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	03/09/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to formulate an advance directive for 1 (Resident #1) of 6 residents reviewed for Advance Directives. The facility failed to ensure Resident #1's OOH-DNR was completed. The OOH-DNR form did not have the physician's signature. This failure could affect all residents who have implemented Advance Directives and established their choice not to be resuscitated at risk of receiving CPR against their wishes. The findings were: Record review of Resident #1's electronic face sheet dated [DATE] reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: Dementia (a general, non-normal aging term for the progressive decline of cognitive functions - memory, language, problem-solving, and thinking - severe enough to disrupt daily life), Type 2 Diabetes Mellitus (a chronic condition where the body becomes resistant to insulin and/or fails to produce enough of it, causing sugar to build up in the blood instead of entering cells for energy), orthopedic aftercare, nondisplaced fracture of lesser trochanter of left femur (a crack in the small bony protrusion of the inner, upper part of the left thigh bone), cerebral infarction affecting right dominant side (stroke), and heart disease. Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected she scored a 03 on her BIMS which reflected severe cognitive impairment. Record review of Resident #1's comprehensive care plan dated [DATE] reflected, Resident #1's Advanced Directives: Code Status: (DNR) Do Not Resuscitate Date Initiated: [DATE] with interventions: Ensure signed DNR is in medical record Date Initiated: [DATE] Revision on: [DATE] If resident has a cardiac arrest, do not call 911 or initiate CPR. Notify MD/RP and follow instructions after notification Date Initiated: [DATE] Revision on: [DATE] Keep resident as comfortable as possible at all times Date Initiated: [DATE] Revision on: [DATE] Send copy of DNR paperwork upon transfer from facility Date Initiated: [DATE] Revision on: [DATE] Social services consult if resident/family want to change code status Date Initiated: [DATE] Revision on: [DATE] Record review of Resident #1's physician's order dated [DATE] reflected DNR (Do Not Resuscitate). Record review of Resident #1's OOH-DNR form dated [DATE] reflected the form was signed in section C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above person's: adult child. The OOH-DNR revealed the form was not signed by the attending physician below section E, Physician's Statement: I am the attending physician of the above noted person and have noted the existence of this order in the person's medical records. I direct health care professionals acting in our-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation. It also revealed the physician did not sign section F, All persons who have signed above must sign below, acknowledging that this document has been properly completed. In an interview on [DATE] at 03:57 pm SW B stated she would review the advanced directives with the family. She said she was responsible for getting the family's signature and then the OOH-DNR was given to MR C. SW B stated MR C was the one who was responsible for obtaining the doctor's signature. SW B stated as soon as (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they got the family's signature, the DON and staff were notified. In an interview on [DATE] at 04:05 pm, MR C stated the SW would scan OOH-DNRs to her and she would email the doctor requesting their signature. She stated normally the doctor signed the OOH-DNR within a day or two. She said she had sent Resident #1's DNR to the doctor's office. She said the doctor's signature was delayed by his office. MR C stated Resident #1's OOH-DNR was signed by the doctor on Friday, [DATE]. In an interview on [DATE] at 04:55 pm the DON stated Resident #1's DNR had been signed on [DATE]. She said she was not sure how the DNR was not signed by the physician before that. She said it had been care planned and there was an order for it, but the DNR had not been signed by the physician. Record review of the facility's Residents' Rights Regarding Treatment and Advanced Directives policy dated [DATE], revealed: Policy:It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical and surgical treatment and to formulate an advance directive.Policy Explanation and Compliance Guidelines: 1.On admission, the facility will determine if the resident has executed an advanced directive, and if not, determine whether the resident would like to formulate an advance directive. 3.Upon admission, should the resident have an advance directive, copies will be made and placed in the chart as well as communicated to the staff. Record review of the [DATE] OOH DNR Order instructions for issuing and OOH-DNR Order revealed: Purpose: The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order on reverse side complies with Health and Safety Code (HSC), Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity. Applicability: This OOH-DNR Order applies to health care professions in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments. Implementation: A competent adult person at least [AGE] years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person attending physician will document the existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows: . In addition: the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making and OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the residents were free from chemical restraints not required to treat the resident's medical symptoms for 2 (Resident #2 and Resident #3) of 6 residents reviewed for unnecessary medications. 