| 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 | 10/29/2025 |

| 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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform residents in advance about any care and treatment for 1 of 5 residents (Resident #3) reviewed for resident rights, in that: The facility failed to ensure consent forms were properly completed or signed by a responsible party prior to administration of a psychotropic medication (Remeron) for Resident #3. This failure could place residents at risk of not being aware of changes related to their care/treatment. Findings include: Record review of Resident #3's admission Record dated 10/21/2025, revealed an [AGE] year-old male, admitted to facility on 06/06/2025. His diagnoses included: Wedge compression fracture of first lumbar vertebra (a type of spinal fracture where the front part of the vertebra collapses, creating a wedge-shaped deformity), dementia (a general term for a group of diseases that cause a loss of cognitive functioning, such as thinking, remembering, and reasoning, to the point that it interferes with daily life), heart disease, and hypertension (high blood pressure). Resident #3 was discharged from the facility to the hospital on [DATE] and did not return to the facility. Record review of Resident #3's Medicare 5-Day MDS dated [DATE] revealed Resident #3 had a BIMS score of 15, indicated cognitive function was intact. Resident #3 had clear speech, understood others and was able to be understood by others. Resident #3 required supervision or touching assistance with eating. Resident #3 was dependent on toileting hygiene and showers/baths requiring the assistance of two or more helpers. Record review of Resident #3's Order Summary dated 06/01/2025 to 07/01/2025 revealed, Resident #3 had the following order written by PA HH:Start Date: 06/18/2025 Remeron Oral Tablet 30 MG (Mirtazapine)Give 1 tablet by mouth one time at bedtime for appetite stimulant.Medication Class: Tetracyclic antidepressants. Record review of Resident #3's consent form for Remeron (Mirtazapine) dated 06/18/2025 revealed no resident/responsible party signature or verbal consent was obtained to give Remeron. Record review of Resident #3's June 2025 MAR revealed Resident #3 had received Remeron Oral Tablet 30mg at bedtime for appetite stimulant from 06/18/2025 through 06/26/2025. Record review of Progress Notes dated 06/18/2025 at 12:09 pm written by PA HH revealed PA HH ordered Remeron Oral Table 30mg at bedtime for appetite stimulant. In an interview on 10/28/2025 at 03:16 pm LVN GG stated the nurse who received the psychotropic order from the physician would be responsible for getting signatures or verbal consent for the consent form. The nurse would explain to the family the medication and side effects and the family would decide if they wanted the resident to have it or not. She said if the family wanted the resident to take the medication, the nurse would either get verbal consent documented on the consent form or the Responsible Party would sign the consent form for the psychotropic. LVN GG stated the medication was not given to the resident until the consent for the psychotropic was signed or verbal consent was documented on the consent form. LVN GG stated the resident had the right to take the medication or refuse it. She said it was a patient's right. In an interview on 10/28/2025 at 05:15 pm The DON stated the nurse who took the order for a psychotropic or antipsychotic was the one responsible for getting signatures of the doctor and RP. The DON stated the nurse was not to give the medication until signatures were on the consent form. She said the negative effect of not getting signatures on the consent form would be that it would not show the RP or resident was informed of the side effects of the medication and the consent to give the medication. She said it was a resident's right to accept the medication or refuse it. Review of facility's policy Use of Psychotropic Medication(s) dated 03/05/2025 revealed:Policy Explanation and Compliance Guidelines: 9. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase.10. The resident has the right to accept or decline the initiation or increase of psychotropic medication.11. The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deems to use (e.g., written consent form, narrative note, etc.). |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>(continued on next page) |

