STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676042	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McAllen Transitional Care Center	2109 South K St MC Allen, TX 78503

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident # 2) reviewed for care plans.1. The facility failed to implement the care plan to ensure Resident #2 required assistance with feeding. 2. The facility failed to update Resident #2's Kardex (ADLs: eating and transfer). This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings include:Record review of Resident #2's admission record dated 10/06/25, reflected a [AGE] year-old male with an admit date of 09/18/25 and an original admission date of 01/14/24. His relevant diagnoses included quadriplegia (a condition characterized by paralysis or loss of movement and sensation in all four limbs (arms and legs), lack of coordination (a neurological symptom characterized by clumsy, uncoordinated movements that can affect walking, speaking, or using hands), need for assistance with person care, muscle wasting and atrophy (a condition where muscles lose mass and strength).Record review of Resident #2's quarterly MDS assessment dated [DATE], reflected a BIMS score of 15, which indicated his cognition was intact. Further review reflected Resident #2 had limited range of motion to his upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremities. His functional abilities for eating, oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer were coded as being dependent (helper does all of the effort) Resident #2's diagnosis of quadriplegia was listed as an active neurological disorder. Resident #2's quarterly care plan dated 05/19/25 reflected:Problem: [Resident #2] ADL self-care performance.may need 1-2-person extensive assist with bed mobility, toileting, personal hygiene, dressing and set up encouragement/limited assist (date initiated 01/15/24, revised on 05/19/25). Interventions: Transfer (chair/bed to chair transfer, toilet transfer) requires 2 person assist with staff participation with transfers (date created 01/15/24 and revised on 05/19/25). Bed mobility (roll left and right, sit to lying, lying to sitting on side of bed): Requires 1-2 person assist/staff participation to reposition and turn in bed (date initiated 01/15/24) Dressing (lower and upper body dressing, putting on/taking off footwear): requires 1-2 person assist/staff participation to dress (date initiated 01/15/24) Transfer (chair/bed to chair transfer, toiler transfer): requires Hoyer lift x2 staff assistance with transferring (date initiated 01/15/24 and revised 05/19/25)Resident #2's ADL for eating was not included as an intervention on Resident #2's care plan.Record review of Resident #2's Kardex dated 10/06/25 reflected:Transfers: Transfer (chair/bed to chair transfer, toiler transfer): requires 1-2 person asst/staff participation with transfers. Transfer (chair/bed to chair transfer, toiler transfer): Requires 2 person assist with staff participation with transfers. Transfer (chair/bed to chair transfer, toiler transfer): Requires Hoyer lift x2 staff assistance with transferring.Eating: Dietary: avoid food or beverages that tend to irritate esophageal lining, i.e., alcohol, chocolate, caffeine, acidic or spicy foods, fried or fatty foods. Monitor and record food intake at each meal. Monitor intake to assure an adequate fluid intake to prevent dehydration. OT to screen and provide adaptive equipment for feeding as needed.There was no mention Resident #2 required the assistance of 1 person for feeding.In an observation and interview on 10/06/25 at 3:54 pm, Resident #2 was observed lying in bed. Resident #2 said he was quadriplegic and had no feeling or movement from his neck down. He said he required assistance with all his ADLs as he was not able to assist. Resident #2 said he would get assistance with eating all three meals. In an interview on 10/07/25 at 10:00 am, CNA E, said Resident #2 was quadriplegic and required a 1 person assist for eating and a 2 person assist for all other ADLs. CNA E said Resident #2 only had movement from his neck up. CNA E said if she needed to verify a resident's level of assistance, she would check Kardex on their electronic medical record. She said Kardex was a tool for CNAs used to assist in determining the resident's level of care.In an interview on 10/07/25 at 12:42 pm, CNA F, said Resident #2 was quadriplegic and required a 1 person assist for eating and a 2 person assist for all other ADLs. CNA F said Resident #2 was not able to move from his neck down. She said if she needed to verify if a resident required a 1 or 2 person assist, she would check Kardex in their electronic medical record.In an observation and interview on 10/06/25 at 5:15 pm, LVN G, said Resident #2 was quadriplegic and was a was a two-person transfer with a mechanical lift. She said Resident #2 required 1 person to assist for feeding. She said Resident #2 only had movement from his neck up. LVN G said if a

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(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. (continued on next page)

