| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676446 | A. Building<br>B. Wing | 08/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mission Valley Nursing and Transitional Care | 1200 S Bryan Rd<br>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 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>(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 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | **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 that described the services to be provided to attain or maintain the residents' highest practicable physical, mental, and psychosocial needs, for 1 of 4 residents (Resident #1) reviewed for care plans in that: The facility failed to ensure an individualized care plan to address Resident #1's level of assistance that was required for ADLs by a 1 or 2 person assist. The CNA made the determination to provide perineal care by herself, resulting in Resident #1 to fall and was discharged to the hospital on [DATE]. An Immediate Jeopardy was identified on 08/22/2025. The Immediate Jeopardy template was provided to the facility on [DATE] at 12:20 p.m. While the Immediate Jeopardy was removed on 08/23/2025 at 3:30 p.m. The facility remained out of compliance at a scope of isolation and a severity of not actual harm with potential for more than the minimal harm that was not an immediate jeopardy because of the facility's need for continued monitoring of implemented procedures. This failure could place residents at risk of injuries and their individual medical, physical and psychosocial needs not being met. The findings were: Record review of Resident#1 electronic admission record dated 08/21/2025, revealed a [AGE] year-old female with an admission date of 12/11/2022 and an original admission date of 04/09/2021. Resident #1's pertinent diagnosis included Dementia, Cerebral Vascular Accident (stroke) with right sided weakness, epilepsy (seizures), Heart Failure, and Atrial Fibrillation (irregular heartbeat). Record review of Resident #1's comprehensive MDS dated [DATE], revealed a BIMS score of 02, indicating severe cognitive impairment. Resident #1 was noted in section GG- Functional Abilities coded as a 03 (Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for self-care tasks and transfers. Resident #1 was noted to be bowel and bladder always incontinent. Record review of Resident #1's comprehensive care plan dated 05/22/2025, revealed Resident#1 had an ADL self-care performance deficit related to CVA with hemiplegia, Dementia. Interventions: BED MOBILITY: The resident requires (extensive assistance) by (1-2) staff to turn and reposition in bed daily and as necessary. Care needs may vary. TOILET USE: The resident requires extensive assistance by 1-2 staff for toileting. Care needs may vary. Record review of Resident #1's narrative of the incident dated 08/20/2025, revealed the resident was receiving perineal care from CNA A. As CNA A turned to dispose of the soiled brief in the trash can at bedside, the resident rolled over onto the floor mat at bedside. Charge nurse was immediately notified and performed a head-to-toe assessment prior to bed transfer. Resident #1 was initially able to communicate and stated she had right sided shoulder pain. Family and NP were informed. Neuro checks were initiated, and a change of condition with AMS was noted approximately 20 minutes into the neuro checks, 911 call was activated and resident was transferred to hospital.In an interview on 08/21/2025 at 11:06 a.m., CNA A stated that she was the one who determined if the resident would be a one or two person assist. She stated that she would determine this by seeing if the resident was cooperative and followed commands, prior to starting the task. If they were, then she would proceed with doing the task on her own. If they do not want to cooperate and assist, then she would get another staff member to assist. She stated that the Kardex (summary of a patients care plan and needs during their shift) had Resident #1 as a 1-2 person assist. CNA A stated that she normally does Resident #1's perineal care on her own.In an interview on 08/21/2025 at 11:43 a.m., CNA C stated that she was familiar with Resident #1's care and that she would normally do perineal care on her own. She stated that she looked in the computer Kardex to see if the resident would be a one person or two person assist. If the resident was a 1-2 person assist, then she determined if she could do it on her own or if she would need assistance. She would determine this after she talked to the resident and informed them of the task. If the resident was cooperative then she would continue to do the task on her own. If she saw that they were not, then she would get another person to assist. In an interview on 08/21/2025 at 12:30 p.m., LVN B stated that Resident #1 was a 1-2 person assist depended on the task. She stated Resident #1 was a one person assist the day of the incident, 08/20/2025, because she was cooperative. LVN B stated that the CNAs that provided the care would determine if the patient cooperated. The CNAs were more hands-on with them. Then they would report to her that they were transferred well. In an interview on 08/22/2025 at 2:25 p.m., CNA G stated that she worked at the facility for about