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|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to review and revise comprehensive care plans for 1 (Resident #3) of 5 residents reviewed for comprehensive care plan revisions. The facility failed to review and revise Resident #3's comprehensive person-centered care plan from Full Code Status to DNR Status in a timely manner reflecting both Full Code and DNR status on the care plan. This failure could affect residents and place them at risk of not receiving appropriate interventions to meet their current needs. Findings include: Record review of Resident #3's admission Record dated [DATE], revealed an [AGE] year-old male, admitted to facility on [DATE]. His diagnoses included: Wedge compression fracture of first lumbar vertebra (a type of spinal fracture where the front part of the vertebra collapses, creating a wedge-shaped deformity), dementia (a general term for a group of diseases that cause a loss of cognitive functioning, such as thinking, remembering, and reasoning, to the point that it interferes with daily life), heart disease, and hypertension (high blood pressure). Resident #3 was discharged from the facility to the hospital on [DATE] and did not return to the facility. Record review of Resident #3's Medicare 5-Day MDS dated [DATE] revealed Resident #3 had a BIMS score of 15, indicated cognitive function was intact. Resident #3 had clear speech, understood others and was able to be understood by others. Resident #3 was dependent on toileting hygiene and showers/baths requiring the assistance of two or more helpers. Record review of Resident #3's Care Plan dated [DATE], revealed: 1: FOCUS: Resident #3 is a full code Date Initiated: [DATE] Revision on: [DATE] Resolved Date: [DATE] GOALS: Facility will comply with resident/family wishes Date Initiated: [DATE] Revision on: [DATE] Target Date: [DATE] Resolved Date: [DATE] INTERVENTIONS/TASKS: If resident has a cardiac arrest, initiate CPR and call 911. Notify MD/RP and follow MD orders after notification. Date Initiated: [DATE] Revision on: [DATE] Resolved Date: [DATE] LN [DATE] Keep emergency cart well supplied and ready for use at all times Date Initiated: [DATE] Revision on: [DATE] Resolved Date: [DATE] LN [DATE] [NAME] chart and all pertinent documents with FULL CODE Date Initiated: [DATE] Revision on: [DATE] Resolved Date: [DATE] LN SS [DATE] FOCUS: Resident is a DNR Date Initiated: [DATE] Revision on: [DATE] Cancelled Date: [DATE] GOAL: Facility will comply with resident/family wishes Date Initiated: [DATE] Revision on: [DATE] Target Date: [DATE] Cancelled Date: [DATE] INTERVENTIONS/TASKS: Ensure signed DNR is in medical record Date Initiated: [DATE] Revision on: [DATE] Cancelled Date: [DATE] LN SS [DATE] If resident has a cardiac arrest, do not call 911 or initiate CPR. Notify MD/RP and follow instructions after notification Date Initiated: [DATE] Revision on: [DATE] Cancelled Date: [DATE] LN [DATE] [NAME] chart and all pertinent documents with DNR status Date Initiated: [DATE] Revision on: [DATE] Cancelled Date: [DATE] LN [DATE] Send copy of DNR paperwork upon transfer from facility Date Initiated: [DATE] Revision on: [DATE] Cancelled Date: [DATE] LN [DATE] Record review of Resident #3's OOH-DNR signed by RP, witnesses, physician, and notary was signed on [DATE]. In an interview on [DATE] at 12:52 pm, RN M stated that the admitting nurse was responsible for putting the code status of a resident in the care plan. She said if the resident code status changed to DNR after the admitting care plan, the nurse who was notified of the change of code status would put it in the Care Plan and remove the Full Code status. RN M stated she would want to see the signed DNR with signatures before she changed the code status on the Care Plan. RN M stated that usually the nurse who took the psychotropic order was the one who put the psychotropic or antipsychotic in the care plan. RN M stated for psychotropic medication orders, she would let the Care Team know, and they would put it in the care plan. In an interview on [DATE] at 01:40 pm, RN X stated that the admitting nurse was the one who completed the care plan on admission. She said the admitting nurse adds the code status of a resident on admission and if their code status changed, the nurse who received the change in code status was the one who updated the care plan with the change in code status and discontinued the full code status to DNR. RN X stated that the nurse who received the order for a psychotropic was responsible for getting the signed consent for psychotropics. She said the medication was not to be put in the computer until the family had signed consent for the psychotropic. She said that way, the order would not show up on the MAR and the medication would not be given until the consent was signed. In an interview on [DATE] at 03:16 pm, LVN GG stated that the admitting nurse completed the initial care plan and the RN reviewed the care plan then signed off on them. She said the admitting nurse was responsible for entering the code status on admission. LVN GG stated if the resident's code status changed, the Social Worker would let the nurse know of the change in code status and the nurse changed the status |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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 | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents hazards and supervision:1.The facility failed to ensure Resident # 1 was not left unattended in his wheelchair in his room by CNA A, which resulted in an unwitnessed fall. Resident #1 sustained a hip fracture from the fall. 2.The facility failed to ensure CNA A and Med-Aide B notified a nurse of Resident #1's fall and transferred Resident #1 to bed without being assessed. The non-compliance for Resident #1 was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 04/21/2025 and ended on 04/23/2025. The facility corrected the non-compliance before the investigation began. This failure could place the residents at risk for injury or death. Findings included:Record review of Resident #1's admission sheet dated 10/21/25, reflected an [AGE] year-old male with an admission date of 05/03/25 and an initial admission date of 07/30/23. His relevant diagnoses included hemiplegia (a condition that causes paralysis or weakness on one side of the body), hemiparesis (weakness on one side of the body that can affect the arm, leg, and sometimes the face), displaced intertrochanteric fracture of right femur ( a break in the femur (thigh bone) just below the femoral head and above the lesser trochanter), pain to right hip, Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline), lack of coordination, muscle weakness, and need for assistance with personal care. Record review of Resident #1's quarterly MDS assessment dated [DATE], reflected a BIMS score of 04, which indicated his cognition was severely impaired. Further review reflected Resident #1 was dependent ( helper does all of the effort. Resident does none of the effort to complete the activity. OR the assistance of 2 or more helpers is required for the resident to complete the activity) for transfers and used a wheelchair as a mobility device.Record review of Resident #1's quarterly care plan dated 09/23/25, reflected a:Problem: [Resident #1] is high risk for falls r/t unsteadiness on feet, other lack of coordination, other abnormalities of gait/mobility (dated initiated 07/30/23 and revised on 04/23/25)Interventions: in part included to anticipate and meet needs (date initiated 07/30/23 ad revised on 09/23/25), be sure the resident's call light is within reach and encourage/remind the resident to use call light for all assistance (dated initiated 07/30/23 and revised on 09/23/25), Ensure floor mats in place (dated initiated 08/25/25), provide resident with mobility device: WC, walker, or cane (date initiated 04/23/25), Pt evaluate and treat as ordered or PRN (date initiated 11/12/24)Problem: [Resident #1] has had an actual unwitnessed fall on: 03/26/25, 04/06/25, 04/09/25, 04/21/25 (date initiated 04/06/25 and revised on 04/23/25)Interventions: in part included, resident reminded to use call light for assistance when needed to avoid falls/injuries (date initiated 03/27/25), visual checks Q2 (date initiated 04/14/25), bed to lowest position w/safety pad on the floor (date initiated 04/22/25), and notify MD/RP of incident (date initiated 04/06/25)Record review of Resident #1's incident report dated 04/21/25 at 8:15 pm, reflected:Incident description: Around 8:00, CNA reported that upon entering the room, resident noted lying on the floor, left side of his bed, on his right-side position. Assisted X2 to bed, call light had not been triggered.Resident Description: [Resident #1] stated that he wants to walk. C/o pain to right hip/waist area when move/reposition. Denies of hitting his head.Record review on 10/21/25 of Resident #1's progress note dated 04/21/2025 at 8:24 pm, authored by LVN D reflected .notified NP. New orders for [pain medication], apply [pain gel] to affected area on right hip/waist, & x-ray hip/pelvis 2v in am. Will carry out orders.Record review on 10/21/25 of Resident #1's change in condition communication form dated 04/21/25 at 8:00 pm reflected: the change of condition was pain to right hip/waist area which started on 04/21/2025 Record review of Resident #1's x-ray results taken on 04/22/25 reflected a mildly displaced right hip fracture. This appears to be a inter trochanteric fracture.During a telephone interview on 10/21/25 at 1:04 pm, CNA A described Resident #1 as being a very anxious resident who frequently attempted to get up from his wheelchair and required constant supervision. She said when Resident #1 would be in his wheelchair, and he would be placed by the nurse's station so they could keep an eye on him. She said on 04/21/25 between 6:00 and 7:00 pm, she wheeled Resident #1 from the nurse's station back to his room. CNA A said she left him sitting in his wheelchair (wheels locked) while she went out to the hall to look for someone to help her transfer Resident #1 back to bed. She said while she was in the hall trying to motion for assistance from another CNA, the resident from across Resident #1's room asked her to take him to the restroom, and she did. CNA A said when she returned to Resident #1's room, she found him on the floor, lying on his right side between |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide Accuracy in service delivery. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 (Resident #2 and Resident #3) of 5 residents reviewed for medication.1.The facility failed to administer Morphine Sulfate as ordered by the physician on two different occasions.2.The facility failed to document the pain level 0-10 on the physician's order to monitor for pain every shift for Resident #3. These deficient practices could place residents at risk of not receiving therapeutic doses of their medication.The Findings included:1.Review of Resident #2's face sheet reflected a [AGE] year-old female with an initial admission date of 07/14/2018 with a diagnosis of Parkinsonism (Umbrella term for conditions that cause symptoms similar to Parkinson's disease, including tremors, stiffness, and slow movement), Alzheimer's Dementia (Brain disorder that causes memory loss, confusion, and other cognitive decline), Atherosclerotic Heart Disease (Plaque buildup in arterial walls), Atrial Flutter (a heart rhythm problem where two upper chambers of the heart beat too fast, causing them to flutter instead of beating in a strong steady rhythm).Review of Resident #2's MDS dated [DATE] reflected a Brief Interview for Mental Status (BIMS) of 99 (Resident was unable to complete the interview).Review of Resident #2's Care Plan dated 7/28/2025 reflected resident was under hospice care with listed interventions as: medications as ordered and notify physician immediately if there is breakthrough pain. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met.Review of Resident #2's active orders as of 8/01/2025 OK to admit resident to hospice under physician DX: Alzheimer's / DementiaReview of Resident #2's active orders as of 8/01/2025 for Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.5 mL by mouth every 4 hours as needed for Pain.Review of Resident #2's Individual Resident's Controlled Substance Record dated 8/2/25 reflected Morphine Sulf 100 MG/5 ML administer 0.5 ML by mouth as needed every 4 hours for shortness of breath or pain.Review of Resident #2's Individual Resident's Controlled Substance Record reflected Morphine Sulfate 0.25 mL was given on 8/10/20 at 10:00 PM by LVN EE and the same dose of 0.25 mL given on 8/11/25 at 7:00 AM by LVN FF.Review of Resident #2's Medication Administration Record reflected Morphine Sulfate 0.5 mL was given on 8/10/25 at 10:00 PM by LVN EE.Review of Resident #2's Medication Administration Record reflected Morphine Sulfate 0.5 mL was given on 8/11/2025 at 7:01 AM by LVN FF.Review of Resident #2's Nursing Progress Note reflected an entry made on 8/10/2025 at 10:00 PM by LVN EE Note Text: Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.5 ML by mouth every 4 hours as needed for painReview of Resident #2's Nursing Progress Note reflected an entry made on 8/10/2025 at 10:39 PM by LVN EE Note Text: Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.5 ML by mouth every 4 hours as needed for Pain PRN Administration was: Effective Follow-up Pain Scale was: 0Review of Resident #2's Nursing Progress Note reflected an entry made on 8/11/2025 at 6:17 AM by LVN FF Note Text: Received shift with resident in bed with irregular breathing between 24-32 per minute with Pulse of 110. Patient not on O2 per family request as endorsed by LVN EE. At 7 AM administered Morphine Sulfate 0.25 ML only per family due to patient moaning when repositioned. Kept HOB elevated and comfort measures provided. Family at bedside.Review of Resident # 2's Nursing Progress Note reflected an entry make on 8/11/2025 at 8:50 AM by LVN FF Note Text: Morphine Sulfate (Concentrate) solution 20 MG/ML Give 0.5 ML by mouth every 4 hours as needed for Pain Patient moaning and having SOB.In an interview on 10/21/2025 at 3:41 PM with LVN FF stated he had received a report from LVN EE not to give the whole dose (Morphine) as family requested. LVN FF said I asked the family member out of respect and gave 0.25 mL of morphine as the family requested. LVN FF said he had not called the doctor to inform him of the request made by the family to decrease the dosage of the morphine because he was busy and he knew he should have called. LVN FF said he documented on his progress notes the dose of 0.25 ML given as requested by the family.In a phone interview on 10/22/2025 at 11:42 AM with the Branch Manager of hospice, she stated Coordination of Care is done between hospice and facility staff upon admission and facilities are good in communicating with us. She said the facility did inform hospice of a lowered dose requested by the family after the medication was given. She said The facility was supposed to notify hospice of a request for a lowered dose so that we can document and let the doctor know. We would have to maybe send out our nurse to speak to the family and provide