

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: 676042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. :Based on observation, interviews and record review, the facility failed to store food in accordance with professional standards for food service safety for 1 of 1-refrigerator (1 of 1 facility refrigerator) and 1 of 1 freezer (1 of 1 resident freezer reviewed for storage, preparation and sanitation and failed to keep residents room free from pests. -The facility failed to ensure food items in the resident's refrigerator were dated and sealed properly. -The facility failed to ensure food items in the resident's freezer were sealed properly. -These failures could place residents at risk of complications from food contamination. Findings included: Observations during the initial tour of the kitchen on 03/09/26 at 10:30 am revealed one block of sliced cheese wrapped in clear plastic undated, a box of tomatoes of uncovered, cucumbers uncovered exposed to air possibly coming contaminated that were stored in the facility refrigerator. Observation of the freezer revealed a box of raw biscuits open and exposed to the air. Observation of Resident and interview revealed Resident #42 and Resident #79stated they both saw large roaches in their rooms for a couple of days In an interview with DA A on 03/09/26 at 10:30 a.m. said all kitchen staff were responsible for cleaning the refrigerator and made sure that all food was labeled, had not expired, and had a use by date. DA #A stated the fridge was cleaned and all expired food was thrown out daily. DA A could not explain why the cheese did not have a date of when the cheese was placed in the refrigerator. DA A stated she did not know the tomatoes and cucumbers were not stored properly, or she would have stored them properly. DA A stated she did not know of the biscuits that were left open in the freezer. DA A stated she knew that all items in the freezer should be sealed to prevent freezer burn and could become contaminated making residents sick. In an interview on 03/11/06with DA B at 10:41 a.m. he stated he could not recall when the cheese was placed in the refrigerator but knew that all items put in the refrigerator were to have a use by date. DA B stated the staff throw away all expired food daily and clean the refrigerator weekly. DA B said he was not aware of the cheese not being dated but knows that all food in the refrigerator must be dated so the expired food is not used for cooking for the residents. DA B stated the biscuits must have been left open recently and the person must have been in a rush because all food is sealed and dated. DA B stated he knew it was important to keep all open items in the freezer must be resealed so that it does not become contaminated and make residents ill. In an interview with the DM on 03/11/26 at 10:13 a.m. she stated she and the staff clean out the refrigerator daily and the cheese was not dated correctly and if should have been stored with a date when it was put in the refrigerator. The DM said the cheese had not been used for cooking recently, and that could be why the cheese was not noticed with no use by date. The DM stated she did not know why they did not have a date on the cheese or when the cheese was put in the refrigerator as all other items had a date. The DM stated the cheese gets used quite often so could not say who did not date the cheese when it was put in the facility refrigerator. The DM stated she will do a retraining on dating items and making sure they are all covered or in a container sealed correctly and throwing out all expired foods for all forms of storage. Record review of the facility's policy dated 11/2016, titled, Infection Control Policy /Procedure Dietary Services and stated, It is the policy of this facility to prevent contamination of food products and therefore prevent foodborne illness. FDA Food Code 2022 Ch. 3-501.17 (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. to (E) and (F) of this section, refrigerated, Ready-to eat, Time/Temperature Control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights and that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #12) of 6 residents reviewed for comprehensive care plans. The facility failed to include Resident #12 diagnosis of paranoid schizophrenia in his care plan. This failure could place residents at risk for their mental and psychosocial needs not being met. The findings included: Record review of Resident #12's admission record dated 03/11/2026 revealed a [AGE] year-old male admitted to the facility on [DATE] and an original admission date of 01/04/2025. Resident #12's pertinent diagnosis was paranoid Schizophrenia (mental disorder characterized by intense suspicions and false beliefs that others were plotting against or trying to harm them). This diagnosis had an onset date of 02/23/2026. Record review of Resident #12's MDS revealed a completion date of 03/02/2026. Section C-Cognitive Pattern revealed a BIMS score of 5 which indicated severely impaired cognition. Section I-Active Diagnoses revealed a diagnosis of Schizophrenia. Record review of Resident #12's care plan completed on 02/24/2026 revealed no mention of paranoid Schizophrenia except in the diagnoses list on the bottom of the last page of the care plan. In an interview on 03/11/2026 at 2:14 p.m., LVN C stated that she was responsible for completing Resident #12's care plan. She verified that Resident #12 did not have the diagnosis of paranoid Schizophrenia care planned. LVN C stated that she missed it because Resident #12 was a readmission. She stated that she has 14 days from the admission date to complete the care