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	01/08/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on interview and record review, the facility failed to ensure residents have the right to request, refuse, and or discontinue treatment and to formulate an advance directive for 1 (R#22) of 4 residents whose records were reviewed for OOH-DNR Order forms: The facility failed to have the physician sign at the bottom of R#22's Out of Hospital Do Not Resuscitate (OOH-DNR) order, which mad the advance directive invalid. This failure could place residents at risk for not having their end of life wishes honored. The findings included: Record review of R#22's admission record dated 01/08/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] and an initial admitted [DATE]. Her diagnoses included Dementia (A loss of brain function that worsens over time and affects memory, thinking, behavior, and language), and Crohn's disease (inflammatory bowel disease that causes swelling and irritation of the tissues in the digestive tract). Record review of R#22's quarterly MDS assessment dated [DATE] reflected a BIMS score of 1, indicating R#22 cognition was severely impaired. Record review of R#22's quarterly care plan dated 10/23/24 reflected a focus of: [R#22] had a code status of OOH-DNR. Date Initiated: 05/02/24 Revision on: 09/10/24. Interventions included: A copy of the OOH-DNR would be kept in the R#22's medical chart readily available for all to see. Date Initiated: 09/10/2024, and in the event that [R#22] arrested no efforts to resuscitate would be provided in accordance with the Resident wishes. Date Initiated: 09/10/24 Record review of R#22's medical orders reflected an OOH-DNR order dated 10/05/24. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of R#22's Out-Of-Hospital Do-Not-Resuscitate (OOH-DNR) dated 04/06/24 reflected there was no physician signature at the bottom section stating, all persons who have signed above must sign below, acknowledging that this document has been properly completed. An interview on 01/07/24 at 11:05 a.m., SW said part of her duties was to assist the facility's residents and or their representatives understand their end of life wishes. She said if a resident or their representative opted to be a DNR, she would initiate the process by first making sure they understood what a DNR meant and to assist them in completing the OOH-DNR form. She said the form required the resident or their representative, 2 witnesses and their physician signature. She said once the resident or representative and the 2 witnesses signed the OOH-DNR form she would email the form to the resident's PCP and the hard copy would be kept in the facility in case the PCP would visit the facility. The SW said after the resident/representative and 2 witness signed the OOH-DNR form, she would notify the resident's charge nurse so they could obtain a verbal order from their PCP and code the resident appropriately on their electronic medical record. She said that she would give the original OOH-DNR form to the medical records personnel for her to assist in obtaining the primary care PCP signature. The SW said once the facility received the OOH-DNR form signed by the resident's PCP, it would be given to the medical records department to make sure it was completed correctly. If it were correctly completed it would be uploaded to the resident's electronic medical record, a copy would be kept in the nurse's station, and in her office in case of a power outage. She said as long as the form had the physician's signature under physician's statement and the date it was signed it would be considered valid. She said the physician did not have to sign the bottom portion of the OOH-DNR form that stated, All persons who have signed above must sign below, acknowledging that this document has been properly completed. The SW said if a resident were to code, nursing staff would check their electronic medical record under face sheet to check their code status. She said if a resident were coded a DNR, the nursing staff would also check the uploaded DNR form to make sure the form had been signed by the resident/representative, 2 witnesses, and their PCP to be considered a valid form. If the form were missing any of the required signatures, the resident would be considered full code. An interview and observation on 01/07/25 at 11:37 a.m., Medical Records specialist said she would assist the facility's SW in obtaining the resident's PCP signature on their OOH-DNR form. She said as soon as the SW gave her the OOH-DNR form she would walk the form over to the PCP for their signature. She said she once she obtained the PCP's signature, it would the SW's responsibility to make sure the form had been completed correctly. The Medical Records Specialist said as long as the resident's PCP had singed under the physician's statement it would be considered valid. She was observed checking R#22's medical file and pulled out the OOH-DNR form and said it was considered valid because her PCP had signed under physician's statement. She said the OOH-DNR form did not need the physician's signature on the bottom portion of the form that stated, All persons who have signed above must sign below, acknowledging that this document has been properly completed. An interview and observation on 01/07/25 at 1:05 pm, LVN B was observed checking R#22's electronic medical record and said R#22 had a code status of DNR. She said if a resident coded, she would first check their electronic medical record for their code status under their face sheet and then proceed to check the actual OOH-DHR form under miscellaneous tab to ensure the form had all required signatures. She said R#22's DNR was considered valid because it had a physician's signature. LVN B said had been in-serviced in resident's code status when she was first hired and as needed. She said if the OOH-DNR form was missing a required signature, it would be considered invalid, and the resident would be a full code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/08/25 at 8:35 a.m., LVN C said if a resident were to code, he would immediately check their electronic medical record under their face sheet to see what their code status was. He said he would then check the resident's miscellaneous tab to ensure the OOH-DNR form had the resident/RP, 2 witnesses, and