ten months. She stated that she was familiar with Resident #1's care. She stated that Resident #1 would assist with moving her around in the bed, she followed commands, CNA |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate supervision was provided for 1 of 4 residents (Resident #1) reviewed for accidents and supervision. The facility failed to ensure Resident #1 was provided with adequate supervision and assistance while provided incontinent care on 08/20/25. Resident#1 suffered a fall that resulted in a subdural hematoma (a collection of blood that forms on the surface of the brain, between the brain and its outermost protective covering). Resident#1 was discharged to hospital on [DATE] and passed away on 08/21/25. The facility did not have consistent procedures for floor staff to establish level of need for residents requiring 1-2 person assist for ADLs. An Immediate Jeopardy was identified on 08/22/2025. The Immediate Jeopardy template was provided to the facility on [DATE] at 5:37 p. m. While the Immediate Jeopardy was removed on 08/23/2025 at 3:30 p.m. The facility remained out of compliance at a scope of isolation and a severity of harm with potential for more than the minimal harm that was not an immediate jeopardy because of the facility's need for continued monitoring of implemented procedures. This failure could prevent residents from receiving appropriate supervision which could lead to resident sustaining serious injury, harm, or death. Findings included: Record review of Resident#1 electronic admission record dated 08/21/2025, revealed a [AGE] year-old female with an admission date of 12/11/2022 and an original admission date of 04/09/2021. Resident #1's pertinent diagnosis included Dementia, Cerebral Vascular Accident (stroke) with right sided weakness, epilepsy (seizures), Heart Failure, and Atrial Fibrillation (irregular heartbeat). Record review of Resident #1's Comprehensive MDS dated [DATE], revealed a BIMS score of 02, indicating severe cognitive impairment. Resident #1 was noted in section GG- Functional Abilities coded as a 03 (Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for self-care tasks and transfers. Resident #1 was noted to be bowel and bladder always incontinent. Record review of Resident #1's comprehensive care plan dated 05/22/2025, revealed Resident#1 had an ADL self-care performance deficit related to CVA with hemiplegia, Dementia. Interventions: BED MOBILITY: The resident requires (extensive assistance) by (1-2) staff to turn and reposition in bed daily and as necessary. Care needs may vary. TOILET USE: The resident requires extensive assistance by 1-2 staff for toileting. Care needs may vary. Record review of Resident #1' s Order Summary Report revealed Apixaban (anticoagulant) tablet 2.5 mg for A Fib and Keppra (anticonvulsant) tablet 500 mg for Seizures. Record review of Resident #1's narrative of the incident dated 08/20/2025, revealed the resident was receiving perineal care from CNA A. As CNA A turned to dispose of the soiled brief in the trash can at bedside, the resident rolled over onto the floor mat at bedside. Charge nurse was immediately notified and performed a head-to-toe assessment prior to bed transfer. Resident #1 was initially able to communicate and stated she had right sided shoulder pain. Family and NP were informed. Neuro checks were initiated, and a change of condition with AMS was noted approximately 20 minutes into the neuro checks, 911 call was activated and resident was transferred to hospital. Record review of Resident #1's Final report from the Hospital revealed Resident #1 suffered a subdural hematoma (a collection of blood that forms on the surface of the brain, between the brain and its outermost protective covering) secondary to anticoagulant therapy and recent fall with head injury. In an interview on 08/21/2025 at 11:06am, CNA A stated the incident happened around 10:45ish but not before 11am. She stated she went in and notified Resident #1 that she would be doing perineal care. She then proceeded to clean her. She turned her on the right side. She then removed the dirty brief and as she turned halfway to throw it away in the trash can that was beside her, Resident#1 did a quick movement and fell. She was not able to grab her because it happened so quickly. She notified charge nurse immediately. In an interview on 08/21/2025 at 12:30pm LVN B stated that she was called by CNA A to go to Resident #1's room. Resident #1 was awake, alert, and responsive. No visible injuries noted. She stated Resident #1 answered yes when asked if rolled off the bed. Resident#1 was immediately assessed for injuries, no visible injuries were noted. LVN B stated Resident #1 complained of pain to the right-side right shoulder, no swelling or redness noted to affected area. Neuro checks initiated. She stated the NP and RP were notified. LVN B stated Resident #1 was a 1-2 person assist depended on the task. She stated Resident #1 was a one person assist the day of the incident, 08/20/2025. LVN B stated that the CNAs that provided the care would determine if the patient cooperated. The CNAs were more hands-on with them. Then they would report to her if they were transferred well. In an interview on 08/21/2025 at 2:44 p.m., the DON stated she was at the |