

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 12/09/2025
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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident had the right to be free from abuse for five residents (Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6) of 10 residents reviewed for abuse. Resident #2 sustained facial injuries from an altercation with resident #4 on 05/27/25 7:59 PM as they passed each other in the 600 hall. Resident #3 sustained facial injuries from being hit in the face by Resident #2 on 05/19/25 @1:30 PM in Resident #3's room. Resident #5 was slapped in the face by Resident #6 as she was trying to get by Resident #6. Resident #6 was scratched by resident #5 in retaliation for being slapped in the face by Resident #5 on 06/19/25 @4:39 PM. These failures have the potential to result in serious injury. Findings include: Resident#2 Record Review of Resident#2's face sheet dated 10/21/25 revealed a [AGE] year-old male initially admitted on [DATE] with diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), Dementia (A group of thinking and social symptoms that interferes with daily functioning), Depression (a group of conditions associated with the elevation or lowering of a person's mood), Bipolar Disorder (A chronic mental health condition characterized by extreme mood swings between mania and depression), Altered Mental Status (a change in a person's Level of consciousness, alertness, and cognitive Function, Hostility (hostile behavior unfriendliness, or opposition), Mood Disorder (A group of conditions of mental and behavioral disorder where the main underlying characteristic is a disturbance in the person's mood), and unspecified Psychosis not due to a substance or known physiological condition. Record review of Resident #2's MDS dated [DATE] had a BIMS Score of 04-severe cognitive impairment and needed extensive assistance with all ADLs. Behavioral symptoms included other behavioral symptoms not directed toward others like pacing, and rejection of care occurred 1 to 3 days out of the week, and wandering. A record review of Resident #2's Care Plan dated 03/27/25 revealed Resident #2 wandered into another resident's room resulting in discoloration to bilateral hands and abrasion to chin due to altercation with resident. Resident #2's wandered in hall grabbing another resident by arm resulting in altercation with laceration to left lower jaw to resident. Resident #2 has a behavior problem (Wandering) related to Diagnosis of Alzheimer Disease and Dementia. Resident#2 has impaired cognitive function or impaired thought processes related to Alzheimer's Disease and Dementia. Resident #2 has a psychosocial well-being problem (potential) related to Cognitive deficits. Interventions included speaking calmly, moving slowly towards residents, and explained all procedures and why residents were being re-directed at an appropriate date and initiated 05/19/2025. Observe and monitor for signs and symptoms of changes in mental status. Per family, the resident becomes more confused, agitated, or aggressive when he has UTI. Resident #2 was currently on antibiotics for Urinary Tract Infection. Resident #2 was to be redirected positively when seen entering another resident's room. Resident#2 was monitored with a one-to-one care for three days after the incident. Record review of Resident #2's Progress Notes Dated 04/19/2025 to 06/22/25 revealed on 05/19/25 Nursing staff reported Resident #2 had an altercation with Resident #3 after wandering into Residents #3's room. Resident #2 was to continue on neuro checks; continued follow up for physical aggression towards staffs and new order day 2 Keppra (is anti-seizure medication) that include drowsiness increased to 1000 mg 1 tab take by mouth twice a day and Haldis (a powerful antipsychotic medication with a wide range of potential side effects) 5mg/ml inject 2ml every 12 hours as needed for 5 days. On 05/19/25 Resident #2 was in hallway attempting to grab another resident from arm, when alleged Resident #4 began to get physical towards resident. The staff member was unable to arrive on time, and the other resident was able to strike other residents on the face. Nursing staff immediately separated both residents from each other. Resident #2 was assessed; a laceration was noted to lower left jaw line. The nurse practitioner was called and notified. Per the nurse practitioner the wound was to be cleansed in the area with wound cleanser, and applied a steri-strip, the nurse practitioner will be doing an in-house visit later today. The family member of Resident #2 was called and notified of the incident. and could conducted and a follow-up visit for new order of Haldol Dec increased to 100mg intermuscular daily for 14 days for severe psychosis, orders carried out, nursing care on going. Patient continued a follow up check for post resident-to-resident conflict. Resident #2 required constant redirection throughout this shift to prevent the resident from entering other patients' rooms. Resident #2 continued with new orders to add Zolpidem (sedative-hypnotic medication used for the short-term treatment of insomnia) 10 mg tablets by mouth every night at bedtime and change trazadone to 50mg as needed each morning and 100MG as needed each</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</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 interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation were reported immediately, but not later than two hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials, including to the State Agency, in accordance with State Law through established procedures for 2 out of 10 residents (Resident #1 and Resident #2) reviewed for reporting of abuse/neglect. 