plan. If the doctor gives orders, then she would enter the care plan the next day. LVN C stated that the negative outcome of not having the diagnosis of paranoid Schizophrenia care planned would be that Resident #12 could be a risk for behaviors or other delusions. She stated that having it care planned was important to make sure that he was receiving the appropriate treatment. In an interview on 03/11/2026 at 2:30 p.m., the DON stated that LVN C was responsible for updating and completing the care plan once it was reopened. He stated that he was not sure if an acute or comprehensive care plan needed to be completed within one week. The DON stated that there was no negative outcome of not having the diagnosis of paranoid Schizophrenia care planned. He stated that it was important for the diagnosis to be in the care plan so that staff were familiar with it and ensure the correct diagnosis was documented in the chart. The DON stated that having it part of the care plan helps guide the proper care and treatment. Record review of the facility's policy titled Comprehensive Care Planning with a revision/review date of April 2025 revealed the following: Policy: It is the policy of this facility that the interdisciplinary team 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 psychosocial needs that are identified in the comprehensive assessment. The interdisciplinary team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality of care.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #24) of 4 residents who was observed for medication administration. CMA A failed to inform Resident #24 the names of the medications and the indications for the medications that were being administered. This failure could lead to inaccurate administration of medications and ineffective therapeutic effects. Finding included: Record review of Resident #24's face sheet, dated 03/11/26, revealed resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #24's diagnoses included: Mild protein-calorie malnutrition, muscle weakness, blindness right eye, hypertension (high blood pressure), atrial fibrillation (irregular heart rhythm), gastritis (inflammation of the lining of the stomach), osteoarthritis (arthritis affecting joints in hands, knees, hips and spine), GERD (when stomach acid flows back up into the esophagus and causes heartburn) and hyperlipidemia (high cholesterol). Record review of Resident #24's BIMS evaluation dated 02/26/26 revealed the resident had a BIMS of 15 which indicated intact cognition. Record review of Resident #24's care plan dated 02/25/26 revealed there was not a focus, goal, or intervention that indicated resident was not to receive indications regarding the medication she was taking. Record review of Resident #24's current order summary dated March 2026 revealed resident was receiving the following medications: *amiodarone hydrochloride 200 mg 1 tablet by mouth twice a day for atrial fibrillation, *furosemide 40 mg 1 tablet by mouth daily for edema, *metoprolol tartrate 25 mg 1 tablet by mouth daily for hypertension, *losartan potassium 50 mg 1 tablet by mouth daily for hypertension, *famotidine 20 mg 1 tablet by mouth daily for GERD, *diltiazem hydrochloride 180 mg 1 tablet by mouth daily for hypertension, *clopidogrel 75 mg 1 tablet by mouth daily for blood clot prevention, *atorvastatin 80 mg 1 tablet by mouth daily for hyperlipidemia, *apixaban 2.5 mg 1 tablet by mouth twice a day for DVT (a blood clot in a vein located deep within your body, usually in the leg), *iron 325 mg 1 tablet by mouth three times a day for low iron, *docusate sodium 100 mg 1 capsule by mouth daily for constipation, *multivitamin with minerals 1 tablet by mouth daily for risk of malnutrition, and *senokot 8.6 mg tablet by mouth daily in the morning for constipation. Observation on 03/11/26 at 9:02 am revealed CMA A proceeded to administer Resident #24 morning medications: amiodarone hydrochloride, furosemide, metoprolol tartrate, losartan potassium, famotidine, diltiazem hydrochloride, clopidogrel, atorvastatin, apixaban, iron, docusate sodium, multivitamin with minerals, and senokot. All medications were placed in a clear, medication cup and were given to Resident #24 to take. CMA A did not identify medications to the resident, nor did she indicate what medications were for. Resident #24 swallowed all medications with water and handed the medicine cup back to CMA A. In an interview on 03/11/26 at 9:09 am, CMA A stated she did not identify medications nor did she tell Resident #24 what the medications were for because the resident already knew what the medications were for. CMA A stated the resident had been transferred from another facility and had arrived with the same medications. CMA A stated, She already knows what they are for; I don't need to tell her over and over again. CMA A stated it was also offensive to tell Resident #24 what the medications are for because Resident #24 was all there (cognitively) and already knew that information. CMA A stated there was not a need to tell residents the indications of medications stating, I never tell them [residents] what the medications are for. CMA A stated there was no harm in not telling residents what the medications were for. In an interview on 03/11/26 at 9:31 am, RN B stated that when she administered medications, she gave one medication at a time telling the resident what each medication was for. RN B stated she administered medications in that manner as to educate the resident on the medications they were taking. RN B stated it was important for the (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents to know what medications they