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	04/02/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure residents were free of any significant medication errors for 1 of 3 residents (Resident #13) reviewed for pharmacy services. The facility failed to ensure Resident #13 received the correct dose of:Amiodarone HCl oral tablet 200 mg, Apixaban oral tablet 2.5 mg, and Metoprolol Tartrate Oral Tablet 25 mg. This failure could place residents at risk of medical complications and not receiving the therapeutic effects of their medications. Findings included: Record review of Resident #13's admission record, dated 03/18/26, reflected a [AGE] year-old female with an admit date of 02/16/26 and an initial admission date of 02/03/24 with diagnoses that included encephalopathy (any condition that disrupts normal brain function), dependence on renal dialysis (a life-sustaining need regular hemodialysis due to end-stage renal disease or acute kidney failure where the kidneys cannot adequately filter waste or remove fluid), angina pectoris (chest pain or discomfort caused by reduced blood flow and oxygen to the heart muscle), hypertension (a chronic condition where blood forces against artery walls too strongly), paroxysmal atrial fibrillation (an irregular, rapid heart rhythm that starts and stops on its own, usually lasting from minutes up to seven days), unspecified combined systolic and diastolic heart failure (a serious condition where the heart cannot properly pump (systolic) and cannot effectively fill (diastolic), often leading to high filling pressure, pulmonary congestion, systemic edema) and depression (a mood disorder causing persistent sadness, loss of interest, and physical symptoms like fatigue or sleep disturbances, affecting daily life). Record review of Resident #13's 5-day admission MDS assessment, dated 02/19/26 reflected a BIMS score of 12, which indicated her cognition was moderately impaired. Record review of Resident #13's quarterly care plan, dated 03/05/26 reflected the following:Focus: [Resident #13] is on anticoagulant therapy r/t atrial fibrillation, date initiated/revised on 02/17/26. Interventions included to administer med as ordered, date initiated/revised 02/17/26. [Resident #13] has the potential for respiratory distress r/t CHF, date initiated/revised on 02/17/26. Interventions included to give medications as ordered, date initiated/revised on 02/17/26. Record review of Resident #13's physician's order summary, dated 03/18/26 reflected: Amiodarone HCl oral tablet 200 mg, at 6:00 a.m. and 6:00 p.m., give one tablet by mouth two times a day related to paroxysmal atrial fibrillation, hold if HR is below 60 or SBP is below 110, start date 03/10/26. Apixaban oral tablet 2.5 mg, at 6:00 a.m. and 6:00 p.m., give one tablet by mouth two times a day related to paroxysmal atrial fibrillation, start date 02/17/26. Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol tartrate) at 6:00 a.m. and 6:00 p.m., give one tablet by mouth two times a day for htn hold if SBP is less than 110 or pulse less than 60, start date 02/17/26. Record review of Resident #13's February 2026 electronic medication administration record reflected: Amiodarone, Apixaban, and Metoprolol were not administered on 02/18/26 at 6:00 a.m. for a total of 3 missed doses. Record review of Resident #13's March 2026 electronic medication administration record reflected: Amiodarone, Apixaban, and Metoprolol were not administered on 03/04/26, 03/09/26, 03/13/26, 03/18/26, and 03/21/26 for Amiodarone and Metoprolol on 03/21/26 at 6:00 a.m. for a total 14 missed doses. February 2026Metoprolol Tartrate (25 MG) 2/18/2026 absent dialysis day Apixaban (2.5mg) 2/18/26 absent dialysis days Amiodarone (200 MG) 2/18/26 absent (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dialysis days March 2026Amiodarone (200 MG) 3/4/26 absent dialysis day3/9/26 absent dialysis day3/13/26 absent dialysis day3/18/26 absent dialysis day3/21/26 absent dialysis day Metoprolol Tartrate (25 MG) 3/4/26 absent dialysis days 3/9/26 absent dialysis day3/13/26 absent dialysis day3/18/26 absent dialysis day3/21/26 absent dialysis day Apixaban (2.5 mg)3/4/26 absent dialysis day3/9/26 absent dialysis day3/13/26 absent dialysis day3/18/26 absent dialysis dayIn an interview on 03/19/26 at 9:26 a.m., LVN E said Resident #13 had dialysis on Mondays, Wednesdays, and Fridays. She said she would leave the facility by 5:45 a.m. and would return at noon. LVN E said the facility's Med-Aides were responsible to administer Resident #13's medications. She was said if a resident was not in the facility at the time of their medication administration, the Med-Aide would enter a code 3 which meant the resident was not in the facility. She said the Med-Aides had a window of 4 hours to administer a mediation from the scheduled time. She said by the time Resident #13 returned from dialysis it was past the 4-hour window, so the morning