physician's signature. He as long as the physician singed under the physician's statement it would be considered a valid form. LVN C said he had been in-serviced in DNR protocols. He said if the OOH-DNR form was missing a required signature, it would be considered invalid, and the resident would be a full code. An interview on 01/08/25 at 8:41 a.m., ADON she said if a resident were to code, nurses would check their electronic medical record under profile to check what their code status was and then check the resident's OOH-DNR form to ensure all required partied had signed. The LVN/ADON said as long as the OOH-DNR had the physician's under Physician's statement it would be considered valid. She said staff have been in-serviced on the topic of DNR quarterly or as needed. She said if the OOH-DNR form was missing any of the required signature they would be considered full code. An interview on 01/08/25 at 8:50 a.m. DON said the facility's SW was responsible to assist the resident or their representative with their code status decisions. She said if a resident or their representative opted to be a DNR, an OOH-DNR form was required. A completed OOH-DNR form was uploaded to the resident's electronic medical record for nursing staff to have easy access to the form. She said the OOH-DNR form required to have the signatures of the resident or representative, 2 witnesses signatures and the PCP's signature under physician's statement to be considered valid. The DON said if a resident were to code, nursing staff would check their electronic medical record face sheet to check what their code status was. They would next need to check the miscellaneous tab to ensure the actual OOH-DNR form had all required signatures. She said if the OOH-DNR form was missing any of the required signatures, it would be considered invalid, and the resident would be a full code status. She said the OOH-DNR form did not need the physician's signature on the bottom portion of the form that stated, All persons who have signed above must sign below, acknowledging that this document has been properly completed. Record review of the facility's Do Not Resuscitate Order (revised April 2017) reflected: Policy Statement: Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain like functions on a resident when there is a Do Not Resuscitate Order in effect . Policy Interpretation and Implementation: 1. Do not resuscitate orders must be signed by the resident's attending physician on the physician's order sheet maintained in the resident's medical record. 2. A do not resuscitate (DNR) order form must be completed and signed by the attending physician and resident (or resident's legal surrogate, as permitted by state law) and place in the front of the resident's medical record .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301 Based on observations, interviews, and record review the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 4 residents (Resident #34) reviewed for respiratory care. The facility failed to ensure Resident #34 received oxygen at the prescribed rate. This failure could place residents at risk for respiratory distress. The findings included: Record review of Resident #34's face sheet dated 1/6/25 reflected the resident was an 81 -year-old male admitted to the facility on [DATE]. Resident #34 had diagnoses which included the following: acute (rapid onset) and chronic (persistent and long-lasting) respiratory failure, acute bronchitis (inflammation of the bronchial tubes in the lungs), and chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems). Record review of Resident #34's MDS assessment, dated 12/16/24, reflected the resident had a BIMS score of 15 which suggests cognitively intact. Special treatments, procedures, and programs reflected resident received oxygen therapy. Record review of the most recent Care Plan for Resident #34, dated 12/18/24, reflected the resident had Oxygen Therapy r/t CHF, Respiratory illness Date Initiated: 12/13/2024. Interventions reflected: Give medications as ordered by physician. Oxygen Settings: O2 via nasal cannula at 3L continuously. Record review of the Doctor's Order Summary dated 1/6/25 reflected Resident #34 was prescribed O2 3L via nasal cannula every shift start date 12/20/24. Record review of the MAR for January 2025 reflected the resident was prescribed O2 3L via nasal cannula every shift -Start Date- 12/20/2024. Observation on 01/06/25 10:05 AM Resident #34 observed in room sitting up in bed head of bed elevated and receiving O2 at 4Lpm via NC. Resident #34 verbalized that was the rate he received at home and that he has informed staff the same. Resident denied any headache, dizziness, or other not normal symptoms. Observation on 01/06/25 at 5:58 PM Resident #34 observed in room sitting up in bed with head of bed elevated and receiving O2 at 4 Lpm via NC. Resident denied any headache, dizziness, or other not normal symptoms. Observation on 01/07/25 10:32 AM Resident #34 observed in room sitting up in bed with head of bed elevated and receiving O2 at 3.5 Lpm via NC. Resident denied any headache, dizziness, or other not normal symptoms. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/7/25 at 10:45 am with LVN J she said the orders for Resident #34's oxygen say he should receive 3L of oxygen via nasal cannula. She said they must check rate every 2 hours when check on resident or as needed. She said she checked on O2 and that call light was in reach every time she went in the room. She said she went into Resident #34's room about 15 minutes ago and the O2 was set at 3L and that she did not have to adjust the flow rate. She said LVN K, the charge nurse also checked prior told her it was set at 3L. She said they also checked on O2. She said Resident #34 was not able to change the setting himself because the concentrator was too far from him, and that he was aware he was not to be moving the rate. LVN J said Resident #34 does get visitors. The family member was very supportive. LVN J said she had not witnessed Resident #34's family member changing the oxygen setting. LVN J said that if a Resident was receiving more oxygen than prescribed, they could have hyper oxygen and that could damage the lungs. LVN J entered Resident #34's room to check the oxygen settings with surveyor. O2 setting was at 3L at that time. In an interview on 1/7/25 at 