re-education.In a phone interview on 10/23/2025 at 1:14 PM with the pharmacy |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>(continued on next page) |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 resident (Resident #3) of 5 residents reviewed for medical records accuracy, in that: The facility failed to document the doctor and RP had been notified of Resident #3's fall on 06/16/2025 at 05:07 am. This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care and treatment.Findings included: Record review of Resident #3's admission Record dated 10/21/2025, revealed an [AGE] year-old male, admitted to facility on 06/06/2025. His diagnoses included: Wedge compression fracture of first lumbar vertebra (a type of spinal fracture where the front part of the vertebra collapses, creating a wedge-shaped deformity), dementia (a general term for a group of diseases that cause a loss of cognitive functioning, such as thinking, remembering, and reasoning, to the point that it interferes with daily life), heart disease, and hypertension (high blood pressure). Record review of Resident #3's Medicare 5-Day MDS dated [DATE] revealed Resident #3 had a BIMS score of 15, indicated cognitive function was intact. Resident #3 had clear speech, understood others and was able to be understood by others. Resident #3 was dependent on toileting hygiene and showers/baths requiring the assistance of two or more helpers. Record review of Resident #3's Care Plan dated 06/07/2025, revealed: FOCUS: Resident #3 has had an actual fall -06/16/25 UW fall Date Initiated: 06/16/2025 Revision on: 07/17/2025 Cancelled Date: 07/17/2025GOAL: The resident will resume usual activities without further incident through the review date. Date Initiated: 06/16/2025 Revision on: 07/17/2025 Target Date: 09/17/2025 Cancelled Date: 07/17/2025INTERVENTIONS/TASKS: 06/16/25 Encourage and educate resident on importance of using call light for all assistance. Date Initiated: 06/16/2025 Revision on: 07/17/2025 Cancelled Date: 07/17/2025 RN LN 07/17/2025 Monitor/document /report PRN x 72h to MD for s/sx: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Date Initiated: 06/16/2025 Revision on: 07/17/2025 Cancelled Date: 07/17/2025 LN RN 07/17/2025 Neuro-checks x (72 hours) Date Initiated: 06/16/2025 Revision on: 07/17/2025 Cancelled Date: 07/17/2025 LN RN 07/17/2025 Notify MD/RP of incident Date Initiated: 06/16/2025 Revision on: 07/17/2025 Cancelled Date: 07/17/2025 RN LN 07/17/2025. Record review of Resident #3's Progress Notes on 06/16/2025 at 05:07 am written by LVN GG revealed, PATIENT WAS FOUND ON THE FLOR NEXT TO THE BED WITH PILLOW UNDER HIS HEAD. PATIENT STATES THAT HE WAS REACHING FOR THE BED SIDE TABLE WHEN THE AIR MATTRESS SHIFTED, CAUSING HIM TO LOSE BALANCE AND FALL ONTO THE FLOOR. PT DENIES HITING HIS HEAD AND DENIES PAIN AT THIS MOMENT. NEURO CHECKS PERFORMED AND WNL. PATIENT ASSISTED BACK TO BED WITH 3 STAFF AND STATED HE WAS COMFORTABLE WHEN FIXED INTO BED. EDUCATED THE PATIENT ON THE IMPORTANCE OF USING THE CALL LIGHT WHEN IN NEED OF ASSISTANCE. Record review of Resident #3's Progress Notes on 06/16/2025 at 04:35 pm written by PA HH revealed, No issues per nurse. During an interview on 10/21/2025 at 05:19 pm, PA HH stated she could not remember if she had been notified of Resident #3's fall on 06/16/2025, but she was pretty sure the nurse notified her of the fall. PA HH stated, If there are no notes on the fall, that's on me. I must have forgotten. PA HH stated she should have mentioned the fall in her notes. She stated again, If there are no notes on the fall or orders written in my notes, that is on me. I have a lot of patients I see. During an interview on 10/22/2025 at 02:36 pm, the DON stated the nurse should have documented the NP and RP were notified. The DON stated she did not know why PA HH did not document in her notes she was notified of the fall for Resident #3 when she came to see him that day of the fall (06/16/2025). During an interview on 10/28/2025 at 03:16 pm, LVN GG stated when a resident had a fall, she would notify the doctor, notify family, notify DON, and start the neuro checks. She said she did not know why her Progress Note did not show the notifications to the doctor and RP when Resident #3 fell on [DATE]. During an interview on 10/28/2025 at 05:15 pm, the DON stated the nurses should put all information in the Progress Notes when there was a fall. She said the nurse (LVN GG) should have documented the NP/PA and RP were notified. The DON stated she did not know why the PA did not document in her notes she had been notified of the fall for Resident #3 when she came to see him that day. During an interview on 10/29/2025 at 11:40 am, Doctor II stated it was their practice to document unwitnessed falls of residents. He stated Resident #3's unwitnessed fall should have been documented by his PA (PA HH). Doctor II stated he was looking at the notes from his PA who had seen |