medication(s) were not administered on the days she went out for dialysis. She was not able to say what the negative outcomes to Resident #13 were for not being administered her morning medications as ordered. In an interview and observation on 03/19/26 at 10:01 a.m., Med Aide A said her responsibility as a Med-Aide was to administer medications. She said her morning shift started at 7:00 a.m. and the first thing she did when she clocked in was to assist in the dining room with breakfast. She said she would start medication administration between 8:30 a.m. and 9:00 a.m. Med Aide A said she had been assigned to administer medications to Resident #13's hall on 03/04/26, 03/09/26, 03/13/26, and 03/18/26. She said Resident #13 was a dialysis patient and she was not in the facility on when she administered the morning medications on 03/04/26, 03/09/26, 03/13/26, and 03/18/26. She said the facility's protocol for when a resident was not in the facility when medication was being administered was to enter code 3 on their electronic medical administration record. Med Aide A said she had a window of four hours to administer medication(s) from the scheduled time and if a resident was not in the facility during the 4-hour window, the medication would not be administered. Med-Aide A said a negative outcome to Resident #13 not being administered medications as ordered would be that she would not be getting the full effects of the medications. During an interview on 03/19/26 at 10:35 a.m., the DON said Resident #13 went to dialysis on Mondays, Wednesdays, and Fridays at 6:30 a.m. She said Resident #13 would leave the facility before 6:00 a.m. and return between 12 and 1:00 p.m. The DON was observed as she reviewed Resident #13's electronic medical record and said Resident #13 had a code 3 for the following medications at 6:00 a.m., Amiodarone, Apixaban and Metoprolol on 2/18/26, 03/04/26, 03/09/26, 03/13/26, and 03/18/26. She said code 3 indicated the resident was not in the facility at the time the medication was being administered. She said the facility had a four-hour window to administer medication from the scheduled time and if the resident was not in the facility during the four window, the medication would not administer. The DON said she was not aware Resident #13 was not being administered her morning medications on the days she was scheduled dialysis and her physician had not been notified. She said it was the Med-Aide's responsibility to notify her that Resident #13 was not being administered her morning medication the days she had dialysis. She said, what we should have done is called Resident #13's physician to let him know that she was not in the facility during morning med pass the days she had dialysis. if he wanted to change the time or leave as is. The DON said the negative outcomes to Resident #13 not being administered Amiodarone, Apixaban, and Metoprolol was not getting the full effects of the medications, but she had not had any change of conditions the month of February 2026 or March 2026. The DON said the facility had 6 dialysis residents but only Resident #13 had missed doses of ordered medications. During an interview on 03/19/26 at 11:45 a.m., the NP said Resident #13 had been ordered Amiodarone, twice a day to control her heart rhythm. The NP said if Resident #13 was not administered Amiodarone as ordered it could possibly exacerbate her arterial fibrillation but since she had received at least 1 dose, it was ok. She said Resident #13 had been ordered Apixaban for her atrial fibrillation, twice a day and if she missed a dose, she was risk of forming a blood clot, but since she received at least one dose a (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	day the negative outcome was not too severe she that mean that Resident #13 received 1 of 2 doses of medication so the chances of her experiencing any negative outcome were minimal. The NP said the facility should have notified her or the doctor that Resident #13 was not in the facility when the medications were ordered, she said at that point they would have changed the time or discontinue the medication. The NP said she had not been notified of any change in condition for Resident #13 during the month of February or March 2026. In telephone interview on 04/02/2026 at 3:30 p.m., the Dr. said when he called in an order for a resident, he would give the name of the medication, frequency, dosage, and route. He said it was the nurse's responsibility to set the time when the medication would be administered. He said if the resident was not at the facility during that time, the facility should have called him to let him know. The Dr. said there were no negative outcomes to Resident #13 for missing 17 doses of Amiodarone Apixaban, and Metoprolol. He said he had not received any calls from the facility reporting any change of conditions for Resident #13. He said the likelihood of any negative outcomes were unlikely because