

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Mission Valley Nursing and Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 2 of 4 medication carts (400 Hall medication cart and 100/200 Hall medication cart) reviewed for pharmacy services.1. The facility failed to properly label the Med Plus 2.0 that was on the 400-Hall medication cart with an open date. 2. The facility failed to dispose of the medication from 400-Hall medication cart a blister pack of tamsulosin 0.4 MG (medication used to treat an enlarged prostate) capsules which had expired on 01/25/2026.3. The facility failed to dispose of the medication from Hall 100/200 Med-Cart a bottle of Over-the-Counter meclizine 12.5 MG (medication used to treat dizziness, nausea, and vomiting) tablets which had expired on January 2026 and had an opened date of 1/16/2026. These deficient practices could place residents at risk for adverse effects and not receiving the therapeutic effects of the medication or treatment. The Findings included: 1. An observation on 02/10/2026 at 8:05 a.m., revealed during medication pass, MA M opened a new bottle of Med Plus 2.0 that was placed on the 400 hall Medication Cart, and she did not write an open date. In an interview on 02/10/2026 at 8:50 a.m., the MA M stated the Med Plus 2.0 should have an open date written on it. She stated that she was focused on the medications and forgot to write the open date on the bottle. The MA M stated that the OTCs and liquids should have an open date. She stated that it was important to write the open date to know how long the bottle had been opened because the Med Plus 2.0 was milk and it can go bad. The MA M stated the negative outcome would be that it could upset the residents' stomach. In an interview on 02/11/2026 at 11:00 a.m., ADON H stated that the nurses and medication aides were responsible for writing the open date on OTC medications and Med Pass whenever they opened a new bottle. ADON H stated that the negative outcome would be that it could be expired not knowing when it was opened, and could cause stomach upset. He stated the in service for medication administration was done on 01/22/2026. In an interview on 02/11/2026 at 11:09 a.m., the DON stated that the MA M was responsible for writing the open date on the Med Plus 2.0. The DON stated that it was important for the open date to be on the bottles so that they do not administer anything that was expired. 2. In an observation on 2/10/2026 at 2:55 PM of the Hall 400 Med-Cart, it was revealed that a blister pack of tamsulosin 04. MG had an expiration date of 1/25/2026. In an interview on 2/10/2026 at 3:05 PM with CMA D, she said she checked expiration dates on (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications before administering them to the residents. She said that because the tamsulosin was given in the mornings, she did not see the expiration date. CMA D said that it was her responsibility to check all the medication for expiration dates and because she had been in charge of her Med-Cart during her shift, it was her responsibility to ensure no expired medications were in the cart. She said a negative outcome of administering expired medications was that it could be unsafe because it would be unknown the type of damage it could cause to the resident. CMA D said that Resident #23 had a history of refusing his medication and that it was documented on his MAR. She said the last training she received was about six months ago on medication administration which included checking for expired medication but received frequent reminders from management regarding expired and labeled medications. In an interview on 2/10/2026 at 3:11 PM with ADON H, he said that the medication aides were the ones who checked the Med-Carts for expired medications every morning. He said the pharmacy consultant performed monthly audits of the Med-Carts during their rounds. The ADON said he performed random spot checks to ensure expired meds were not in the carts. He said expired medication may not be as effective. The ADON said that the physician and family were aware of the continued refusal of medication by Resident #23. 3. In an observation on 2/10/2026 at 3:17 PM of the Hall 100/200 Med-Cart, it was revealed an Over-the-Counter bottle of meclizine, with an opened date of 1/16/2025, had an expiration date of January 2026. In an interview on 2/10/2026 at 3:17 PM with CMA E, he said he checked the Med-Cart daily for expired meds. He said that he pulled out expired medications from the carts and placed them in the designated spot for discontinued medication in the medication storage room. He said he remembered he had opened the over- the-counter bottle of meclizine and had labeled it with an open date of 1/16/2026. He said that administered expired medications would be less effective for the residents. In an interview on 2/22/2026 at 2:37 Pm with the DON, she said medication aides check the Med-Carts daily, the ADONs perform