11:05 am LVN K. She said she went into Resident #34's room a few minutes ago. She said she adjusted the O2 setting when she went in his room and made sure it was at 3L. LVN K said Resident #34 was non-compliant on certain things but did not know if the resident moved the setting or not because she had never witnessed. She said they usually check the O2 settings every time they go into a Resident's room. She said if the oxygen was set higher than prescribed, it could affect a Resident's overall condition with their lungs depending on their diagnosis. LVN K said she believed nursing staff got checked-off yearly on oxygen administration. LVN K said they used to have an RT provide in-services but now ADON/LVN or DON in-service nursing staff. In an interview on 1/7/25 at 11:17 am ADON/LVN. She said if an order reads for 3L of oxygen to be administered, it should be followed. If oxygen was bumped up, would have to get an MD order. ADON/LVN said if a resident received too much oxygen and had COPD (Chronic Obstructive Pulmonary Disease - a chronic lung disease caused by damage to the lungs that leads to inflammation and swelling in the airways which limits airflow and makes breathing difficult) as a diagnosis, it could be a problem. ADON/LVN said they could get acidosis. She said if a resident was given 4 L of oxygen and the order reads 3L and there was no order for the increase, then it was considered a medication error. The ADON/LVN said they do in-services on oxygen therapy frequently and skills checkoffs were also done by the DON. In an interview on 1/7/25 at 12:00 pm the DON stated that LVN K called the family member of Resident #34, and family member said that she adjusted the resident's oxygen rate at times. The DON said the family member was informed that was not allowed. The DON said they started in-servicing staff and will complete care plan to include family adjusts O2 rate. In an interview on 1/8/24 at 7:00 pm DON, she said the order for Resident #34's oxygen was for 3L. She said the frequency for checking oxygen settings is case by case depending on what the order said. DON said that for Resident #34, the order said check every shift. The DON said the adverse effect for a resident receiving more O2 than prescribed could be hyperoxemia (a condition in which there is too much oxygen in the blood usually caused by high levels of oxygen) if receiving more oxygen than prescribed. The DON said Resident #34's original order that he received from hospital was 2-4 Lpm. The DON said the resident was not over oxygenated. She said his O2 saturations were not over oxygenated and there were no signs of distress while under their care. She said if any signs of distress had been noticed a change in condition would have been completed and they would have notified the doctor. The DON said the nurses were following the orders, they did not change it and they do not check the prescribed rate frequently because he is not one-on one care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Oxygen Therapy skills check-off reflected: Purpose: Validation of skills associated with administering oxygen therapy: 1. Oxygen is a medication and should not be adjusted without a physician's order. 4. Attach oxygen deliver device (e.g., cannula, mask to oxygen tubing) and attach to humidified oxygen source adjusted to prescribed flow rate, usually between 1 and 6 L/min. 8. Assess flow meter and oxygen source for proper setup and prescribed flow rate. Record review of the facility's record of in-service dated 10/24/24 reflected: Objectives of the In-Service . Brief evaluation of the participants' responses to the in-service: Oxygen policy (Administration, Assessments, etc.) . Record review of the facility's most recent Record of in-service dated 1/7/24 reflected In-service of oxygen settings: Objectives of the In-Service: 1. Always assess all residents for the need of oxygen 2. Follow O2 orders as stated from MD 3. Us of O2 for emergencies doesn't require an order 4. Therapy can adjust momentarily if needed for SOB, but must notify charge nurse to contact MD. 5. All changes to O2 will dictate a change of condition and need MD Notification 6. Always check concentrator vs orders with each entry. Record review of facility's Oxygen Administration policy revised March 2004, reflected: Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure . 8. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute 10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. 13. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on interviews and record reviews, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable, physical, mental, and psychosocial well-being for 1 (CNA D) of 4 CNAs reviewed for competent nursing care. The facility failed to ensure CNA D communicated R#22's change of condition to the charge nurse on 12/23/2024. This failure could place residents at risk of not having change in conditions assessed immediately resulting in delayed treatment and a decreased in quality of life. The findings included: Record review of R#22's admission record dated 01/08/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] and an initial admitted [DATE]. Her diagnoses included Dementia (A loss of brain function that worsens over time and affects memory, thinking, behavior, and language), and Crohn's disease (inflammatory bowel disease that causes swelling and irritation of the tissues in the digestive tract). Record review of R#22's quarterly MDS assessment dated [DATE] reflected a BIMS score of 1, indicating R#22 cognition was severely impaired. Record review of R#22's weekly skin review dated 12/24/2024 at 7:53 a.m., reflected: redness to her right upper arm, chest, and abdomen. RP and physician had been notified on 12/24/2024. Record review of R#22's progress note on 12/26/2024 at 5:44 a.m., authored by LVN A reflected: CNA D stated that since Monday she has noticed a small rash on her left side. Since then, the rash has progressed all over her upper chest down to her abdomen and both of her arms. The resident states no discomfort but you can tell she visibly has been scratching herself nonstop. I gave the patient Hydrocortisone for the itchiness during the night. I let NP know about the situation and am awaiting new orders. Record review of R#22's change in condition evaluation effective 12/26/2024 reflected: signs and symptoms identified as other change in condition (red bump rash all over upper body) and change in skin color or condition. Date stated signed 12/23/2024. Vitals were within normal range. R#22's primary care clinician notified on 12/26/2024 at 5:55 a.m. and he recommended for R#22 to be applied Permethrin cream neck below x1 for dermatitis. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/07/24 at 2:46 p.m., CNA D, said her regular work schedule was the overnight shift. She said on 12/23/24, she went into R#22's room and noticed she was scratching her chest. She said she noticed R#22 had a rash which she described being red bumps on her chest. She said the rash looked like an allergic reaction. She said she told herself she was not going to report it to her charge nurse until the following day and see if it went away. She said on 12/24/24, she checked the resident's chest again and noticed the rash had already run down to her breast area and at that point she told herself she needed to report it immediately to her charge nurse but got occupied with other residents and forgot to report it. She said on 12/25/24 she was assigned a different hall and did not reported it. CNA D said on 12/26/24 she was assigned R#22's hall and went to check on R#22 and noticed it was really bad, like if she had chicken pox, a lot of red dots from her chest down to her belly, and her back. She said R#22 was non-verbal but did not display any facial grimacing. She said after seeing R#22's rash had gotten worse, she immediately reported it to LVN A. She said she and LVN A went back to R#22's room and observed LVN A assess the resident. She said LVN A took a picture of the rash and sent it to R#22's NP. CNA D said she had been in-serviced in recognizing changes in residents and reporting them to their charge nurse immediately. CNA D was not able to say how her not reporting R#22's rash to her charge nurse immediately could have negatively impacted her. A telephone interview on 01/07/24 at 3:37 p.m., LVN A said on 12/26/24, CNA D communicated to her that R#22 had a rash on her chest, belly, and back and had been seen scratching nonstop. LVN A described the rash as being pinkish/red bumps. She said she took a picture and notified R#22's NP. She said while she was waiting for NP's response, she applied hydrocortisone to alleviate the itchiness during the night (which she had a standing order). She the NP responded the same day and prescribed Permethrin cream to be applied from the neck down, one time only for dermatitis. She said she did a change of condition on 12/26/24. She said, resident was not in pain or any discomfort just itchy. She said CNA D told her she had first noticed the rash on R#22 on 12/23/24. LVN A said any skin discolorations, skin tears and or rashes should be reported to the charge nurse immediately. An interview on 01/08/25 at 9:19 a.m., CNA E said that on 12/24/24 she had given R#22 a bed bath and noticed the resident had a rash on chest, stomach, arms and back. She said she immediately notified LVN E and she informed the treatment nurse. She said she was in-serviced in recognizing change in conditions and to report any changes to her charge nurse immediately upon being hired, quarterly, or as needed . An interview on 01/08/25 at 9:25 a.m., LVN L said on 12/25/24 she was R#22's charge nurse. She said R#22 had a standing order for hydrocortisone cream to be applied every morning to her arms and legs due to dry and itchy skin. She said couple of months ago, R#22 broke her right arm and required to wear sling. She said R#22 did not like the sling and constantly tried to remove it. She said R#22 would use her left hand to try to remove the sling and while doing so, she would scratch her chest and abdomen area in the process. She said CNA E had told her she had noticed a rash on R#22's chest and abdomen on 12/24/24. She said she assessed R#22 and determined that the rash was due to R#22 trying to remove the sling. LVN L said she immediately informed the wound care nurse who told her to just monitor R#22 since she already had scheduled orders for hydrocortisone. She said if a CNA noticed any skin discoloration, they need to let their charge nurse know immediately. She said the charge nurse would advise the resident's PCP, RP, ADON/DON and do a change in condition evaluation. She said nursing staff, and CNA 's have received in-services on what to do when change of condition skin occur and what steps to follow. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/08/25 at 10:05 am, Treatment nurse/LVN said she was responsible for conducting weekly skin assessments on R#22. She said she had done a skin assessment on 12/24/24 and noticed a slight redness on her chest and abdomen, she said no blisters or open areas. She said R#22 required to wear a sling on her right arm and would constantly try to remove it. She said R#22 would pull down the sling and the movement of her trying to remove it caused the redness to her chest and abdomen area. She said it was reported to RP and PCP on 12/24/24. She said the PCP recommended for R#22 to be monitored. An interview on 01/08/25 at 10:56 a.m., NP said he received a call from the facility on 12/26/24 to inform him R#22 had a rash to her chest, abdomen, and back. The NP said the facility's nurse sent him a picture of R#22's chest and abdomen area. He said he prescribed a 1-time application of topical ointment called Permethrin to be applied to her neck and below for the diagnosis of dermatitis. He said the ointment he prescribed was for a 1 time use only. He said 12/26/24, he had not been updated on R#22 skin condition. An interview on 01/08/25 at 3:35 pm, DON said the CNA 's have been in-serviced to report any change in condition to their charge nurse as soon as possible. She said CNA 's can bathe residents but are not supposed to diagnose residents because they do not have a license to assess. She said CNAs were in-serviced on the topic of change of conditions and what to report. The DON said there were no negative outcome for R#22 since CNA E had previously reported her rash on 12/24/24 and the facility had already acted on treating the rash. The DON said the facility did not have a policy that indicated how long the CNA had to report a change in condition but were in-serviced on reporting it immediately to their charge nurse.