Resident #13 was administered 1 of 2 daily doses. Record review of the facility's Administering Mediations policy revised on December 2012, reflected: Medications shall be administered in a safe and timely manner, and as prescribed.Policy Interpretation and Implementation: 3. Medications must be administered in accordance with the orders, including any required time frames. Record review of the facility's Adverse Consequences and Medication Errors policy, revised April 2024 reflected: Policy Statement: The interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such adverse drug reactions (ADRs) and side effects. Adverse consequences shall be reported to the attending physician and pharmacist, and to federal agencies as appropriate. Policy interpretation and implementation: 5. A medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 6. Examples of medications errors include a. omission-a drug is ordered but administered.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the baseline care plan for one (Resident #89) of three residents reviewed for base line care plans. The facility failed to provide Resident #89 a written summary of his baseline care plan completed within 48 hours of admission. This failure placed three newly admitted residents reviewed at risk of not receiving continuity of care and communication among nursing home staff, increase resident safety and safeguard against adverse events that are most likely to occur right after admission.Finding include: Record review of Resident #89's face sheet, dated 3/18/26 reflected she was a [AGE] year-old female with an admission date of 3/4/26. Her diagnoses included chronic obstructive pulmonary disease (a progressive, treatable, but incurable lung disease that causes chronic airflow restriction, making it hard to breath). Record review of Resident #89's MDS revealed that was still in progress. Record review of Resident #89's baseline care plan reflected it had not been completed as of 3/17/26. During an interview with MDS Coordinator on 3/18/26 at 4:00 p.m., she stated that now the facility does an assessment instead of the baseline care plan. She stated that she was responsible for the comprehensive care plan. MDS Coordinator stated that she had until 3/18/26 to complete the comprehensive care plan. She stated that she does not see the negative outcome. During an interview on 3/19/26 at 9:27 a.m., RN B stated that she was the nurse that admitted Resident #89. RN B stated that she was responsible to do the baseline care plan but she forgot. RN B stated that the negative outcome could be the lack of communication between staff. During an interview and record review on 3/19/26 at 11:00 a.m., DON stated that the baseline should be done within 48 hours after admission. DON did record review and confirmed that the baseline care plan was not in the electronic chart. DON stated the admitting nurse was in charge to initiate the baseline care plan. DON stated that the care plan was a way of communication between the nursing team. DON stated that the risk to residents who do not have care plans entered timely was inaccurate care being provided by staff. The DON stated that care plans were a process that began with the MDS nurse and admitting nurse entering the baseline care plan. The DON stated she did not know what happened to Resident #89's baseline care plan. Record review of the facility's policy, Care Plans-Baseline with a revision date December, 2016, reflected, A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 #38) of 6 residents reviewed for comprehensive care plans. The facility failed to include Resident #38's enhanced barrier precautions in his care plan. This failure could place residents at risk of not receiving the appropriate care, services or treatment needed in a timely manner.Findings included: Record review of Resident #38's face sheet, dated 03/17/2026, reflected a 57 -year-old male admitted [DATE]. Resident #38's diagnoses included peripheral vascular disease (a slow, progressive circulation disorder where blood vessels outside the heart and brain) and wound to left heel. Record review of Resident #38's Quarterly MDS assessment, dated 10/10/2026, reflected BIMS of 2 indicating severely cognitively impaired. Record review of Resident #38's most recent Care Plan, 03/06/2026, reflected enhanced barrier precautions were not addressed on his care plan and there were no interventions. Record review of Resident #38 Physician's Order, dated 03/13/2026, reflected cleanse with normal saline, apply betadine then cover with gauze and wrap with roll gauze and secure with tape once daily for wound on left heel. During an interview on 03/19/2026 at 9:36 a.m., MDS D stated she was responsible for developing care plans for Resident #38. MDS D stated the wound care nurse developed the care plans for wound care orders. She stated the care plan needed to be completed within 48-72 hours from receiving the new order. MDS