random spot checks, and the pharmacy consultant performed monthly audits. She said she personally made rounds throughout the day and saw medication aides clean the med-carts and pulled out discontinued medication in blister packs and given to her for destruction. She said the medication aides turned in expired medication to her or the ADON for destruction. She said monthly and PRN meetings were held with the clinical staff which included training in ANE and medication administration. Record review of the facility policy, Medication Administration dated 10/24/22, revealed Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: 2. Cover and date fluids and food. Record review of the facility's policy and procedure manual titled: Expiration Dating and Expired Medication with a revised date: 10/01/29 indicated .7. If the expiration date is expressed in terms of month and year only, the medication will not be utilized after the last day of the month. 8. It is the (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	responsibility of all nurses who administer medications to monitor the expiration dates of the medications. Expired medications will not be administered in the facility. All expired medication will be disposed of per facility policy.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, 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 4 (Resident #13, Resident #116, Resident #10, Resident #79) of 8 residents observed for infection control. 1.The facility failed to ensure MA use proper infection control during her medication administration for Resident #13 on 02/10/2026. 2.The facility failed to ensure RN J changed gloves after touching the bed sheets and the bed remote during medication administration via Gastrostomy tube for Resident #116 on 02/11/2026. 3.The facility failed to ensure Resident #10 was placed under EBP due to a stage 3 sacral wound that started on 02/04/26. 4. CNA F failed to follow Enhanced Barrier Precautions for an indwelling medical device (indwelling catheter) for Resident #79 on 2/10/26. 5. CNA F did not remove their contaminated gloves after cleaning the posterior area and used the same gloves to don clean brief for Resident #79 on 2/10/26. These failures place residents at risk of healthcare associated with cross contamination and infections. The Findings included: 1.Record review of Resident #13's electronic face sheet dated 02/11/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Diabetes Mellitus (chronic condition where the body cannot properly manage blood sugar for energy, causing the buildup in the bloodstream), Hypertension (high blood pressure), Parkinsonism (progressive movement disorder of the nervous system), Peripheral Vascular Disease (a slow and progressive disorder of the blood vessels), Muscle Wasting and Atrophy (decrease in size or wasting away of muscle), and Quadriplegia (a severe medical condition characterized by the partial or total loss of function in all four limbs). Record review of Resident #13's quarterly MDS assessment dated [DATE] revealed she scored a 12 on her BIMS which indicated she was cognitively intact. During an observation on 02/10/2026 at 8:39 a.m., revealed during medication pass, MA placed her clean gloves inside her waistband of her scrub pant. She then proceeded to use the same pair of gloves to administer eye drops for Resident #13. In an interview on 02/10/2026 at 8:50 a.m., MA stated that she did not know that she was supposed to put them inside her waistband of her scrub pant. She stated that she had a lot of medications to administer on her tray and did not have room to put the gloves anywhere else. The MA stated that she should not have put the gloves on her waistband because the gloves were clean and once, they touch her pant, then they get contaminated. She stated the negative outcome would be that the patient can get an infection. The MA stated that she had an in service for infection control monthly. In an interview on 02/11/2026 at 11:00 a.m., ADON H stated that MA should not have put the clean gloves in her waistband of her scrub pant. He stated that this was to prevent contamination and infection control. ADON H stated that they have in-services for infection control frequently. In an interview on 02/11/2026 at 11:10 a.m., the DON stated that the MA should have grabbed the clean gloves and taken them with her on a clean surface. She stated since the MA had multiple medications that she should have cleaned the bedside table and placed her medications and gloves on the clean surface. 