

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

Printed: 10/09/2026
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 07/30/2026
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 interviews 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 6 residents (Resident #1) reviewed for accuracy and completeness of clinical records. The facility failed to ensure MA documented Resident #1's blood pressure on the eMAR when Resident #1's metoprolol (blood pressure medication) was held on July 4th of 2026. This failure could place residents at risk of not receiving proper care or having needs met due to inappropriate documentation. The findings included: Record review of Resident #1's face sheet dated 07/29/26 revealed an [AGE] year-old female with an original admission date of 03/14/26 and a current admission date of 11/14/24. Diagnosis included Essential Primary Hypertension (chronic high blood pressure with no single, identifiable cause, developing slowly over time). Record review of Resident #1's Quarterly MDS Assessment with an unknown date revealed a BIMS score of 0 which indicated severe cognitive impairment. Record review of Resident #1's Comprehensive Care Plan dated 07/29/26 revealed the problem [Resident #1] has hypertension (HTN) and Hyperlipidemia (elevated cholesterol), at risk for elevated blood pressure and other complications initiated on 04/02/24. An intervention listed for the problem included Obtain blood pressure readings as ordered initiated on 04/02/24. Record review of Resident #1's order summary dated 07/29/26 revealed an active order for metoprolol 50 MG give 1 tablet by mouth one time a day for HTN Hold for SBP (top blood pressure number) Less 110 or HR Less than 60 initiated on 10/08/25 Record review of Resident #1's eMAR for July 2026 revealed no blood pressure was recorded on the morning of 07/04/26. Further review revealed MA did not administer metoprolol to Resident #1 on the morning of 07/04/26 because her blood pressure was outside the physician's parameters. During an interview at 3:26 PM on 07/29/26, MA stated before administering a blood pressure altering medication she always checked the resident's blood pressure to ensure it was inside the physician's parameters. The MA stated she forgot to add in Resident #1's blood pressure to the eMAR when she held the metoprolol on the morning of 07/04/26. The MA stated there was no way to prove she held the medication appropriately. The MA stated it was important to document the blood pressure, so the doctor had a record to review and find any patterns to alter the dosage of the medication. The MA stated holding a blood pressure medication inappropriately could result in hypertension in the residents. During an interview at 4:20 PM on 07/29/26, the DON stated nurses and medication aides should always check the resident's blood pressure and pulse as needed per physician's orders. The DON stated she was unable to find any documentation in Resident #1's electronic health record stating what her blood pressure was when MA held the metoprolol on the morning of 07/04/26. The DON stated there was no proof MA held the metoprolol appropriately on the morning of 07/04/26. The DON stated it was (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675162	Facility ID: 675162 If continuation sheet Page 1 of 2

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	important to document blood pressures to keep a record for the doctor so they could look at it and adjust the dose as needed. Record review of the facility policy Medication Administration dated 10/24/22 revealed the following: .8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters.		