

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675162	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Briarcliff Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 7 residents (Resident #1) reviewed for comprehensive care plans. The facility failed to develop a care plan to include Resident #1's behaviors and interventions. This failure could place residents at risk of not receiving safe and appropriate care. The findings include: Record review of Resident #1's face sheet, dated 11/20/25, revealed an [AGE] year-old male who was initially admitted to the facility on [DATE]. Resident #1 had diagnoses which included: vascular dementia (a decline in thinking skills caused by conditions that damage blood vessels and reduce or block blood flow to the brain), moderate with mood disturbance, obstructive (blockage that prevents urine from flowing out of the body) and reflux uropathy (urine flows backwards from the bladder) , unspecified, and retention of urine (inability to completely empty the bladder), unspecified. Record review of Resident #1's quarterly Minimum Data Set assessment, dated 09/29/25, revealed Resident #1 had a BIMS score of 03, which indicated he was severely cognitively impaired. Resident #1's MDS did not indicate any behaviors. Record review of Resident #1's care plan retrieved on 11/14/25 did not include any documentation related Resident #1's behavior of urinating in trash cans or on the floor in his room. Record review of Resident #1's care plan retrieved on 11/20/25 included a problem of, [Resident #1] has episodes of urinating in inappropriate areas (wastebasket, floor) and is at high risk for falls related to incontinence and wet floor hazards. With an initiated date of 11/19/25. During a record review and interview with the DON on 11/20/25 at 5:07pm she stated Resident #1 had a behavior of urinating in the trash bins in his room and restroom. The DON stated Residents #1's behavior of urinating in the trash cans started about 6 months prior to November 2025. The DON stated staff had never physically seen Resident #1 urinating in the trash cans, but they had found yellow liquid in the trash cans that smells. The DON stated herself, SW A and ADON B were responsible for adding these behaviors to Resident #1's care plan. The DON stated she had been aware of the behavior previously and had discussed these behaviors with both SW A and ADON B. The DON stated SW A had told her the behavior had been care planned. The DON stated this kind of behavior should be included on the residents care plan to make sure everyone was aware and to make sure they were checking the trash liners and taking them out. The DON stated she had reviewed Resident #1's care plan after this surveyor asked questions on 11/19/25 regarding Resident #1's behaviors and did not see his behaviors care planned and stated they added Resident #1's behaviors afterwards on 11/19/25. The DON stated it was important to include behaviors on the care plan because it was the plan of care and communication from staff to staff. The DON stated the interdisciplinary team reviewed care plans for all required information including behaviors quarterly and as needed. The DON stated they did this by reviewing 24 hour reports and 72 hour reports to review for any documented behaviors from staff and then determined what the behavior was and have it reflected on their care plan so everyone was aware and would be aware of the interventions to try to minimize those behaviors. The DON stated both her and SW A have been trained over developing a care plan and what should be included. The DON stated the facility policy regarding care plans stated it should include residents behaviors and changes should be made as needed and were on going. The DON stated this policy was not followed due to Residents #1's care plan not being updated. The DON stated not including residents behaviors on their care plan could impact the communication among direct care staff. During an interview with SW A on 11/20/25 at 5:59pm SW A stated from what she was aware of Resident #1 did not urinate outside of the restroom and stated based off her previous interviews Resident #1 always urinated in the restroom and stated that was the room she checked and had never seen urine outside of the restroom. SW A stated Resident #1 may miss the toilet and get urine on the floor in the restroom but that was it. SW A stated nothing had been reported to her that it was a behavior Resident #1 had. During an interview with ADON B on 11/20/25 at 7:32pm stated you could smell urine and see it in the trash cans but stated she had never seen him physically do it. ADON B stated she did not recall when Resident #1 started urinating in the trash can but states leadership had been aware and had discusses it in the morning meetings and had discussed it with both the DON and SW A. ADON B stated no one had seen Resident #1 urinate in the room and never reported seeing it either but had only found urine in the trash can. ADON B stated generally SW A</p>		