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Mission Nursing & Rehabilitation Center	1013 S Bryan Rd Mission, TX 78572

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 26141 Based on interview and record review, the facility failed to provide pharmaceutical services including procedures that ensure accurate administering of all drugs and biologicals to meet the needs for 2 of 10 (Resident #5 and Resident #22) residents reviewed for pharmacy services. 1. The nursing staff did not administer Resident #5's Tramadol as prescribed by her physician. This failure could place resident s with pain at risk of not receiving the intended therapeutic benefit of their medications. 2. MA documented she had administered Resident #22 a frozen nutritional treat on 01/07/2025 when the facility did not have the frozen nutritional treat available on 01/07/2025. This failure could place residents at risks of not receiving the intended therapeutic benefit of their medications. The findings were: Record review or Resident #5's Admission Record dated 01/08/25 revealed an [AGE] year-old female with an initial admitted [DATE] with diagnoses of Alzheimer's disease (a progressive irreversible brain disorder that destroys memory ad thinking skills), Heart failure, and Type 2 Diabetes mellitus with unspecified complications (a disease that occurs when your blood glucose, also called blood sugar, is too high). Record review of Resident #5's Physician's Orders for January of 2025 revealed an order for Tramadol HCl oral tablet 50 mg (Tramadol HCl) give two tablets by mouth every 8 hours as needed for Pain. Give 2 tablets of 50 mg to equal 100 mg prn q8h, start date of 04/09/24. Record Review of Resident#5's Quarterly MDS assessment dated [DATE] revealed Resident #5 had a BIMS of 07 that indicated Resident #5 had severe cognitive impairment and had received scheduled pain medication regimen within the past five days. Resident #5 replied to no to having had pain or hurting at any time withinn the past five days. The question for pain intensity was blank. Record review of Resident#5's Care Plan revised on 04/18/24 stated Resident #5 had the potential for pain r/t Depression, wound (admitted with stage 3 PU to sacrum) with interventions to anticipate resident's need for pain relief and respond immediately to any complaint of pain and to observe/record/report to nurse resident complaints of pain or requests for pain treatment. Record review of Resident #5's e-MAR dated July of 2024 revealed an order for tramadol HCl Oral tablet 50 mg, give 2 tablets by mouth every 8 hours as needed for pain. Give 2 tablets to equal 100mg prn q8h, start date 04/09/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Control Drug Administration Record dated 06/05/24 for Resident #5 revealed Tramadol 50 mg tab give 1 tab by mouth every 8 hours as needed. The Control Drug Administration record revealed only 1 tablet was administered on the following dates: *06/09/24 at 9:52 p.m., *06/10/24 at 11:00 a.m., *06/11/24 at 9:45 p.m., *06/17/24 at 8:05 p.m., *06/22/24 at 9:41 p.m., *06/30/24 at 1:52 a.m., *07/04/24 at 5:54 p.m., *07/06/24 at 1:16 a.m., *07/07/24 at 7:41 a.m., and *07/11/24 at 5:50 a.m. In an interview on 01/07/24 at 2:30 p.m., the DON said there might be a difference in the order on the blister pack/Controlled Drug Administration log and the e-MAR because the physician called the pharmacy directly. The DON said when that happens the facility does not get the orders. The DON said the nurse should have called the physician to clarify the order. In an interview on 01/08/25 at 6:43 p.m., LVN J said she administered the tramadol on dates 07/07/24 and 07/20/24.LVN J said when passing out medications she verified that the medication was accurate by checking the resident's name, the right route, the right dosage, right time, and right medication. LVN J said she checked the PCC under the MARS tab. The medication was tramadol 50mg every eight hours, one tablet as needed. On 07/07/24 LVN J said she gave one tablet to Resident #5 and on 07/20/24 she gave Resident #5 two tablets. LVN J said if there was a PRN order, she would check the MAR for PRN orders and would compare the blister pack with the sheet. If there were any changes to the order, there would be a sticker on the blister pack indicating a change. LVN J said if they made an error, they would call the doctor and the DON. Then they would get a new blister pack, or they put in the new information in electronic medical record for other staff to follow. LVN J said the negative effect was that the resident would not have the correct dosage to relieve her pain. LVN J said they received the sealed pack from the pharmacy, and she would open it and compare the blister pack to the orders in the MAR. If the order is incorrect, they would call the doctor to ask for a new prescription. LVN J said she did not call the doctor to verify the orders. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/08/25 at 7:00 p.m., LVN C said he administered the tramadol medication on 07/09/24 for two tablets and on 10/26/24 it was one tablet. LVN C said to verify if administering the correct medication, he would check the MAR to make sure it was the right route, right resident, right time, and right dosage. He would check the order and the log. LVN said he would then take the blister pack and pop the medication out. The LVN said if there was a change in direction there would be a sticker with a change in direction or to refer to the MAR. LVN C said he did notice a discrepancy on the log and noticed that the order said one tablet. LVN said on the time that he administered one tablet he looked at the order on the blister pack and when he gave the two tablets, he probably looked at the MAR. LVN C said if he had caught the mistake, he would have called the doctor and he would not have administered the medication. LVN C said he did not call the doctor to clarify the orders. LVN C said they did have an in-service on medication administration conducted by the DON. LVN C said the negative outcome of one tablet would be that the resident's pain would not be relieved but if he gave the two tablets the resident would just be sedated and relaxed. An interview on 01/08/25 at 7:10 p.m., The DON said nursing staff were responsible to sign off any medication given or not given to residents. She said nursing staff and med aides were supposed to check the e-MAR and label to make sure they matched. The DON said nursing staff and med aides are in-serviced quarterly or as needed on the topic of medication administration. The DON said if a medication was signed off on the resident's e-MAR when it was not administered it could cause them to not get the full effects of the medication. The DON said she had called the physician and he had clarified the order. In an interview on 01/08/25 at 07:15 p.m., the Administrator said he did not have very much to do with the nursing procedures. The Administrator said they had the daily clinical meetings, and they went over the 24-hour report and any other concerns. There was follow through throughout the day. The nursing department followed through with concerns such as orders, treatments, and resident care. They also had managers on duty during the weekend and they had an RN that also worked during the weekend for any issues that came up. Record review of facility's policy for Medication and Treatment Orders revised in July 2016 revealed: Policy Statement Orders for medications and treatments will be consistent with principles of safe and effective order writing. 1. Medications shall be administered only upon written order of a person duly licensed and authorized to prescribe such medication in this state. 9. Orders for medications must include: a. number and strength of drug b. Number of doses, start and stop date, and/or specific duration of therapy. c. Dosage and frequency of administration (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Route of Administration e. Clinical condition or symptoms for which medication is prescribed; and f. Any interim follow-up requirements (pending culture and sensitivity reports, repeat labs therapeutic medication monitoring, etc.) Record review of facility's policy for Administering Medications revised in December 2012 revealed: Policy Statement Medications shall be administered in a safe and timely manner, and as prescribed. 1. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. 3. Medications must be administered in accordance with he orders, including any required time frame. 5. If a dosage is believed to be inappropriate or excessive for the resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns. 7. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time, and right method, (route) of administration before giving the medication. 18. If a medication is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial, circle the MAR space provided for that drug and dose. 19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 20. As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered. b. The dosage. c. The route of administration. d. The injection site (if applicable). e. Any complaints or symptoms for which the drug was administered, and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Any results achieved and when those results were observed, and g. The signature and title of the person administering the drug. 2. 2. Record review of Resident #22's admission record dated 01/08/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] and an initial admitted [DATE]. Her diagnoses included Dementia (A loss of brain function that worsens over time and affects memory, thinking, behavior, and language), hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), and Crohn's disease (inflammatory bowel disease that causes swelling and irritation of the tissues in the digestive tract). Record review of Resident #22's quarterly MDS assessment dated [DATE] reflected a BIMS score of 1, indicating Resident #22 cognition was severely impaired. Record review of Resident #22's quarterly care plan dated 10/23/204 reflected a focus of unintended weight loss on 01/05/2024 of 6 months trigger with 7-pound loss, 4 pounds in 3 months with BMI of 13.2. Date initiated 11/28/2022 and revised on 05/14/2024. Interventions included to provide a frozen nutritional treat daily as a supplement .continue with current care plan per registered dietician. Record review of Resident #22's MAR for the month of January 2025 reflected an order for a frozen nutritional treat one time a day for supplement, start date of 03/09/2022. Med-Aide had signed off on 01/07/2024 at 12 noon. Record review of Resident #22's meal ticket dated 01/07/2025 reflected a regular-puree diet. She was served pureed classic baked ziti-8 oz, pureed parmesan and herb roasted cauliflower, pureed garlic bread, pureed chocolate brownie, pudding, tea, and for frozen nutritional treat was scratched off with a note saying, not available. An observation and interview on 01/07/25 at 1:17 p.m., CNA E was observed feeding Resident #22 in her room during her lunch meal. Resident #22 had been served pureed ziti, pureed parmesan & herb roasted cauliflower, pureed garlic bread, pureed brownie, and a cup of chocolate pudding. CNA E said Resident #22 had eaten about 75 % of her meal. CNA E said