1.The facility failed to have an adequate indication for the use of the medication Lurasidone (an antipsychotic) for Resident #2 before administering the medication with a black box warning. 2.The facility failed to have an adequate indication for the use of the medication Haldol (an antipsychotic) and Seroquel (an antipsychotic) for Resident #3 before administering the medication with a black box warning. This failure could put residents at risk of harm from adverse reactions or harmful side effects. The findings included: Record review of Resident #2's admission record dated 03/03/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Alzheimer's Disease (a progressive, irreversible neurodegenerative brain disorder that destroys memory, thinking, skills, and eventually the ability to perform daily tasks), hypertension (high blood pressure), and Type 2 Diabetes Mellitus (a chronic condition where the body becomes resistant to insulin and/or fails to produce enough of it, causing sugar to build up in the blood instead of entering cells for energy). Record review of Resident #2's Quarterly MDS, dated [DATE], revealed a BIMS score of 00, indicating severe cognitive impairment. Antipsychotics, antidepressants, anticoagulants (e.g. warfarin, heparin, or low-molecular weight heparin), antibiotics, and hypoglycemic (including insulin), and anticonvulsants were received on a routine basis. Record review of Resident #2's Care Plan dated 01/26/2026 revealed: FOCUS: (Resident #2) is resistive to care r/t Dementia, resident refuses showers, treatments, ADL care at times. (Resident #2) is refusing in/out catheterizations ordered by urologist, refuses treatments/ medications Date Initiated: 12/09/2025 Revision on: 12/09/2025. FOCUS: (Resident #2) has impaired cognitive function or impaired thought processes r/t Dx. Alzheimer's and Dementia. Date Initiated: 01/18/2025 Revision on: 02/13/2025. : (Resident #2) uses antipsychotic medications latuda/topamax r/t mood disorder and psychosis. Date Initiated: 12/13/2025 Revision on: 03/03/2026.INTERVENTIONS/TASKS: Latuda Oral Tablet Black Box Warning Warning: Increased mortality in elderly patients with dementia-related psychosis Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Lurasidone is not approved for the treatment of patients with dementia-related psychosis.() Suicidal thoughts and behaviors Antidepressants increased the risk of suicidal thoughts and behavior in pediatric and young adult patients in short-term studies. Closely monitor all antidepressant-treated patients for clinical worsening, and for emergence of suicidal thoughts and behaviors. Date Initiated: 01/21/2026 LN RN Monitor for adverse reactions. Monitor/document/report PRN any adverse reactions of antipsychotic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Date Initiated: 12/13/2025 Revision on: 03/03/2026 LN RN Monitor vital signs as ordered by MD and PRN Date Initiated: 03/03/2026 LN. Record review of Resident #2's Physician's Order dated 02/27/2026, revealed Order Summary: Lurasidone HCl Oral Tablet 40 MG (Lurasidone HCl)Give 1 tablet by mouth one time a day related to UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOLOGICAL CONDITION (F29). Black Box Warning:Increased mortality in elderly patients with dementia-related psychosisElderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Lurasidone is not approved for the treatment of patients with (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dementia-related psychosis. Record review of Resident #2's February 2026 MAR revealed Lurasidone HCl 40 mg tablet was administered daily on 02/28/2026. Record review of Resident #2's March 2026 MAR revealed Lurasidone 40 mg tablet was administered daily from 03/01/2026 through 03/03/2026. 2.Record review of Resident #3's admission record dated 03/03/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease (a progressive, irreversible neurodegenerative brain disorder that destroys memory, thinking skills, and eventually the ability to perform daily tasks), early onset, heart disease, Type 2 Diabetes Mellitus (a chronic condition where the body becomes resistant to insulin and/or fails to produce enough of it, causing sugar to build up in the blood instead of entering cells for energy), hypertension (high blood pressure), bipolar disorder (a chronic mental health condition characterized by extreme, often debilitating shifts in mood, energy, and activity levels), current episode mixed, severe, with psychotic features, intermittent explosive disorder, and mood disorder due to known physiological condition, and unspecified intellectual disabilities. Record review of Resident #3's Quarterly MDS, dated [DATE], revealed a BIMS score of