D stated it was important for wound care to be care planned for infection control and to ensure protection for staff as well. During an interview on 03/19/2026 at 10:38 a.m., the WCN stated she was responsible for developing the care plan for the wound care orders. She stated she was not aware she needed to care plan Resident #38's wound treatment order since treatment was being done as a preventative. The WCN stated it was important for wound orders to be care planned to ensure they were doing the right preventative measures to help heel the wound. During an interview on 03/18/2026 at 3:40 p.m., the DON stated enhanced barrier precautions needed to be care planned. She stated MDS staff was responsible for developing the care plans. The DON stated that EBP was implemented for residents with wounds, urinary catheters, PEGS (soft, flexible tube placed directly into the stomach through the belly skin to deliver food, liquids, or medication when someone cannot eat enough by mouth), IV's (a method to deliver fluids, medicine, or nutrients directly into a vein using a small, flexible tube), and dialysis ports (a surgically created, dedicated entry point into your bloodstream, usually in the arm or chest, acting as a highway for blood to flow out, get cleaned by the machine, and return, acting as a substitute for failing kidneys). The DON stated these residents have a blue curtain hanging on the door with PPE. During an interview on 03/19/2026 at 1:37 p.m., the DON stated enhanced barrier precautions should have been care planned for Resident #38 and were to be completed as soon as they got the order. The DON stated it was important for it to be completed to protect Resident #38 from getting infection and to let staff know about the interventions that needed to be provided for the resident. Record review of the facility's Care Plans, Comprehensive Person-Centered policy, date revised December 2016 revealed:Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the residents physical, psychosocial and functional needs is developed and implemented for each resident.Policy Interpretation and Implementation: 8. The comprehensive, person centered care plan will: Include measurable objectives and timeframes;Describe the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being;13. Assessments of residents are ongoing and care plans are revised as information about the residents and residents' conditions change.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and restore continence to the extent possible for 1 of 3 resident (Resident#10) reviewed for indwelling catheters. The facility failed to prevent Resident#10's urinary catheter tubing (bag) from touching the floor. This failure could place residents at risk for cross contamination and urinary tract infections. Findings included: Record review of Resident#10's face sheet with a date 3/18/26 revealed a [AGE] year-old male originally admitted on [DATE]. Resident#10 had admitting diagnosis of neuromuscular dysfunction of the bladder, unspecified (a loss of bladder control caused by nerve damage from diseases or injuries like stroke, diabetes or spinal cord damage). Record review of Resident #10's care plan dated 3/3/2026 revealed Resident #10 has a indwelling catheter due to obstructive uropathy kidney neoplasm(a blockage in the urinary tract) Date initiated 3/17/26 and revised on 3/17/26, Interventions listed the the resident #10 position catheter bag and tubing below the level of the bladder and away from entrance room door. Record review of Resident #10's MDS dated [DATE], Section C-Cognitive patterns revealed Resident #10 had a BIMS score of 3 which indicated Resident #10 had intact cognition. Section H-Bladder and bowel revealed resident #10 has an indwelling catheter. Record review of Order Summary has order printed 3/18/26 revealed order to Change Foley Catheter 16 # French with 10milliliters balloon as needed for obstruction or if closed system is compromised. Order Foley catheter care every shift and as needed start dated 03/3/26. During an observation conducted on 03/17/26 at 12:20 PM, Resident #10's indwelling catheter bag was noted dragging on the floor while resident was in wheelchair. During interview with LVN A on 03/17/26 at 12:20 PM, LVN A was informed catheter bag was dragging on the floor. She stated it should not be touching the floor. She replied that a negative outcome of foley catheter bag being on the floor the catheter wouldn't drain well and pick up bacteria from floor. During interview with DON on 03/19/26 at 11:06 AM, she stated that no, it should not be touching the floor, if on the floor, the tubing and the bag should be change immediately. She stated the negative outcome was that Resident #10 could get an infection or the bag could get ripped. Record Review of Policy Titled Catheter Care, Urinary with revised date April 2010, revealed: Be sure the catheter tubing and drainage bag are kept off the floor.