2. Record review of Resident #116's electronic face sheet dated 02/11/2026, reflected an [AGE] (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	year-old female admitted to the facility on [DATE]. Her diagnoses included Gastrostomy (a tube inserted through the belly that brings nutrition directly to the stomach), Type 2 Diabetes Mellitus (chronic condition where the body cannot properly manage blood sugar for energy, causing the buildup in the bloodstream), Pressure Ulcer of Sacral Region (area at the base of your spine), Vascular Dementia (group of thinking and social symptoms that interfere with daily functioning), Alzheimer's (a progressive brain disorder that slowly destroys memory and thinking skills, eventually making it difficult to carry out simple daily tasks), and Hypertension (high blood pressure). Record review of Resident #116's MDS assessment dated [DATE] revealed she scored a 0 on her BIMS which indicated she was cognitively severely impaired. During an observation on 02/11/2026 at 8:15 a.m., RN J donned gloves and touched multiple areas of the bed sheet and the bed remote. She then proceeded to touch Resident #116's G-tube and administered medication using the same pair of gloves. In an interview on 02/11/2026 at 8:25 a.m., RN J stated that after touching the bed sheets and the bed remote with gloves, she was to remove gloves and put on new pair of gloves. She stated that she forgot to change them. RN J stated that she was to change gloves every time she touches anything prior to starting the medication administration procedure. She stated that everybody touches the bed remote and it could be contaminated. RN J stated that it was important to change gloves to prevent infection. She stated that she had infection control in service about 2-3 weeks ago. In an interview on 02/11/2026 at 11:00 a.m., ADON H stated that staff were to change gloves after touching the bed remote when going to administer medications via G-tube. He stated that the G-tube was an opening and that it could get contaminated. ADON H stated that the negative outcome would be infection to the G-tube site or sepsis. In an interview on 02/11/2026 at 11:10 a.m., the DON stated that staff were to change gloves after touching the bed sheets and bed remote that was touched by staff, family, and resident. Their hands were dirty, and the staff should change gloves before touching the G-tube, syringe, and the medication. She stated that it was important to change gloves for infection control. The DON stated that they have annual skill check offs and as needed for medication administration. 3. Recod review of Resident #10's admission record dated 02/09/26, reflected a [AGE] year-old male with and admi date of 12/14/24 and an initial admission date of 12/07/24. His relevant diagnoses included vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, damaging brain tissue), Parkinsonism (a clinical syndrome characterized by motor dysfunction) and age-related physical debility (general physical deterioration, frailty, or senile asthenia). Record review of Resident #10's quarterly MDS assessment dated [DATE] reflected a BIMS score of 99, which indicated his cognition was severely impaired. His active diagnoses included a wound infection (other than foot). Record review of the Resident #10's quarterly care plan assessment dated [DATE] reflected a problem [Resident #10] (stage 3) pressure ulcer (sacrum) r/t immobility, incontinence. Date initiated 02/04/26. His interventions in part included cleanse coccyx with Daikin's (antiseptic wound cleanser) 0.125 pat dry pack with moist collagen sheets/powder and adaptic pack green foam and cover with drapes @125MMHG. There was no mention of EBP. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #10's order summary reflected no order for EBP. He had an order that reflected cleanse coccyx (tailbone) with Daikins 0.125 skin prep peri wound pat dry pack with moist collagen sheets or powder and adaptic pack green foam and cover with drapes @ 125MMHG as needed for stage 3 pressure injury date ordered 02/05/26. An observation on 02/09/2026 10:48 a.m., Resident #10 did not have an EBP sign on his door. In an interview on 02/09/26 at 5:00 p.m., LVN A said Resident #10 had a stage 3 ulcer to the sacral area that was covered with a wound vacuum. He said Resident #10 did not need to be under EBP because his wound was not open and was contained. LVN A said during peri-care, CNAs followed the facility's protocol and wore gloves. He said there was a possibility the wound vacuum could come off during peri-care and at that point the CNAs would notify the charge nurse. He said there were no negative outcomes to Resident #10 or other residents if he was not under EBP. LVN A said the facility's Wound Care Nurse was responsible for EBP. In an interview on 02/09/26 at 5:06 p.m., ADON B said Resident #10 had one wound to his sacrum. She said Resident #10's was not required to be under EBP because his wound was not open, was contained and had a wound vacuum. She said CNAs wore gloves during peri-care and that was sufficient. ADON A said if the vacuum came off during peri-care, the CNAs knew to notify the charge nurse. ADON A said there were no negative outcomes to Resident #10 not being under EBP because he did not need to be. In an interview on 02/10/26 at 10:00 a.m., the wound care nurse said Resident #10 had a stage 3 ulcer to his sacral area and had a wound vacuum to help it heal faster. He said he was not aware Resident #10 required to be under EBP since his wound was contained. The wound care nurse said a negative outcome Resident #10 not being under EBP could be cross contamination. In an interview on 02/10/26 at 2:13 p.m., the DON Resident #10 had a wound vacuum applied to a stage 3 sacral wound. She said the his wound was open but covered but nonetheless, he still needed to be under EBP. The DON said she was not sure why Resident #10 had not been under EBP since a negative outcome to Resident #10 not being under EBP would be possibly an infection. 