blank, indicating Resident #3 had severe cognitive impairment. Resident #3 was rarely/never understood by others and rarely/never understood others. Resident #3 was dependent (Helper did ALL of the effort. Resident #3 did none of the effort to complete the activity. Or, the assistance of 2 or more helpers was required for the resident to complete the activity) for toileting, showering, and personal hygiene. Antipsychotics, antidepressants, antibiotics, and anticonvulsants were received on a routine basis. Record review of Resident #3's Care Plan dated 02/21/2026 revealed: FOCUS: (Resident #3) uses antipsychotic medications (Seroquel)and (Haldol) r/t Psychosis Targeted Behaviors: Agitation/Yelling/grabbing at other residents and/or staff. She uses an anticonvulsant for Labile Moods. Date Initiated: 03/11/2025 Revision on: 11/18/2025. Record review of Resident #3's Physician's Order 12/17/2025 revealed Order Summary: Haldol Decanoate Intramuscular Solution 50 MG/ML (Haloperidol Decanoate)Inject 50 mg intramuscularly one time a day starting on the 1st and ending on the 1st every month for psychosis related to UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOLOGICAL CONDITION (F29) (Administer every last day of the of the month) Black Box Warning:Increased mortality in elderly patients with dementia-related psychosisElderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration, 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was approximately 4.5%, compared with a rate of approximately 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be cardiovascular (eg, heart failure, sudden death) or infectious (eg, pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. Haloperidol is not approved for the treatment of patients with dementia-related psychosis. Record review of Resident #3's January 2026 MAR revealed Haldol Decanoate Intramuscular Solution 50 MG/ML (Haloperidol Decanoate) Inject 50 mg intramuscularly one time a day starting on the 1st and ending on the 1st every month for psychosis related to UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOLOGICAL CONDITION (F29) (Administer every last day of the of the month) was administered on 01/01/2026 in the morning. Record review of Resident #3's February 2026 MAR revealed Haldol Decanoate Intramuscular Solution 50 MG/ML (Haloperidol Decanoate) Inject 50 mg intramuscularly one time a day starting on the 1st and ending on the 1st every month for psychosis related to UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOLOGICAL CONDITION (F29) (Administer every last day of the of the month) was administered on 02/01/2026 in the morning. Record review of (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3's March 2026 MAR revealed Haldol Decanoate Intramuscular Solution 50 MG/ML (Haloperidol Decanoate) Inject 50 mg intramuscularly one time a day starting on the 1st and ending on the 1st every month for psychosis related to UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOLOGICAL CONDITION (F29) (Administer every last day of the of the month) was administered on 03/01/2026 in the morning. Record review of Resident #3's Physician's Order dated 01/27/2024, revealed Order Summary: SEROquel Oral Tablet 300 MG (Quetiapine Fumarate)Give 2 tablet by mouth at bedtime for PSYCHOSIS related to UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOLOGICAL CONDITION. Black Box Warning:Increased mortality in elderly patients with dementia-related psychosisElderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration, 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was approximately 4.5%, compared with a rate of approximately 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be cardiovascular (eg, heart failure, sudden death) or infectious (eg, pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. Haloperidol is not approved for the treatment of patients with dementia-related psychosis. Record review of Resident #3's January 2026 MAR revealed 2 Seroquel 300 mg tablets were administered 01/27/2026 through 01/31/2026 at bedtime. Record review of Resident #3's February 2026 MAR revealed 2 Seroquel 300 mg tablets were administered 02/01/2026 through 02/28/2026 at bedtime. Record review of Resident #3's March 2026 MAR revealed 2 Seroquel 300 mg tablets were administered 03/01/2026 through 03/04/2026 at bedtime. Record review of Resident #3's Physician's Order dated 02/19/2026 revealed, Order Summary: SEROquel Oral Tablet 300 MG (Quetiapine Fumarate)Give 1 tablet by mouth one time a day for PSYCHOSIS related to UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOLOGICAL CONDITION. Black Box Warning:Increased mortality in elderly patients with dementia-related psychosisElderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration, 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was approximately 4.5%, compared with a rate of approximately 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be cardiovascular (eg, heart failure, sudden death) or infectious (eg, pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. Haloperidol is not approved for the treatment of patients with dementia-related psychosis. Record review of Resident #3's February 2026 MAR revealed 