Resident #22 had not received her frozen nutritional treat and didn't know why. CNA E said Resident #22 would get a frozen nutritional treat daily with her lunch tray. An observation and interview on 01/07/25 at 1:30 pm, Dietary Manager Trainer said the DM had stepped out of the facility, but she was willing to answer any questions. She was observed reviewing Resident #22's medical orders on her electronic medical record and said Resident #22 had an order for a frozen nutritional treat with her lunch tray every day. She was shown a picture of resident's meal ticket for 01/07/25 where it showed the frozen nutritional treat had been scratched off and a note saying not available had been written on the bottom portion of the meal ticket. The Dietary Manager Trainer was observed checking the freezer and said they were out of the frozen nutritional treats. She was then observed calling the DM on the phone to inquire on the frozen nutritional treats and was told by the DM that the facility was out of the frozen nutritional treats, but she had already placed an order and were due to be delivered on 01/08/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/07/25 at 4:00 p.m., Med-Aide was observed when she checked Resident #22's MAR on electronic medical record and said she had signed off a frozen nutritional treat for Resident #22 on 01/07/2024 at 12 noon. She said she had not physically checked Resident #22's tray to make sure the frozen nutritional treat had been included in her lunch tray. She said she trusted the kitchen staff to include it in her lunch tray. The Med-Aide said she was supposed to check if the frozen nutritional treat had been included before signing if off on Resident #22's MAR. She Resident #22 could be negatively affected in that she was not getting the added nutritional treat that she was ordered to receive. The Med-Aide said she said had been in-serviced on medication administration when she was first hired and as needed and felt confident in performing her job duties. An interview on 01/07/25 at 4:25 pm, DM said the facility had run out of frozen nutritional treats on 01/05/25. The DM said on 01/06/25 they had substituted the frozen nutritional treat with regular ice cream. She said on 01/07/25, regular ice cream should have been included but the kitchen staff failed to put it on Resident #22's lunch tray. The DM said she had borrowed frozen nutritional treats from a sister facility to be able to administer Resident #22 until their order comes in. She said no negative outcome to Resident #22 because aside from her regular menu she had been given pudding as a supplement. An interview on 01/07/25 at 5:00 p.m., the Dietician said Resident #22 was on a 2300 calorie diet. He said Resident #22 also had orders for a frozen nutritional treat (290 calories) and pudding (150 calories) to be administered during with her lunch tray. The Dietician said Resident #22 was on a high caloric diet but was not gaining weight. He said her age and medical diagnoses were a contributing factor in her no gaining weight. The Dietician said Resident #22 had not sustained any negative effects for not receiving the frozen nutritional treat on 01/07/2025. An interview on 01/07/25 at 5:25 p.m., DON said Nurse's and Med Aides were responsible to administer residents their medication(s) and sign them off on the residents MAR after the medication(s) had been administered. The DON said if the medication was not administered for whatever reason they were to use the chart codes listed on the bottom of the MAR to indicate the reason why a medication had not been administered. She said Resident #22's frozen nutritional treat should not have been signed off by the facility's Med-Aide because it had not been administered to her. She said she and the ADON have conducted in-services to all nursing staff and med-aides on the topic of medication administration upon hire, quarterly, and or as needed. The DON said she and the facility's Dietician had discussed that on 01/07/2024, Resident #22 had not been administered a frozen nutritional treat and had agreed that there were no negative effects to Resident #22 because she had been served, he regular diet plus pudding for lunch. Record review of the facility's Documentation of Medication Administration policy revised on April 2007 reflected: Policy Statement: The facility shall maintain a medication administration record to document all medications administered . Policy Interpretation and Implementation: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. A nurse or certified medication aide (where applicable) shall document all medications administered to each resident on the resident's medication administration record (MAR). 2. Administration of medication must be documented immediately after (never before) it is given. 3. Documentation must include, as a minimum: e. reason(s) why a medication was withheld, not administered, or refused (as applicable 47828

