

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER McAllen Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2109 South K Street McAllen, 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs for 1 of 4 residents (Resident #2) reviewed for care plans. The facility failed to ensure Resident #2's comprehensive care plan reflected refusals of medications (on 05/16/26, 05/17/26, 05/25/26, 05/29/26, 05/30/26, 05/31/26, 06/03/26, 06/04/26, 06/08/26, 06/09/26, 06/12/26, 06/13/26, 06/14/26, 06/17/26, 06/18/26, 06/22/26, 06/26/26, 06/27/26, 06/28/26, 07/01/26, 07/02/26, 07/06/26, 07/07/26, and 07/15/26) and skin assessments (on 05/20/26, 05/27/26, 06/03/26, 06/10/26, 06/17/26, 06/24/26, 07/01/26, and 07/08/26). This failure could place residents at risk of not receiving appropriate interventions and care to meet their needs. Findings included: Record review of Resident #2's face sheet, dated 07/14/26, reflected a [AGE] year-old female, admitted on [DATE], diagnoses included: chronic obstructive pulmonary disease (incurable lung disease that causes restricted airflow and severe breathing difficulties), type 2 diabetes mellitus (insulin resistance and high blood sugar levels), unspecified dementia (decline in cognitive function severe enough to interfere with daily life affecting memory loss, language, problem solving, and other cognitive abilities), hemiplegia/hemiparesis (paralysis of one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, mood disorder due to physiological condition (mental health disorder where depressive or manic symptoms arise directly from a medical or neurological condition affecting brain function), and major depressive disorder (mental health condition with persistent feelings of sadness, loss of interest, various emotional/physical problems). Record review of Resident #2's quarterly MDS assessment, dated 06/12/26, reflected a BIMS score of 15, which indicated intact cognition. The MDS reflected Resident #2 had impairment on one upper extremity and no impairment to lower extremities. Record review of Resident #2's care plan, dated 07/14/26, reflected [Resident #2] had cerebral accident (stroke) with hemiplegia affecting left non-dominant side. Date initiated: 02/16/26. Interventions included: give medications as ordered by the physician, monitor/document/report to MD, and provide assistance. [Resident #2] had a self-care performance deficit. Date initiated: 02/09/26. Interventions included: required partial/moderate assistance with bathing/showering. [Resident #2] had bowel/bladder incontinence. Interventions included: licensed nurse will monitor skin at least weekly and report any changes to MD. Care plan did not reflect refusals of medications and skin assessments. Record review of Resident #2's progress notes, dated 05/13/26-07/15/26, reflected Resident #2 refused all medications on 05/16/26, 05/17/26, 05/25/26, 05/29/26, 05/30/26, 05/31/26, 06/03/26, 06/04/26, 06/08/26, 06/09/26, 06/12/26, 06/13/26, 06/14/26, 06/17/26, 06/18/26, 06/22/26, 06/26/26, (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	06/27/26, 06/28/26, 07/01/26, 07/02/26, 07/06/26, 07/07/26, and 07/15/26. During an interview and observation, on 07/14/26 at 12:30 PM, Resident #2 stated she was doing well. Resident #2 stated she took her medications when she wanted. Resident #2 stated the nurses checked her skin when she let them. Resident #2 stated there were times she told them no to everything because she was fine. Resident #2 was observed with no visible injury. During an interview, on 07/14/26 at 1:40 PM, LVN A stated Resident #2 refused medications, the PA was made aware, and the PA gave no new orders. LVN A stated they educated and encouraged Resident #2 to take her medications but it was her right to refuse. During an interview, on 07/14/26 at 1:55 PM, the PA stated she was notified when Resident #2 refused medications. The PA stated the staff explained the importance of taking her medications but Resident #2 had the right to refuse. The PA stated the staff monitored Resident #2 and she had no changes resulting from medication refusals. During an interview, on 07/15/26 at 8:50 AM, MA B stated Resident #2 refused medications a lot of the time. MA B stated when Resident #2 refused medications, she attempted to explain the importance of taking her medications but Resident #2 still refused. MA B stated she told the nurse on shift and they tried to convince Resident #2 but she still refused. MA B stated she did not remember what days Resident #2 refused but she documented a progress note each time. During an interview, on 07/15/26 at 9:20 AM, LVN C stated Resident #2 refused skin assessments. LVN C stated they cannot force Resident #2 to allow them to check her skin and she had the right to refuse. During an interview, on 07/15/26 at 10:30 AM, the MDS Nurse stated if Resident #2 refused care, that should have been included in her care plan. The MDS Nurse stated she was aware that Resident #2 refused medications, but it was not included in her care plan because she missed adding it. The MDS Nurse stated she was not aware that Resident #2 refused skin assessments, but that should have also been added to her care plan. The MDS Nurse stated the team communicated changes that needed to be added to the care plan, but Resident #2's skin assessments refusals were not been reported to her. The MDS Nurse stated any refusals of care should have been added to the care plan. The MDS Nurse stated there was no negative outcome for Resident #2 as staff encouraged, explained, and educated her on the importance of allowing for care, but it was her right to refuse. The MDS Nurse stated it was important for the care plan to be developed accurately to ensure all staff were aware of Resident #2's refusals and what interventions to attempt. During