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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 observations, interviews and record reviews, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 7 residents (Resident #71) reviewed for pharmacy services. The facility failed to compare the instructions written on Resident #71's blister pack with the physician's order for Gabapentin before it was administered on 03/19/2026. This deficient practice could place residents at risk of not receiving the therapeutic effects from their medications as intended by the prescribing physician order.Record review of Resident #71's face sheet, dated 03/19/26, revealed a [AGE] year-old female admitted on [DATE] and readmitted [DATE]. The diagnoses included Cirrhosis of the liver (chronic condition of the liver in which the normal functioning tissue is replaces with scar tissue and regenerative nodules as a result of chronic liver failure), Bipolar Disorder (a chronic mental health condition characterized by intense, long-lasting shifts in mood, energy, and activity levels, ranging from extreme highs to lows), and Type 2 Diabetes Mellitus (a chronic metabolic condition where the body develops insulin resistance and fails to produce enough insulin, leading to high blood sugar levels). Record review of Resident #71's MDS Assessment, dated 03/04/26, revealed a BIMS score of 15 indicating intact cognition. Record review of Resident #71's care plan, dated 2/24/2024, revealed the focus area, The resident is on pain medication therapy related to disease process. An intervention listed for the problem stated, Administer medications as ordered (morphine, baclofen, and gabapentin). Record review of Resident #71's Physicians order, dated 8/27/2025, revealed an active order in PCC (electronic health record) for gabapentin 800 MG to give 1 tablet by mouth three times per day. Record review of the blister pack containing Resident 71's Gabapentin 800 MG revealed the order stated, TAKE 1 TABLET BY MOUTH TWO TIMES PER DAY. During an observation of medication administration at 10:00 a.m., on 03/19/26, CMA A prepared morning medications for administration. CMA A popped the medications she needed to administer to Resident #71 out of their blister packs, including the Gabapentin 800 MG. Observation revealed and noted on the blister pack was, Gabapentin 800 MG, give 1 tablet by mouth two times per day. During an interview on 3/19/2026, at 11:45 am, CMA A stated before administering any medication she confirmed the right person, dose, drug, route and time. CMA A stated she was supposed to compare the order on the blister pack to what the order stated in the electronic health record and ensured there were no discrepancies. CMA A stated there was a difference in how many times the medication was administered. CMA A stated the physician orders were for three times a day, but the blister pack indicated two times a day. CMA A stated she gives all medication according to the physicians' order and not according to the blister pack. During an interview on 3/19/2026 at 1:20 p.m., the DON stated it is her expectation that blister packs match the physicians order in the electronic health record. The DON stated the CMA A should have notified the nurse about the blister pack not matching the physicians order in the electronic health record. The DON stated Resident #71 was taking Gabapentin for pain and took other medication for pain as well. The DON stated Resident #71 was not without her medication at any time. During an interview on 3/19/2026 at 2:10 p.m., Resident #71 stated her pain was controlled well with her medications. Resident #71 stated when she was in pain, she requested medication and it was given to her, and all medications are given appropriately. Resident #71 stated she had no issues or concerns with her medication.Record review of the facility policy titled, Administering Medications, dated April 2019, stated the following: .7. The individual administering the medication checks must check the label to verify the right resident, right medication, right dosage, right time and the right method (route) of administration before giving the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were labeled and stored appropriately for 1 of 3 residents (Resident #28) reviewed for labeling and storage. The facility failed to put an open date for Resident #28's Trelegy inhaler. This failure could have placed residents at risk of not receiving the therapeutic effects of the medication. The findings included: Review of Resident #28's admission Record, dated 3/19/26, revealed she was a [AGE] year-old female originally admitted to the facility on [DATE] with diagnosis including Chronic obstructive pulmonary disease with exacerbation (a sudden worsening of symptoms typically increased shortness of breath, cough, and thicker or discolored mucus). Review of Resident #28's Care Plan dated 1/7/26 revealed: Revised on 5/9/25 Focus: Resident #28 has Emphysema/ Chronic obstructive pulmonary disease related to Physiological atrophy. Review of Resident #28's quarterly MDS Assessment, dated 1/9/26 revealed her BIMS was 12 meaning she was moderate cognitive impaired. Further review revealed she had a diagnosis of Chronic obstructive pulmonary disease. Review of Resident #28's Order Summary Report, dated 3/19/26, revealed Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 mcg/act (Fluticasone-Umeclidinium-Vilanterol) 1 inhalation inhale orally one time a day for Chronic obstructive pulmonary disease. An observation on 03/18/2026 at 10:32 a.m., of the 600 Hall Medication Cart with LVN C , revealed Resident #28's Trelegy inhaler did not have an open date. During an interview on 03/18/26 at 10:32 a.m., LVN C stated that the inhaler should be labeled with an open date. She stated that the person responsible for labeling the bottles was the person who initially opened them. LVN C stated that they need to know when the inhaler was opened, so they know when it expires. During an interview on 03/19/2026 at 11:20 a.m., the DON stated that trelegy inhaler should have an open date. DON stated that it was important to have an open date because the medications had a life span and without an open date could not track when the inhaler was opened. Record review of the facility's Labeling of Medications Containers policy, with a revision date April/07, revealed All medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations.