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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** 49301 Based on observation, interview, and record review, the facility failed to establish an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for, 1 of 5 residents (Resident #32) observed for infection control issues in that: CNA F and CNA G revealed CNA F used wipes to cleanse the perineal area, folding it, and using the wipes again and CNA G noticed not sanitizing between glove changes. This deficient practice could place residents at-risk for infection due to improper hand sanitizing and incontinent care practices. The findings were: Record review of Resident #32's electronic face sheet dated 1/8/25 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnosis included unspecified sequelae of cerebral infarction (long-term complications from a stroke where specific nature cannot be clearly identified), muscle weakness, muscle wasting and atrophy (decrease in size or wasting away of muscle), and unspecified lack of coordination. Record review of Resident #32's comprehensive person-centered care plan, dated 10/23/24, reflected Resident #32 has an indwelling Catheter: neuromuscular dysfunction of bladder. Interventions included: Change catheter as indicated and observe/record/report to MD for s/sx UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Care plan also reflected Resident #32 has bowel incontinence r/t loss of bowel control. Interventions included Check resident during rounds and assist with toileting as needed, provide loose fitting, easy to remove clothing, and provide pericare after each incontinent episode. Monitor for and report to MD s/sx (signs and symptoms) of UTI (urinary tract infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Care plan also revealed Resident #32 has an ADL Self Care Performance Deficit. Interventions included: TOILET USE: The resident requires total assist of 1-2 staff for incontinent care. Record review of Resident #32's Quarterly MDS dated [DATE] reflected Resident #32 was dependent for self-care of toileting hygiene, had a catheter for urinary incontinence, and was always bowel incontinent. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an incontinent care observation for Resident #32, on 1/7/25 at 4:50 PM., CNA F and CNA G performed incontinent care on Resident #32. CNA G changed gloves twice and did not sanitize hands between glove changes. CNA F used a wipe to sanitize between labia of vaginal area wiped from clean to dirty, folded it and used the wipe again, then disposed of wipe. CNA F proceeded to wipe, fold, and wipe again 2 more times. CNA F completed cleansing vaginal area, she did not change gloves and sanitize hands prior to assisting resident on her side. CNA G applied sanitizer to gloves and assisted resident on side. She did not change gloves and sanitize hands. Resident #32 was on her other side, CNA G removed soiled diaper, then pulled clean diaper out from under resident using same gloves. CNA G then changed gloves without sanitizing between glove change. CNA F and CNA G left resident in comfortable position with call light in reach. In an interview on 1/7/25 at 5:30 pm., CNA F stated while using wipes during incontinent care, she should wipe, fold over the wipe, wipe again then dispose of wipe. She said she had never been told to only use one wipe per swipe or that she cannot fold over a wipe and use again. She said she had never been told that she must sanitize hands between glove changes. CNA F stated she had been doing this since she started working as a CNA. She said that the nurses at times assisted her when she performed pericare and had never been told she was doing anything wrong. In an interview on 1/7/25 at 5:35 pm CNA G stated that she had been performing pericare the same way since she remembered and had never been told that she must sanitize between glove changes. CNA G said she did not recall sanitizing her gloves. In an interview on 1/8/25 at 6:00 pm, DON stated she completed incontinence care check offs upon hire of staff and annually. She stated she also included in the monthly meetings and as needed. She said hand hygiene must be completed before and after care of residents, between glove changes and after every time they wipe a resident when performing incontinent care. She said CNAs were instructed to only use one wipe per swipe. DON said protocols must be followed to prevent cross contamination. Record review of Clinical Skills Checklist (CMAs and CNAs) for CNA F and CNA G dated 11/21/24 Perineal Care (Female Resident) indicated Procedure . 9. For a female resident: . a. using toilet tissue removes excess soiling as needed. b. discard soil gloves, sanitize hands and apply clean gloves c. Using the pre-moisten disposable/non disposable washcloth wash perineal area, wiping from front to back . 2. Continue to wash the perineum .Do not reuse the same pre-moistened disposable/non disposable washcloth to clean the urethra or labia 4. If needed gently dry perineum of excess moisture . b. Discard soil gloves, sanitize hands and apply clean gloves (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Using the pre-moisten disposable/non disposable washcloth wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not reuse the same pre-moisten disposable washcloth to clean the labia. Disposal a. Discard brief and other disposable items in plastic bag b. Discard soil gloves, sanitize/wash hands and apply clean gloves c. Apply clean brief on resident Record review of facility's Handwashing/Hand Hygiene policy revised August 2015, revealed: Policy Statement This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty; b. Before and after direct contact with residents; . h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin; j. After contact with blood or bodily fluids; . m. After removing gloves; . 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not r3eplace hand washing/hand hygiene. Integration of glove use along with routine hygiene is recognized as the best practice for preventing healthcare-associated infections. 10. Single-use disposable gloves should be used: a. Before aseptic procedures; (continued on next page)

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	01/08/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. When anticipating contact with blood or body fluids; .