an interview, on 07/15/26 at 11:00 AM, the ADON stated Resident #2 refused medications, but she was not sure what days. The ADON stated she was made aware today (07/15/26) that Resident #2 refused skin assessments. The ADON stated the refusals of care should have been in Resident #2's care plan. The ADON stated the MDS Nurse developed and updated the care plans, but it was a team effort to communicate changes to the MDS Nurse and ensure the care plan was accurate. The ADON stated for refusals of care, interventions were to educate the resident, encourage, and notify the MD. The ADON stated the staff had already implemented those interventions for Resident #2's refusals of medications and skin assessments. The ADON stated there was no negative outcome for Resident #2 but it was important to include behaviors, such as refusals, in the care plan so everyone was aware of the plan of care. During an interview, on 07/15/26 at 11:45 AM, the PA stated she was notified that Resident #2 refused skin assessments. The PA stated Resident #2 had the right to refuse and the staff respected her wishes. During an interview, on 07/15/26 at 3:00 PM, the DON stated care plans were developed and updated by the MDS Nurse. The DON stated Resident #2 refused medications and skin assessments. The DON stated the refusals of care should have been included in the care plan. The DON stated there was no negative outcome or risk of injury for Resident #2 as staff notified the PA, the PA gave no new orders, and the staff implemented interventions to address her refusals such as educating and explaining the importance of (continued on next page)		

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	taking her medications and allowing the skin assessments. The DON stated it was important for the care plan to be developed accurately to ensure everyone was aware of the resident's needs and behaviors. Record review of the facility's Comprehensive Person-Centered Care Planning policy, dated November 2016 and revised April 2025, reflected - Policy: It is the policy of this facility that the IDT shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychological needs that are identified in the comprehensive assessment.		

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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 medical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 4 residents (Resident #2) reviewed for accuracy of records. LVN C failed to document progress notes for skin assessment refusals on Resident #2's electronic medical record on 05/20/26, 05/27/26, 06/03/26, 06/10/26, 06/17/26, 06/24/26, 07/01/26, and 07/08/26. This failure could affect residents whose records are maintained by the facility and could place them at risk for errors in care. Findings included: Record review of Resident #2's face sheet, dated 07/14/26, reflected a [AGE] year-old female, admitted on [DATE], diagnoses included: chronic obstructive pulmonary disease (incurable lung disease that causes restricted airflow and severe breathing difficulties), type 2 diabetes mellitus (insulin resistance and high blood sugar levels), unspecified dementia (decline in cognitive function severe enough to interfere with daily life affecting memory loss, language, problem solving, and other cognitive abilities), hemiplegia/hemiparesis (paralysis of one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, mood disorder due to physiological condition (mental health disorder where depressive or manic symptoms arise directly from a medical or neurological condition affecting brain function), and major depressive disorder (mental health condition with persistent feelings of sadness, loss of interest, various emotional/physical problems). Record review of Resident #2's quarterly MDS assessment, dated 06/12/26, reflected a BIMS score of 15, which indicated intact cognition. The MDS reflected Resident #2 had impairment on one upper extremity and no impairment to lower extremities. Record review of Resident #2's care plan, dated 07/14/26, reflected [Resident #2] had cerebral accident (stroke) with hemiplegia affecting left non-dominant side. Date initiated: 02/16/26. Interventions included: give medications as ordered by the physician, monitor/document/report to MD, and provide assistance. [Resident #2] had a self-care performance deficit. Date initiated: 02/09/26. Interventions included: required partial/moderate assistance with bathing/showering. [Resident #2] had bowel/bladder incontinence. Interventions included: licensed nurse will monitor skin at least weekly and report any changes to MD. Record review of Resident #2's Braden scale (tool) for predicting pressure ulcer risk evaluation, dated 05/11/26, reflected a low risk with no need for treatment at this time. Record review of Resident #2's skin checks reviewed on 07/15/26 at 4:00 PM, reflected a skin check on 05/13/26 with no new skin issues. There were no other skin checks completed until 07/15/26 at 2:19 PM. Resident #2 had a rash to the left lower quadrant midline. Record review of Resident #2's progress notes, dated 05/13/26-07/15/26, reviewed on 07/15/26 at 4:05 PM, reflected Resident #2 had a scattered rash on 07/13/26, the PA was notified, and Resident #2 was seen by the PA who prescribed her a topical ointment and oral medication. There was no documentation found for Resident #2's refusals of skin assessments on 05/20/26, 05/27/26, 06/03/26, 06/10/26, 06/17/26, 06/24/26, 07/01/26, and 07/08/26. Record review of Resident #2's nurse aide skin identification form (shower sheet), dated 05/15/26-07/10/26, reflected no new skin site or change. During an interview and observation, on 07/14/26 at 12:30 PM, Resident #2 stated she was doing well. Resident #2 stated the nurses checked her skin when she let them. Resident #2 stated there were times she told them no to everything because she was fine. Resident #2 was observed with no visible injury. During an interview, on 07/15/26 at 9:20 AM, LVN C stated Resident #2 refused skin assessments. LVN C stated they cannot force Resident #2 to allow them to check her skin and she had the right to refuse. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN C stated he did not recall when the last time was Resident #2 allowed him to do the skin assessment. LVN C stated he was unsure if he documented Resident #2's refusals. LVN C stated he explained to Resident #2 why he needed to do the skin check but she told him that there was nothing wrong with her skin and refused. LVN C stated he notified the PA when Resident #2 refused skin checks, but there was no other intervention or order, and they continued to monitor. LVN C stated it was important to do the skin checks or attempt to, to see if there were any skin changes. LVN C stated the ADON checked his work and ensured the weekly skin assessments were done. LVN C stated it was important to document so staff were aware of skin changes or the refusals. During an interview, on 07/15/26 at 11:00 AM, the ADON stated she reviewed the skin system and ensured the assessments were done. The ADON stated LVN C completed weekly skin assessments on all the residents. The ADON stated today (07/15/26) LVN C informed her that Resident #2 refused weekly skin checks, but there was no documentation of her refusals. The ADON stated she reviewed Resident #2's file and the last skin check was completed on 05/13/26, with no skin issues. The ADON stated Resident #2 should have had weekly skin assessments or a note on 05/20/26, 05/27/26, 06/03/26, 06/10/26, 06/17/26, 06/24/26, 07/01/26, and 07/08/26. The ADON stated Resident #2's weekly skin assessment was scheduled for today (07/15/26) and they were going to attempt. The ADON stated she did not know why Resident #2 refused skin checks or why LVN C had not documented the refusals. The ADON stated she was told by LVN C that he notified the PA of the refusals and there were no new orders. The ADON stated there was no documentation to show LVN C's actions. The ADON stated there was no negative outcome for Resident #2 and Resident #2 was vocal, able to voice needs or issues. The ADON stated the floor staff would have reported any skin changes noted during brief/clothing changes or showers. The ADON stated it was important that the weekly skin assessments were completed or attempted to capture any skin changes, and it was important to document to show the staff's efforts. During an interview, on 07/15/26 at 11:45 AM, the PA stated she was notified that Resident #2 refused skin assessments and she gave no new orders. The PA stated Resident #2 had the right to refuse, and the staff respected her wishes. During an interview, on 07/15/26 at 3:00 PM, the DON stated the skin system was overseen by the ADON and LVN C. The DON stated LVN C completed weekly skin assessments on all the residents. The DON stated if the resident refused a skin check, LVN C should have notified the doctor and documented a progress note about the refusal. The DON stated he reviewed Resident #2's file and there was no documentation for refusals regarding skin checks on 05/20/26, 05/27/26, 06/03/26, 06/10/26, 06/17/26, 06/24/26, 07/01/26, and 07/08/26. The DON stated the ADON completed audits and ensured the weekly skin assessments were done. The DON stated the last skin check, before today (07/15/26), was on 05/13/26 when Resident #2 was noted with no skin issues. The DON stated the floor staff completed skin checks during showers and had not reported any skin changes. The DON stated Resident #2 was very particular, so LVN C probably attempted the skin check and she refused, but there was no documentation to show LVN C's actions. The DON stated the policy for skin and wounds was to assess the residents weekly and to document the assessment, document a note, or document the refusal. The DON stated there was no negative outcome to Resident #2 as she did not have wounds or major skin issues, and she was at low risk of developing pressure wounds since she was still able to wheel herself around, move around in bed, and voice her needs, wants, or dislikes. The DON stated it was important for the weekly skin assessments to be completed or attempted with follow up documentation as a preventative measure to avoid any skin integrity issues. During an interview, on 07/15/26 at 4:45 PM, the DON stated there was no risk of injury for Resident #2 as skin changes would not go unnoticed since CNAs completed skin checks during showers and noted skin (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes on shower sheets. The DON stated even if there was no skin change noted by the CNAs, LVN C was the licensed staff to assess and say there was an actual skin change or abnormality that could lead to further issues. Record review of the facility's Skin and Wound Monitoring and Management policy, dated March 2015 and revised April 2025, reflected, Policy: It is the policy of this facility that: A resident who enters the facility without pressure injury does not develop pressure injury. and receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing.1.g. Ongoing skin and wound assessments: A licensed nurse will assess/evaluate a resident's skin at least weekly.4.b. Weekly skin check: Licensed nurse should document skin evaluations in accordance with this policy and document on the appropriate skin assessments/evaluation weekly and as needed.8.a. if the resident is not able to or chooses not to participate in the care plan relative to prevention of skin breakdown.the nursing staff shall communicate with the resident's physician to discuss an appropriate intervention or response.		