are taking because it involved the residents in their care. RN B stated that telling what the medications were for was part of the Rights of Medication Administration (set of safety checks designed to prevent errors and ensure patient safety). In an interview on 3/11/26 at 4:15 pm, the DON stated he was not aware that CMA A had not informed Resident #24 of the indications for the medications administered. DON stated he expected all CMAs or nurses that administered medications would provide all the information to the residents about the medications they received. DON stated he taught his staff accurate medication administration with return demonstration. Record review of the facility policy and procedure titles Medication Administration dated revised 05/2024 revealed: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection for 1 (Resident #47) of 4 residents reviewed for infection control. The facility failed to ensure that LVN B changed her gloves and performed hand hygiene during Resident #47's medication administration. These failures could place residents at risk for contamination and infection. The findings included: Record review of Resident #47's face sheet, dated 07/07/2025, revealed an [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #47 diagnoses included: Cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), chronic respiratory failure with hypoxia (the body or a region of the body is deprived of an adequate oxygen supply), gastrostomy status (indicates the presence of a gastrostomy tube, also known as a g-tube or peg tube, for nutritional support), dysphagia (difficulty swallowing), vascular dementia (dementia caused by reduced blood flow to the brain), and cognitive communication deficit. Record review of Resident #47's BIMs assessment dated [DATE] revealed a score of 3 which indicated severe impairment. Record review of Resident #47's care plan dated 07/09/24 revealed [Resident #47] requires tube feeding. Goal: Feeding tube insertion site will be free of s/sx of infection. Interventions: Provide local care to feeding tube site as ordered and monitor for s/sx of infection. During an observation on 03/10/26 at 7:49 am, While inside of Resident #47's room, LVN B donned gown and gloves. LVN B had bedside table with medications and water prepared as ordered. LVN B walked over to Resident 47's bedside. LVN B pushed the pause button on resident's feeding pump. LVN B disconnected the pump tubing from Resident #47 peg tube site and hung it over the feeding bottle on the feeding pump pole. LVN B checked for peg tube placement (verification that the feeding tube remains correctly positioned in the stomach by using a stethoscope) and residuals (to check for gastric content). LVN B administered medications via peg tube. After all medications had been administered, LVN B reconnected feeding tubing and pressed the start button. LVN changed gloves but did not perform hand hygiene between change. LVN B rinsed feeding syringe in the sink, dried and placed the syringe back in its original plastic bag. LVN B cleaned up the trash on the bedside table and threw it in the trash bin. LVN removed her gown, threw it in the trash bin, then removed her gloves and threw it in the trash bin as well. LVN B washed her hands and exited the room. During an interview on 03/10/26 at 8:30 am, LVN B stated she did not have to change gloves after pushing the pause button on the feeding pump and prior to feeding. LVN B stated she felt that the feeding pump is not a contaminated surface. LVN B stated she did not have to perform hand hygiene between glove changes because she had not done incontinent care. LVN B stated she removed gloves and washed her hands before rinsing the syringe because she was going to store the syringe. LVN B stated poor hand hygiene could spread germs and cause infections. During an interview on 03/11/26 at 4:15 pm the DON stated he did not feel there was a reason to change gloves during the medication administration. DON stated he felt the feeding pump was not a contaminated surface therefore LVN B did not have to change gloves nor perform hand hygiene. DON stated he felt LVN B had done the medication administration task correctly. DON stated he taught his staff accurate medication administration with return demonstration. Record review of the facility's Hand Hygiene Policy with original date of 05.2007 and last revised on 12.2003 revealed: 2. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: o Before and after direct contact with residents; o Before performing any non-surgical invasive procedures; o Before and after handling an invasive device (e.g., urinary catheter, IV access sites); o After touching contaminated surfaces; o After changing gloves; Record review of the CDC guidelines Clinical Safety: Hand Hygiene for Healthcare Workers updated on (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/27/2024 revealed Know when to clean your hands,- Immediately before touching a patient.- After touching a patient or patient's surroundings- After contact with blood, body fluids, or contaminated surfaces- Immediately after glove removal.