STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455560	A. BUILDING _____ B. WING _____	**09/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MCALLEN NURSING CENTER	**600 N CYNTHIA ST 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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the right to be free from abuse, for one Resident (R#1) of five residents reviewed for abuse. The facility did not protect R#1 from verbal abuse by Certified Nurse Aide B. This failure could place residents at risk for abuse. The findings were: Record review of R#1's February 2020 Medication Review Report (Physician's orders) revealed R#1 was a [AGE] year-old woman who was admitted to the facility on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's quarterly Minimum Data Set assessment, dated 07/10/20, revealed R#1: -had adequate hearing; -had clear speech; -was able to make herself understood; -was able to understand others; -had moderately impaired vision; -was cognitively intact; -had no mood or behavior changes; -required supervision with locomotion on unit, locomotion off unit and eating; -required extensive assistance with bed mobility, dressing, toilet use and bathing; and -was not steady, only able to stabilize with staff assistance when moving from seated to standing position and surface to surface transfer. Record review of the facility's Provider Investigation Report, dated 06/22/20, revealed R#1 made an allegation against Certified Nurse Aide B. R#1 said Certified Nurse Aide B used inappropriate language against R#1 and yelled at R#1 on 06/20/20 at approximately 6:30 p.m. Record review of R#1's written statement about the incident revealed: (Certified Nurse Aide B) came into leave tray. (Certified Nurse Aide B) me das un vaso de agua (R#1 asked Certified Nurse Aide B for a glass of water). Give me 20 min. (Said by Certified Nurse Aide B to R#1). Certified Nurse Aide B passed out trays and went to R#2's room to feed other resident. Hello I need ice. 3 times R#1 said. (Said by R#1 to Certified Nurse Aide B) R#1 got out of room and Certified Nurse Aide B came to R#1. What do you want?! Go back to your room or I won't give you ice. (Said by Certified Nurse Aide B to R#1). Get out of my face. You think I'm scared of you, I may not walk, but I can get up. (Said by R#1 to Certified Nurse Aide B). R#1 told Certified Nurse Aide B I'm not the only person here and I understand, but I asked you for a cup of ice nicely. Certified Nurse Aide B got in R#1's face and R#1 told Certified Nurse Aide B to get out of R#1's face I just want ice. Certified Nurse Aide B told R#1 go back to your room I'll get it when I'm finished and R#1 said I need ice for my drink and Certified Nurse Aide B told R#1 get the f*** in the room and R#1 said don't talk to me get out of my face. R#1 told someone to call nurse. In an interview on 09/22/20 at 1:31 p.m., Licensed Vocational Nurse A said he was at the nurse's station when he was notified by Certified Nurse Aide C that R#1 and Certified Nurse Aide B were having an argument. Licensed Vocational Nurse A said when he entered the hall he saw R#1 standing in the doorway of her room and Certified Nurse Aide B was standing in the opposite room. Licensed Vocational Nurse A said he observed Certified Nurse Aide B tell R#1 to, Tell the f**** truth and to not be f**** lying because it will make him look like the bad guy. Licensed Vocational Nurse A said he observed Certified Nurse Aide B be verbally abusive to R#1. Licensed Vocational Nurse A said he told Certified Nurse Aide B to go to another hall, but he refused. Licensed Vocational Nurse A said he told another nurse to take R#1 to her room. On 09/22/20 at 1:29 p.m. a telephone call was made to Certified Nurse Aide C. There was no answer, a message was left to return the phone call. R#1 was not interviewed because she passed away on 07/27/20. On 09/22/20 at 2:51 p.m. a telephone call was made to Certified Nurse Aide B. The phone call was not answered and was not returned. Record review of Certified Nurse Aide B's personnel file revealed a clear employee misconduct registry check, nurse aide registry check, and criminal history check. In an interview on 09/22/20 at 3:30 p.m., the Administrator said she was informed by staff of the incident between R#1 and Certified Nurse Aide B. The Administrator explained they investigated and interviewed staff and residents. The Administrator said they found evidence that Certified Nurse Aide B used inappropriate language and cursed at R#1. Certified Nurse Aide B was terminated. Review of the facility policy, Abuse Policy, with a revision date of 09/13/17, revealed in part: Policy: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, physical and chemical restraint not required to treat the resident's symptoms, involuntary seclusion and corporal punishment. Fundamental Information: Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.