4. Review of Resident #79's admission Record, dated 2/10/26, revealed she was a [AGE] year-old female originally admitted to the facility on [DATE] with diagnosis including Neuromuscular dysfunction of bladder (occurs when nerve damage from conditions like spinal cord injury, or Parkinson's disrupts signals between the brain and bladder), Parkinson's Disease (a progressive, neurodegenerative movement disorder caused by the loss of dopamine-producing brain cells). Review of Resident #79's quarterly MDS Assessment, dated 1/26/26 revealed her BIMS score was 7 meaning she was moderate cognitive impaired. Further review revealed she had a diagnosis of Parkinson's Disease; Resident #79 had a indwelling catheter while a resident. Review of Resident #79's Care Plan dated 11/26/24 revealed: Revised on 2/7/25 Focus: The resident has the need for Enhanced barrier precautions due to foley catheter. Goal: Resident will not experience signs or symptoms of depression as evidenced by no episodes of sad facial expressions or tearfulness secondary to Enhanced Barrier Precautions. Interventions included: Assess the resident for risk factors or current injuries or treatments that could put the patient at risk for infection (wounds, central lines, drains, catheters, tracheostomy). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #79's Order Summary Report, dated 2/10/26, revealed Enhanced Barrier Precautions: Use gown and gloves for high contact resident care activities for those with known to be colonized or infected with a CDC targeted MDRO as well as those with increased risk of MDR. (Foley Catheter/Colostomy) every shift. During an incontinent care observation on 2/10/26 at 10:30 a.m. CNA F commenced incontinent care and indwelling catheter care of Resident #79. CNA F entered Resident #79's room after knocking. CNA F began with washing hands for 30 seconds, gloved up, and prepared table of needed supplies. CNA F continued by the raising bed and then discarded gloves. After discarding the gloves, CNA F continued with applying hand sanitizer and applied new gloves. CNA F proceeded with catheter care and cleaned the bowel movement. Once bowel movement was cleaned, using same pair of gloves, CNA F her removed brief, applied a new brief. CNA F did not use a gown during incontinent care. During an interview on 02/10/26 at 10:40 a.m. CNA F stated any resident with a indwelling catheter was required to be in enhanced barrier precautions. She stated she should have worn a gown and just overlooked it when she entered the room. She stated that she should have changed the gloves before placing the new brief. She stated the risk of not following Enhanced Barrier Precautions was the spread of infection. During an interview on 2/11/26 at 10:45 a.m. LVN C said that it was important to use the EBP to protect residents from whatever microorganisms that she could carry, and to protect other residents. LVN C said residents could be at risk of infection. During an interview on 2/11/26 at 2:20 p.m., the DON stated EBP was staff needing to wear a gown and gloves for individuals with a catheter, feeding tube, or wounds. DON said that it was important to use PPE to prevent introducing any kind of infection to residents. The DON said not using EBP could put residents at higher risk for infection. Record review of the facility's Infection Prevention and Control Program dated 05/13/2023 revealed Policy: This facility has established and maintains 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 as per accepted national standards and guidelines. Policy Explanation and Compliance Guidelines: .2. All staff are responsible for following all policies and procedures related to the program. 4. Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Record review of the facility's Enhanced Barrier Precautions policy dated 11/24/25 reflected: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Definition: enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organism that employs targeted gown and gloves use during high contact resident care activities. Policy Explanation and Compliance Guidelines: 2. Initiation of Enhance Barrier Precautions: b. An order for an enhanced barrier precautions will be obtained for residents with any of the following: i. wounds (e.g., chronic wounds such as pressure ulcers.)		