1 Seroquel 300 mg tablet was administered 02/19/2026 through 02/28/2026 daily in the morning. Record review of Resident #3's March 2026 MAR revealed 1 Seroquel 300 mg tablet was administered 03/01/2026 through 03/05/2026 daily in the morning. During an interview on 03/09/26 at 12:27 pm MHNP A stated psychosis is a proper diagnosis for some residents. She said over 50% of dementia residents in nursing homes are psychotic and need antipsychotics. She said, What if all the people in nursing homes who were psychotic did not get medications? She said over half the residents would be crawling on the floor, aggressive, and all would have to live with a brain imbalance. She said if she did not medicate them, then she would get tagged for not medicating and she would be tagged for (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	putting psychosis as the indication for an antipsychotic. She said to not treat psychosis would be like hanging someone from a tree. MHNP stated she had been doing this for 40 years. She said she wished she could educate CMS about antipsychotics. She said with the black box warning showing there was a risk of death for a dementia resident receiving Seroquel or any other antipsychotic with a diagnosis of psychosis was not pertinent because we were all going to die sometime. She said she did not believe the risk of death with geriatrics and antipsychotics was increased. She said by the time someone was a geriatric, they already had other issues like cardiovascular, kidneys, liver problems, etc. She said the right medication can pinpoint the area in the dementia resident's brain that helps calm them. During an interview on 03/09/26 at 02:14 pm LVN D stated they would call the doctor if a resident had behaviors like crawling on the floor, yelling out during the night, being aggressive with staff or other residents, or just being agitated. He gave an example of agitation as when the resident verbalizes anything against anyone. He said the doctor will order medication. LVN D stated they sometimes had to ask the provider for the indication for the medication. LVN D stated he did not know that for a resident who had dementia or Alzheimer's, psychosis was not a proper indication for an antipsychotic. He said the doctor or NP gave an order and nurses followed the order given by the doctor. He said as long as they had consents signed for antipsychotics, it was ok to give the antipsychotic. LVN D stated if the resident had any symptoms of the medication making behaviors worse, he would notify the doctor who gave the antipsychotic order. During an interview on 03/09/26 at 02:44 pm NP E stated Resident #2 was her patient and Resident #2 had aggressive dementia which meant she was verbally and physically aggressive. She said Resident #2 was placed in the secure until due to wandering behaviors. She said until she went into the secure unit it was mostly verbal aggression. NP E stated she believed Resident #2 was still having intermittent behaviors since she had started on Latuda. She said the pharmacy would send GDR recommendations. She said she knew CMS did not like antipsychotics being given to residents with diagnosis of Alzheimer's/dementia with an inappropriate indication for the antipsychotic. During an interview on 03/09/26 at 04:55 pm The DON stated the facility had 37 active antipsychotic orders. She stated that psychosis was not an appropriate indication for an antipsychotic for a resident who had the diagnosis of Alzheimer's or dementia. The DON stated for residents with new behaviors, they would notify the physician of the new behaviors, have labs drawn, and have non-pharmacological interventions in place. The DON stated they had IDT meetings twice a week going over the antipsychotics for each resident to ensure it was working for the resident or if behavior was getting worse or stabilizing. She stated that sometimes the family does not want an antipsychotic for their loved one. She said sometimes the resident will come in from the hospital with an antipsychotic and diagnosis. She said when the doctor or NP writes an order, they cannot refuse to give the medication even if it has an indication that was inappropriate. She said some doctors or NPs would not change the indication. Record review of the facility's Psychotropic Drug Use policy dated 03/05/2025 reflected Policy: It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience which would deem it a chemical restraint. of this facility to ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. Definitions Chemical restraint refers to any drug used for discipline or makes it more convenient (i.e., less effort) for staff to care for a resident, and not required to treat medical symptoms. This includes instances when a psychotropic medication may be approved to treat certain symptoms, however, nonpharmacological interventions should be used or attempted, unless clinically contraindicated because they are less dangerous to a resident's health and safety. Policy Explanation and Compliance Guidelines:1.A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hypnotics. 2.Psychotropic medications are to be used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s).