchange. The intervention of the care plan was OXYGEN SETTINGS: O2 via nasal cannula at 2 liters per minute. During an observation on 1/29/25 at 3:35 p.m. Resident's #3 was lying in his bed with oxygen set at 1.5 liters per minute via nasal cannula. During an interview on 1/29/25 at 3:05 p.m., RN C said Resident #2's oxygen rate was at 3 liters per minute per nasal cannula. He said she was supposed to run at 2 liters per minute as per the physician order. RN C said, I notice that the settings were different from the order since I started working here back in October, I told the nurse that was training me, but he said that was fine because she has been like that since she was admitted . RN C said that by not following the physician's orders it could harm the resident, and that the resident could have shortness of breath, exacerbation or the resident could get ill. RN C said that the last training he had on oxygen was back in October when he was hired. During an interview on 1/29/25 at 3:40 p.m., LVN D said that nurses were responsible to check every shift the oxygen settings at the beginning of the shift and at the end of the shift. LVN D said that if not administered correctly per order the resident could be harmed, have respiratory distress or the oxygen level could drop. LVN D said that the last training on oxygen was 3 months ago but could not remember the exact day. During an interview on 1/29/25 at 4:50 pm ADON said that the nurses were responsible to check the oxygen settings every shift, especially with continuous oxygen use. ADON said that management made morning rounds each morning. The ADON said that an adverse reaction to the resident was that the oxygen level could drop, shortness of breath or change in respiratory status if not administered the appropriate oxygen ordered by the physician. ADON said that the last training on oxygen was done two months ago, and this training was done quarterly. During an interview on 1/29/25 at 5:06 p.m., the DON said the charge nurses were responsible for following the physician's orders and to check oxygen settings at the beginning of the shift and as needed during the shift and at the end of the shift. She said that if not given the correct oxygen as the physician prescribed the Resident could have a change in condition or shortness of breath. DON said that managers make rounds every morning and before leaving to make sure oxygen settings were at the correct setting. During an interview on 1/30/25 at 9:30 a.m., DON said that this facility does not have a policy on Oxygen Administration. Record review of facility policy titled, Medication Reconciliation date implemented as of April 10, 2023, revealed This facility reconciles medication frequently throughout a resident's stay to ensure that the resident is free of any significant medication errors, and that the facility's medication error rate is less than 5 percent. Daily Processes: Verify medications labels match physician orders and consider rights of medication administration each time a medication is given.