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, 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 5 residents (Resident #3) reviewed for accuracy and completeness of clinical records. The facility failed to ensure Resident #3's order for a house supplement included the route of administration and dosage and order for liquid protein included the route of administration.This deficient practice could place residents at risk for incomplete or inaccurate clinical records, which could lead to miscommunication, a delay in services, or a potential decline in the resident's health. he findings include:Record review of Resident #3's admission record dated 10/13/25, reflected a [AGE] year-old female with an admit date of 06/03/25, an original admission date of 12/04/24 and a discharge date of 06/27/25. Her relevant diagnoses included sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection), mild protein-calorie malnutrition (a condition where a person does not consume enough protein and calories to meet their nutritional needs), cognitive communication deficit (difficulty with communication caused by problems with the brain's thinking abilities, rather than a physical speech or language impairment), dementia (a general term for a group of conditions that cause a decline in cognitive abilities, such as memory, thinking, reasoning, and judgment, severe enough to interfere with daily life), chronic kidney disease (a condition where the kidneys gradually lose their ability to filter waste products from the blood, leading to a buildup of toxins and other substances in the body), and dependence on renal dialysis (a chronic condition where the kidneys have lost their ability to adequately filter waste products from the blood, requiring regular treatments to remove these toxins and maintain overall health).Record review of Resident #3's quarterly MDS assessment dated [DATE], reflected a BIMS score of 3, which indicated her cognition was severely impaired. Further reviewed indicated Resident #3 had a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device.Record review of Resident #3's quarterly care plan dated 03/13/25 reflected the following:focus of has risk of malnutrition (date initiated 06/04/25). The interventions in part included give supplements as ordered (date initiated 05/29/25). Focus of has actual impairment to skin integrity r/t sacral wound PU stage 3 sacrum. The interventions in part included encourage good nutrition and hydration in order to promote healthier skin (date initiated 06/04/25). Record review of Resident #3's order summary dated 10/14/25 the following: House supplement, two times a day for supplement effective 06/06/25 and discontinue date of 07/03/25. Liquid protein, two times a day for aide in wound healing, administer 30 ml effective 06/09/25 and a discontinue date of 07/03/25. Record review of Resident #3's eMAR for the month of 06/25 reflected both the house supplement and liquid protein were administered as orderedIn an interview on 10/13/25 at 3:45 pm, LVN C said that for an order to be considered valid it must include the resident's name, the dosage, the frequency, the diagnosis, and the route. LVN C said if an order did not include any of the above, it would be considered an incomplete order. She said if she were to discover an order that was incomplete, she would call the doctor to obtain the missing information. LVN C said, liquid protein is a general name is ordered to residents who suffer from malnutrition and or have wounds. She said Resident #3's order for liquid protein was missing the route. She said Resident #3's order for house supplement was missing the route and the amount. She said house supplement was ordered to residents as a supplement. LVN C said both orders would be considered incomplete. She said there were no negative outcome as Resident #2 was administered the medication as ordered. In an interview on 10/13/25 at 4:00 pm, LVN D said an order must include the resident's name, dosage, frequency, route, and diagnoses to be considered complete. He said if an order was missing any of the above, it would be considered invalid. LVN D said if he discovered an order was not complete, he would have reached out to the resident's doctor to obtain the missing information. In an observation and interview on 10/13/25 at 5:06 pm, The DON said an order must include the resident's name, route of administration, frequency, dosage, and diagnosis to be considered a complete order. The DON was observed reviewing Resident #3's electronic medical record and said Resident #3's order for a liquid protein and house supplement were missing route of administration. The DON said it was the responsibility of the nurse that received the order to ensure it was complete. The DON said the ADON facility had the responsibility of ensuring all orders received were complete.In an observation and interview on 10/14/25 at 9:20 am, the ADON-LVN said part of her responsibilities included to ensure all orders received were complete. She said an order must include the resident's name, route of administration

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 3 residents (Resident #1) residents reviewed for EBP. The facility failed to post EBP signage and for Resident #1 when she had a permcath (a flexible tube used for dialysis treatment) to right chest. This failure could place residents at risk of MDRO contamination.The findings include:The findings include:Record review of Resident #1's admission record dated 10/06/25, reflected a [AGE] year-old female with an admit date of 09/22/25 and initial admission date of 09/10/25. Her relevant diagnoses included type 2 diabetes (a chronic condition where the body does not use insulin properly or does not produce enough insulin to regulate blood sugar levels), hypertension (a condition where the force of blood against the artery walls is consistently too high), irritable bowel syndrome (a chronic condition that affects the large intestine, causing abdominal discomfort, bloating, and changes in bowel habits), and need for assistance with personal care.Record review of Resident #1's 5-day Medicare MDS assessment dated [DATE], reflected a BIMS score of 15, which indicated her cognition was intact. Resident #1 was also noted to have an indwelling catheter.Record review of Resident #1's comprehensive care plan dated 09/23/25 reflected a problem of has indwelling catheter (date initiated 09/11/25). Her interventions in part included, change catheter bag and tubing as ordered, Monitor/record/report to MD for signs and symptoms of UTI, and position catheter bag and tubing below the level of the bladder and away from entrance room door. In an observation and interview on 10/06/25 at 2:45 pm, Resident #1 was observed with an indwelling foley catheter. There was no EBP signage posted on her door/room and no PPE cart outside the door. In an interview on 10/06/25 at 3:00 pm, CNA A said Resident #1 had an indwelling catheter and was supposed to have EBP signage and a PPE cart outside her door. She said CNAs were only allowed to empty the indwelling catheters. CNA A said even though there was no signage or PPE cart outside the door, she ensured she wore gloves when emptying Resident #1's catheter. CNA A said a negative outcome to Resident #1 not having EBP signage and a PPE cart outside her door could be infection control.In an interview and observation on 10/06/25 at 3:30 pm, LVN B reviewed Resident #1's electronic medical record and said she had an indwelling catheter. LVN B said, all residents who had an indwelling catheter required to be under EBP. He walked into Resident #1's room and said he did not see an EBP signage or PPE cart by her door. LVN B said he was not sure why Resident #1 did not have the required signage or PPE cart by her door. LVN B said a negative outcome of Resident #1 not having the EBP signage and PPE cart by her door would be that staff who would enter her room would not know how to protect themselves. In an observation and interview on 10/06/25 at 3:45 pm, the DON said a resident who had an indwelling catheter required to be under EBP. He entered Resident #1's room and said he did not see the EBP signage or PPE cart outside her door. The DON said Resident #1 had recently transferred to that room and maybe that's where the miscommunication occurred. The DON said a negative outcome for not having EBP signage and supplies readily available could possibly be the spreading an infection. Record review of the facility's Infection Control policy revised on 04/25 reflected:Policy: It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions. Procedure:3. Enhanced Barrier Protection (EBP): used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloved during hi-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to resident or from resident-to-resident. (e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs).A. PPE: The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with:i. wounds and/or indwelling medical devices regardless of known MDRO infection or colonization.indwelling medical devices include, but not limited to central lines, peripherally inserted central catheter lines, urinary catheters, feeding tubes, and tracheostomies.