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	04/02/2026

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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based 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 and to help prevent the development and transmission of communicable diseases and infections for 1 of 6 (Resident #38) residents reviewed for infection control. The facility failed to ensure Resident #38 had an EBP sign on the door. This failure could place residents at risk for healthcare associated cross-contamination and the spread of infection.Findings included: Record review of Resident #38's face sheet dated 03/17/2026 reflected a 57 -year-old male, admitted on [DATE]. Resident #38's diagnoses of Peripheral Vascular Disease (a slow, progressive circulation disorder where blood vessels outside the heart and brain) and wound to left heel. Record review of Resident #38's Quarterly MDS assessment, dated 10/10/2025, reflected he scored a 2 on his BIMS which reflected severely cognitively impaired. Record review of Resident #38 most recent Care Plan, 03/06/2026, reflected Resident #38 did not have enhanced barrier precautions developed on his care plan or interventions. Record review of Resident #38 Physician's Order, dated 03/13/2026, reflected cleanse with normal saline, apply betadine then cover with gauze and wrap with roll gauze and secure with tape one time a day for wound on left heel. During an observation on 03/17/2026 at 9:42 a.m. revealed there was no EBP sign posted on Resident #38's door. During an interview on 03/17/2026 at 10:15 a.m., CNA H stated she was Resident #38's CNA. She stated Resident #38 should have an EBP sign. CNA H stated the nurse was responsible for putting the sign up. She stated she did not notice that the sign was not there. She stated she wore PPE every time she went into his room to provide care. CNA H stated it was important for the EBP sign to be posted so that other staff were aware of the type of precautions in place and to prevent spread of infection. During an interview on 03/17/2026 at 10:33 a.m., LVN G stated she was Resident #38's nurse. She stated she was responsible for posting the EBP sign on Resident #38's door. LVN G stated she did not know the sign was missing. She stated the sign was there this morning, 03/17/2026. She stated the staff was to wear PPE when coming into close contact and doing patient care. She stated the required PPE for EBP consisted of gloves and gowns. LVN G stated that it was important for the sign to be posted to prevent the transmission of infection and ensure the safety of the patient. She stated an infection control in-service was done two weeks ago. During an interview on 03/18/2026 at 3:40 p.m. the DON, stated the residents in the secured unit were there for a reason and they grabbed everything including the EBP sign. She stated they were working on a better system to keep the sign in place. She stated the person responsible for placing the EBP sign on the door would be their part time infectious disease nurse, but they did not wait for her to show up because all their staff were educated on that. The DON stated the signs at the door were important to alert visitors and staff of the type of precaution that was in place. She stated they also had a blue curtain in place that made staff aware that they were on precautions. During an interview on 03/19/2026 at 1:37 p.m., the DON stated Resident #38 was not in isolation but only on enhanced barrier precautions. The DON stated this means that whatever Resident #38 had, it was contained. The DON stated the staff would have to physically touch the wound for contamination. The DON stated the negative outcome would be getting an infection. Record review of the facility policy, titled Enhanced Barrier Precautions, revised April 1, 2024, revealed,Purpose: This policy outlines the guidelines and procedure to implement enhanced barrier precautions to prevent the spread of infectious disease among residents and staff.Definitions: Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Policy: EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following:.Wounds and/or (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	04/02/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO.