

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455761	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2026
NAME OF PROVIDER OR SUPPLIER Mission Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles in 1 of 4 medication carts (700 hall medication cart) reviewed for medication storage. The facility failed to ensure the medication aide medication cart for 700 hall was secured by a lock when it was left unattended by MA A. This failure could place residents at risk of injury if medication left unsecured was consumed. Findings include: Findings include: During an observation on 1/2/2026 at 5:00 PM the 700 Hall medication aide medication cart was left unlocked and unattended on 700 hallway. MA A approached the medication cart and noticed it was unlocked and secured the cart by locking it. There was no one around the medication cart while MA was inside a room. During an interview on 1/2/2026 at 05:05 PM MA A revealed she was responsible for the medication cart that was left unlocked. She stated she was expected to lock the medication cart when she walked away from it. She stated if it was left unlocked then a resident could open a drawer and take anything that was not for them or medications could get stolen. She stated she forgot to lock the cart. During an interview on 1/3/2026 at 02:18 PM the DON revealed numerous staff, which included her and the ADON, were responsible for ensuring medications carts were locked. The DON stated her expectation of staff when they walked away from the medication cart was to lock it. The DON stated the negative outcome for leaving the cart unlocked was a resident or visitor could grab the medication from the cart, and it could harm them. She stated she provided in-services to the staff, and she visually monitored daily. Record review of the facility's, undated, policy Security of Medication Cart: revealed The medication cart shall be secured during medication passes. Medication carts must be securely locked at all times when out of the nurse's view. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room</p>

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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