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain an effective pest control program so the facility is free of pests for Resident #42, Resident #79's rooms and 1 of 1 kitchen reviewed for pests. The facility failed to have pest control effectively treat the kitchen for roaches. The facility failed to ensure Resident #42 and #79s room were free from roaches. This deficient practice could place residents at risk of exposure to pests, diseases, infections, and diminished quality of life. Findings included: Observation and initial tour of the kitchen with the DM on 03/09/26 at 10:35 am revealed there were pest droppings in the dry storage room floor. During the dry storage observation, the right back corner of the storage room had numerous pests dropping and a small dead roach on the floor. The DM stated the rodents could carry diseases and could make the residents sick. In an interview with the DM on 03/09/25 at 10:15 AM, she said pest control comes twice a month and sprays for pest. The DM stated she has not seen a roach while she has been in the kitchen. The only sighting of roaches she knew of was the one that had just been found and pest control was requested to come in and spray. The DM stated the kitchen is kept as clean as possible to keep pests and rodents down. The kitchen staff know to report any sighting immediately so the pest control company can come in and take care of the problem. Record review of Resident #42's face sheet dated 02/26/26 revealed a 77-year-old male initially admitted on [DATE] with a diagnosis of Diabetes Mellitus (a chronic metabolic disorder characterized by high blood sugar due to insufficient insulin production or cellular resistance to insulin), Hypertension (a chronic condition where blood force against artery walls is too high) and Unspecified Mood disorder (A diagnostic category used when a person experiences significant mood disturbances that do not meet the full criteria for any other specific mood disorder) and Muscle wasting and Atrophy, not elsewhere classified. In an interview on 03/10/26 at 3:46 with Resident #42 he stated he and a family member that was visiting last week saw two large roaches in the room. Resident #42 stated the family member tried to kill the roaches but they were fast and went into the closet and could not be found. Resident #42 stated he let the CNA know and has not seen any roaches since that day. Record review of Resident #79's face sheet dated 03/09/26 revealed a [AGE] year-old male initially admitted on [DATE] and readmitted on [DATE] with a diagnosis of Peripheral Vascular Disease Peripheral Vascular disease (a slow progressive circulation disorder characterized by the narrowing or blockage of blood vessels outside the heart), Hypertension (a chronic condition where blood force against artery walls is too high), Diabetes Mellitus (a chronic metabolic disorder characterized by high blood sugar due to insufficient insulin production or cellular resistance to insulin), and Depression (a group of conditions associated with the elevation or lowering of a person's mood). In an interview on 03/10/26 at 4:00 pm with Resident #79 he stated he saw two big roaches in his room sometime last week and the roaches went toward the closet but had not been seen any roaches since then. Resident #79 stated he let the CNA know and had not seen any since then. In a second interview on 03/11/26 10:30 AM the DM stated the pest control company was called to come in on 03/09/26 to come in immediately and spray in and out of the facility and look for the area they might be coming in from. The DM stated maintenance will be and fixing any areas that might be where the pests come in. The DM stated she and the staff will make extra efforts to keep the dry pantry clean and the floor free of fallen food items. In an interview on 03/11/2025 3:42 PM with the maintenance man he stated the pest control company had been contacted to come in and treat for pests by spraying for pests indoors and outdoors. The maintenance man also stated the facility was increasing their visits from the pest control company to keep the pest problem under control. The maintenance man stated maintenance man will do repairs to any walls and closets that have holes to prevent any rodents from outside to be able to enter the facility. The maintenance man stated the kitchen staff was going to keep the kitchen clean to avoid any pests from trying to enter the facility. The administrator stated it was of importance that the facility (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	combats the problem of the pests as the pests can make residents sick. The administrator stated he, housekeeping, the kitchen staff, and DM will be monitoring the facility for pest in any other areas in the kitchen and in the facility. The maintenance man stated all staff is responsible for reporting any kind of pest throughout the facility and the residents are to tell the staff the CNA and then the CNA reports it to him and a work order will be made so the pest control company can come in a spray as needed. In an interview on 03/11/26 at 4:02 PM The administrator stated it was of importance that the facility combats the problem of the pests as the pests can make residents sick. The administrator stated he, housekeeping, the kitchen staff, and DM will be monitoring the facility for pests in any other areas in the kitchen and in the facility. The maintenance man stated all staff is responsible for reporting any kind of pest throughout the facility and the residents are to tell the staff the CNA and then the CNA reports it to him and a work order will be made so the pest control company can come in a spray as needed. In record review of the Venibra Pest Control company receipts for Pest Control dated 01/05/26,01/26/2026, 2/02/26, and the last pest control monthly visit was on 03/03/26 and sprays for gnats, roaches and silverfish. There were no extra dates added for additional visits. In record review of the Pest control Policy the state surveyor asked twice for the policy, and it was not provided. The Dietary Manager and the Maintenance Man were asked for the policy, and it was not provided to the surveyor.		