1. The facility failed to report to the local law enforcement agency a resident-to-resident physical altercation involving Resident #2 and Resident #4 resulting in minor injuries that occurred on 05/27/25. 2. The facility failed to report an allegation of abuse of Resident #1 within 2 hours that occurred on 04/12/25 at around 1:00 PM. These failures could place residents at risk for potential abuse. The findings included: 1. Record Review of Resident#2's face sheet dated 10/21/25 revealed a [AGE] year-old male initially admitted on [DATE] with the diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), Dementia (A group of thinking a social symptoms that interferes with daily functioning), Depression (a group of conditions associated with the elevation or lowering of a person's mood), Bipolar Disorder (A chronic mental health condition characterized by extreme mood swings between mania and depression), Altered Mental Status (a change in a person's Level of consciousness, alertness, and cognitive Function, Hostility (hostile behavior unfriendliness, or opposition), Mood Disorder (A group of conditions of mental and behavioral disorder where the main underlying characteristic is a disturbance in the person's mood), and unspecified Psychosis not due to a substance or known physiological condition. Record review of Resident #2's MDS dated [DATE] had a BIMS Score of 04-severe cognitive impairment and needed extensive assistance with all ADLs. Record review of Resident #2's Care Plan dated 03/27/25 revealed Resident #2 wandered into another resident's room resulting with discoloration to bilateral hands and abrasion to chin d/t altercation with resident. Resident #2 wandering in hall grabbing another resident by arm resulting in altercation with laceration to left lower jaw to resident. Resident #2 has a behavior problem (Wandering) related to Diagnosis of Alzheimer Disease and Dementia. Resident#2 has impaired cognitive function or impaired thought processes related to Alzheimer's Disease and Dementia. Resident #2 has a psychosocial well-being problem (potential) related to Cognitive deficits. Interventions included to speak calmly, to move slowly towards resident, and explain all procedures and why resident was being re-directed when appropriate date and initiated 05/19/2025. Observe and monitor for signs and symptoms of changes in mental status. Per family, the resident becomes more confused, agitated, or aggressive when he has a urinary tract infection Resident #2 was currently on antibiotics for Urinary Tract Infection. Resident #2 was to be redirected positively when seen entering another resident's room. Resident#2 was monitored with a 1:1 care for three days after the incident. Record review of Resident #2's Progress Notes dated 04/19/2025 to 06/22/25 indicated Nursing staff report Resident #2 had an altercation with Resident #3 after wandering into Residents #3's room. The head-to-toe assessment noted purple discolorations to bilateral hand., upon resident-to-resident confrontation, noted during nursing assessment. The Nurse practitioner and daughter were called and notified. A new order as follows: cleanse with wound cleanser and apply steri-strips to area; orders carried out. Resident #2 was placed on a one-to-one for closer observation for 3 days. Resident#2 had an abrasion to the chin, applied topical antiseptic ointment, and continued to be monitored. Resident monitored for discoloration to hands and abrasions to chin area; continued on neuro checks; continued follow up for physical aggression towards staffs and new order day 2 Keppra increased to 1000 mg 1 tab take by mouth twice a day and Haldol 5mg/ml inject 2ml every 12 hours as needed for 5 days. 05/26/25 Skin evaluation completed, abrasion to chin area resolved, skin intact, no signs of infection noted, no drainage noted and no redness around wound area. On 05/27/25 Resident#2 in hallway attempting to grab another resident from arm, when alleged Resident#4 began to get physical towards resident. The staff member was unable to reach the residents in time to prevent the altercation. Record review of Resident #4's face sheet dated 10/22/25 revealed a [AGE] year-old male admitted on [DATE] with a diagnosis of Vascular Dementia (a type of dementia caused by damage to the blood vessels in the brain), and bipolar disorder (A chronic mental health condition characterized by extreme mood swings between mania and depression). Record Review of Resident #4 quarterly MDS revealed a BIMS score of 10 indicates moderate cognitive impairment and may need extra assistance with activities of daily life</p>		