STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455761	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Nursing & Rehabilitation Center	1013 S Bryan Rd Mission, TX 78572

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on interview and record review, the facility failed to implement its written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, for 1 of 4 residents (Resident#2) reviewed for abuse and neglect, in that: Facility staff member, CNA A did not implement their abuse policy related to reporting suspected abuse when Resident #2 was observed to be crying while Resident #2's family member was rubbing her forehead. This failure could place residents at risk of abuse and neglect. The findings were: Record review of Resident #2's face sheet, dated 09/06/24, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: Alzheimer disease, unspecified (progressive disease that destroys memory and other important mental functions), essential (primary) hypertension (high blood pressure), functional quadriplegia (a condition that causes complete immobility due to a severe disability or frailty, but is not caused by spinal cord damage or stroke), peripheral vascular disease, unspecified (narrowed blood vessels reduce blood flow to the limbs), schizoaffective disorder, unspecified (a mental health condition including schizophrenia and mood disorder symptoms). Record review of Resident #2's discharge minimum data set assessment (MDS), dated [DATE], revealed Resident #2 had a BIMS score of 99, indicating the resident was unable to complete the interview. The hearing, speech and vision section of the MDS did not include if resident was able to make herself understood by others. Record review of Resident #2's care plan with an initiated date of 06/28/24 revealed 08/31/2024 discoloration to middle of forehead. Record review of Resident #2's nursing note dated 08/31/24 at 12:33pm by LVN B stated, Nurse noted discoloration to middle of the forehead. Nurse assess [sic] the patient no facial grimace or discomfort noted at this time. Also nurse observe the [family member] of [Resident #2] is touching and rubbing the skin (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's pain assessment in advanced dementia dated 08/31/24 completed by LVN B did not identify any negative vocalization and identified facial expression as smiling or inexpressive. Record review of CNA A's statement dated 09/03/24 about Resident #2's on 08/31/24 did not include any verbiage regarding Resident #2 crying. Record review of Resident #2's physician orders on 09/06/24 revealed an order for Xarelto 2.5MG to be given once daily for peripheral vascular disease with a start date of 06/17/24 and an indefinite end date. Record review of Resident #2's physician orders on 09/06/24 for Xarelto revealed it was classified as an anticoagulant. During an interview with LVN B on 09/05/24 at 5:03pm she stated on 08/31/24 either Resident #2's family member or CNA A notified her of the discoloration to Resident #2's forehead but she could not recall. She stated when she went to assess Resident #2 she noted family member for Resident #2 rubbing her forehead, and stated it was like friction to the forehead. LVN B stated Resident #2's family member was telling her to look at the discoloration which LVN B stated she did note to the middle of her forehead. LVN B stated at the time the discoloration was identified there were no allegations of abuse made. LVN B stated she made notifications to Resident #2's responsible party, DON and the Administrator. During and interview with LVN C on 09/05/24 at 5:30pm he stated on 08/31/24 Resident #2 was not his patient but he went with LVN B to assess Resident #2. LVN C stated Resident #2's family member was doing a swiping motion to Resident #2's forehead. LVN C stated Resident #2 had no signs of pain, no grimacing, no moaning and states she was just sitting in her chair. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA A on 09/06/24 at 3:32pm she stated on 08/31/24 at around 11:00AM Resident #2's family member requested for Resident #2 to be taken out of bed and brought to her in the common area. CNA A stated when she took Resident #2 to her family member in the common area she did not have any discoloration to her forehead. CNA A stated Resident #2's family member then requested a pillow and CNA A went to get it and when she returned she noted Resident #2's family member standing over Resident #2 rubbing Resident #2's forehead while Resident #2 was crying. CNA A stated Resident #2 was not verbal, and her crying could have meant she was in pain. CNA A stated she went to report to LVN B that Resident #2 was crying and that her family member was rubbing her forehead. CNA A stated shortly after that Resident #2's family member went to tell the nurses that Resident #2 had a bruise. CNA A stated she felt it was abuse because Resident #2's family member was hurting Resident #2. CNA A stated she told LVN B about Resident #2 crying and making voices but did not mention she thought Resident #2's family member was abusing her because she did not want to assume things. CNA A stated she had been trained over abuse and neglect at the facility via in-services by the DON and stated she was trained to immediately report any suspected or witnessed abuse to the nurse, ADON, DON and Administrator. CNA A stated she did not report to the Administrator because she did not know the Administrators personal phone number and did not know she was supposed to go to the Administrator. CNA A stated she thought she had to follow the chain of command when reporting and thought LVN B would report to the Administrator. CNA A stated on 09/04/24 she spoke to the Administrator and told him she felt like Resident #2's family member was abusing Resident #2. CNA A stated she told the Administrator she thought Resident #2's family member was hurting Resident #2 because she was crying, and the family member was telling her not to cry. CNA A stated it was important to report abuse for the patient's safety. CNA A stated she did not know the facility policy for reporting before but had since learned it. CNA A stated not reporting abuse could negatively impact residents because if they don't report the abuse then they will keep getting abused. During an interview with the DON on 09/06/24 at 6:02pm she stated staff had been trained over abuse and had been trained to report suspected abuse to the Administrator right away. The DON stated Resident #2 was identified with a bruise to her forehead on 08/31/24. The DON stated LVN B called her and told her that Resident #2's family member was rubbing Resident #2's forehead and after that she went and told the nurses that Resident #2 had a bruise. The DON stated Resident #2 had no signs of crying, pain, no facial grimacing and no other injuries or bruises noted by the nurse. The DON stated there were no allegations of abuse when the discoloration was noted and stated she did not think it was abuse because the patient was not crying. The DON stated CNA A had not reported Resident #2 crying to LVN B and stated ADON D got a statement from CNA A on 09/04/24 that did not include verbiage about Resident #2 crying. The DON stated CNA A spoke to the Administrator on 09/04/24 and did not mention Resident #2 crying. The DON stated her, and the Administrator did not know about Resident #2 crying until 09/06/24. The DON stated she asked LVN B if Resident #2 was crying, and she stated she was not. The DON stated the allegation of abuse was made by CNA A to Surveyor E on 09/06/24 unless CNA A told the Administrator something on 09/04/24. The DON stated CNA A should have reported the suspected abuse to the Administrator. The DON stated CNA A had been trained over reporting abuse on 08/29/24 and 09/04/24 and had been given a 1:1 counseling for not reporting possible physical abuse. The DON stated it was important to report abuse to make sure the residents were well taken care of. The DON stated the facility policy stated to report to the Administrator right away when abuse was suspected or witnessed. The DON stated CNA A did not follow the facility policy when she initially reported because she did not say anything about Resident #2 crying or being in pain. The DON stated not reporting abuse could negatively impact residents because it could affect their care, quality of life, and stated patients could get hurt physically and emotionally. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 09/06/24 at 6:33pm he stated staff were trained over abuse and were expected to notify him immediately if abuse was suspected or witnessed. The Administrator stated on 08/31/24 Resident #2 was identified with discoloration to her forehead by a family member who reported it to LVN B. The Administrator stated LVN B went to assess Resident #2 after she was notified on 08/31/24 and noted discoloration to forehead. The administrator stated the nurse had not noted any signs or symptoms of pain, no crying, and no distress from Resident #2 at that time. The Administrator stated at the time the discoloration was identified on 08/31/24 there were no allegations or suspicions of abuse. The Administrator stated CNA A had not mentioned Resident #2 crying to the nurse on 08/31/24 and stated CNA A provided a statement on 09/03/24 that did not mention abuse or neglect. The Administrator stated CNA A first alleged abuse on 09/04/24 when she told him that she felt the incident with Resident #2's bruising on 08/31/24 was possible abuse. The Administrator stated due to the allegation he then made a self-report at 3:14pm on 09/04/24. The Administrator stated he asked CNA A if she felt Resident #2's family member was trying to cause a mark and CNA A stated yes that it was being done intentionally and she was rubbing hard. The Administrator stated CNA A should have reported any suspicion of abuse to him and stated it was important to report abuse so that they could investigate thoroughly and report to state and keep it from happening. The Administrator stated he and staff monitored and ensured residents were free from abuse and neglect in the facility by doing continuous in-services, completing safe surveys with residents and talking about them during resident council meetings, completing weekly head to toe assessments, and ensuring staff monitored residents for any signs of abuse or neglect with every enteraction. The Administrator stated the facility policy reflected their training to report all suspicions and allegations of abuse to him. The Administrator stated CNA A did not follow the facility policy in regard to reporting The Administrator stated not reporting abuse could negatively impact resident because it would allow abuse to continue. The Administrator stated Resident #2 had no recent falls or other incidents that could have caused bruising and stated after their investigation they determined that the bruising likely came from Resident #2's family member rubbing her forehead. Record review of facility in-services revealed CNA A had been trained over reporting allegations of abuse and neglect on 08/29/24. Record review of a document titled, Record of Disciplinary Measure revealed on 09/04/24 CNA A received counseling over her failure to report an abuse allegation to the abuse prohibition coordinator, the Administrator when she witnessed possible physical abuse on 08/31/24 and did not report until 09/04/24. Record review of facility policy titled Reporting Abuse to Facility Management with a revision date of December 2009 included a section titled, Policy Interpretation and Implementation that included the following verbiage: 5. Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing Services.