

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/17/2026
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview 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 of 3 (Resident #1) residents reviewed for accuracy and completeness of clinical records. The facility failed to ensure LVN A accurately documented his findings on Resident #1's Initial Nursing Evaluation on 06/04/26. This failure could place residents at risk of a health decline. Findings included: Record review of Resident #1's admission record, dated 06/16/26, reflected an [AGE] year-old female re-admitted on [DATE], and an original admission date of 08/16/22. Her relevant diagnoses included Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and the ability to perform simple tasks), dementia (decline in mental ability severe enough to interfere with daily life, affecting memory, communication, and reasoning), senile degeneration of brain (age-related cognitive decline), and glaucoma (a group of eye diseases that damage the optic nerve, typically due to a buildup of fluid and pressure inside the eye.) Record review of Resident #1's quarterly MDS assessment, dated 04/24/26, reflected a BIMS score of 99, which indicated her cognition was severely impaired. Record review of Resident #1's Initial Nursing Evaluation, dated 6/04/26, authored by LVN A reflected he had documented in Section D. Oral/Nutrition that Resident #1 did not have any broken or carious (decayed or affected by cavities) teeth. During an observation and attempted interview on 06/16/26 at 3:30 p.m., Resident #1 was observed lying in bed awake. Resident #1 refused to be interviewed and shouted to get out of her room. During an interview on 06/16/26 at 3:44 p.m., CNA B said she had provided care to Resident #1 since her admission to the facility. She said Resident #1 used to be in the facility's memory unit and before her Alzheimer's progressed, Resident #1 would allow her to perform oral care. She said she had observed Resident #1 had multiple broken upper front teeth. During an interview and observation on 06/16/26 at 3:55 p.m., LVN A said Resident #1 was re-admitted on [DATE] after a brief hospital stay. LVN A was observed as he reviewed Resident #1's electronic medical record and said he was her admitting nurse on 06/04/26. LVN A said during Resident #1's Initial Nursing Evaluation done on 06/04/26, he observed Resident #1 had multiple broken upper front teeth. LVN A said he had erroneously documented Resident #1 did not have any broken or carious teeth. LVN A said there were no negative outcomes to Resident #1 not having her Initial Nursing Evaluation correctly documented. During an observation on 06/17/26 at 8:30 a.m., CNA C fed Resident #1 her breakfast. Observation revealed Resident #1 had multiple broken upper front teeth while eating. After breakfast, CNA C was observed as she attempted to perform oral care on Resident #1 but she refused. CNA C said Resident #1 had some natural teeth but had multiple broken upper front teeth. During an interview and observation on 06/17/26 at 3:30 p.m., the DON said Resident #1 had multiple broken upper front teeth since her admission to the facility. She was observed as she reviewed Resident #1's electronic medical record and said LVN A was Resident #1's admitting nurse on 06/04/26. She said LVN A had erroneously documented Resident #1 did not have broken or carious teeth. The DON said LVN A should have documented yes to having broken or carious teeth. The DON (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 - Few	said there were no negative outcomes to Resident #1 not having her Initial Nursing Evaluation completed accurately on 06/04/26, because it was more of a documentation issue because LVN A knew Resident #1 had multiple upper front teeth missing. Record review of the facility's Documentation in Medical Record policy, dated 10/24/22, reflected: Policy: 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. Policy Explanation and Compliance Guidelines: 1. Licensed staff and interdisciplinary team members shall document all assessment, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 3. Principles of documentation include, but are not limited to: a. Documentation shall be factual, objective, and resident centered. b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.		