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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** Based on observations, interviews and record reviews, the facility failed to ensure residents had the right to formulate an advance directive for 1 (Resident #57) of 6 residents reviewed for Advance Directives. The facility failed to ensure Resident #57's OOH-DNR form included a physician's signature. This failure could affect all residents who have implemented Advance Directives and established their choice not to be resuscitated at risk of receiving CPR against their wishes. The findings included: Record review of Resident # 57's admission record, dated [DATE], reflected a [AGE] year-old male with an admission date of [DATE], an initial admission date of [DATE], and an original admission date of [DATE]. His relevant diagnoses included anemia (lack of healthy blood cells or hemoglobin, reducing oxygen transported to body tissue), epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures caused by abnormal electrical activity in the brain), and atherosclerotic heart disease (caused by plaque in arterial walls). Record review of Resident #57's 5-day Medicare MDS assessment, dated [DATE] reflected a BIMS score of 02, which indicated his cognition was severely impaired. Record review of Resident #57's comprehensive care plan dated [DATE] reflected Problem: [Resident #57] is a DNR, date initiated [DATE], his interventions in part included ensure signed DNR is in medical record, date initiated [DATE]. Record review of Resident #57's order summary included an OOH-DNR order effective [DATE]. Record review of Resident #57's OOH-DNR form dated [DATE], reflected it had not been by the attending physician in section E, Physician's Statement: I am the attending physician of the above noted person and have noted the existence of this order in the person's medical records. I direct health care professionals acting in our-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation. It also revealed the physician had not sign section F, All persons who have signed above must sign below, acknowledging that this document has been properly completed. In an interview on [DATE] at 1:55 p.m., SW said it was her responsibility to discuss code status with all residents. She said if a resident or their RP opted to have a code status of DNR, she would initiate the process of completing the OOH-DNR form. She said she would first obtain the resident's or RP's signature, update their code status on their electronic medical record, and notified the charge nurse of their decision to have a code status of DNR. The SW said she would then forward the OOH-DNR form the facility's medical records department where they would notarize the form and forward the OOH-DNR form to the resident's physician to obtain their signature. The SW was observed as she reviewed Resident #57's electronic medical record and said he had been admitted several times to the facility's transitional unit (short-term). She said the OOH-DNR form on file was dated [DATE], which had been obtained during his previous admission. She said the OOH-DNR form did not have a physician's signature, but the facility would still honor his DNR code status because upon admission on [DATE], his RP opted for him to continue with a code status of DNR. In an interview on [DATE] at 2:07 p.m., Medical Records representative said if a resident requested a code status of DNR, the facility's SW initiated the process of getting the OOH-DNR form signed by the resident or their RP. She said once their signatures had been obtained, the SW would forward the OOH-DNR form to her. She said she notarized the OOH-DNR form and requested their physician's signature. She was observed as she reviewed Resident #57's electronic medical record and said the OOH-DNR form on file was dated [DATE] and had not been signed by his physician. She said even though Resident #57's OOH-DNR form had not been by his physician on [DATE], the facility would still honor Resident #57's RP wish for him to be a DNR. She said when a resident was sent to the hospital, the charge nurse would include their OOH-DNR form with the paperwork that was sent with the resident. She said a negative outcome to Resident #57 could be that the hospital would not (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	honor his OOH-DNR form because it did not have a physician's signature and could possibly consider him a full code. In an interview on [DATE] at 2:13 p.m., the DON said it was the responsibility of the facility's SW to discuss code status with all residents. She said if a resident opted to be a DNR, the SW would ensure she got the resident's or their RP signature and then forward the OOH-DNR form to the medical records department. She said the medical records personnel notarized the OOH-DNR form and ensured a physician signed it. She said Resident #57 had been admitted several times to the facility's transitional unit. She said Resident #57's most recent admission was on [DATE] and prior to that was on [DATE]. The DON said Resident #57's RP had signed an OOH-DNR form on [DATE] and since his code status continued being a DNR for his [DATE] admission, the facility did not need to get a new OOH-DNR form. She said the OOH-DNR form followed the resident. The DON said it was the facility's ADONs and her responsibility to ensure all OOH-DNR forms were completed correctly. She said even though Resident #57's OOH-DNR form had not been signed by a physician, the facility would still honor his code status of DNR. The DON said there were no negative outcomes to Resident #57 not having his OOH-DNR form signed by a physician because his electronic medical records indicated he was a DNR. She said the facility did not have a policy related to code status.		

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NAME OF PROVIDER OR SUPPLIER Mission Valley Nursing and Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 S Bryan Rd Mission, TX 78572	
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record review, the facility failed to provide the right to personal privacy, which includes accommodations during medication administration for 1 (Resident #116) of 6 Residents reviewed for Privacy. The facility failed to ensure RN K closed the door or the curtain during medication administration via gastrostomy tube for Resident #116 on 02/10/2026. This failure could place the residents at risk of not having their personal privacy maintained during medical treatment. The Findings included: Record review of Resident #116's electronic face sheet dated 02/11/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. A diagnosis was Gastrostomy (a tube inserted through the belly that brings nutrition directly to the stomach). Record review of Resident #116's MDS assessment dated [DATE] revealed she scored a 0 on her BIMS which indicated she was cognitively severely impaired. Nutritional approach was feeding tube. During an observation on 02/10/2026 at 4:36 p.m., RN K kept the door and the curtain open during the medication administration procedure via G-tube (a soft, flexible tube into the stomach to deliver liquid nutrition, fluids, and medications directly to the digestive tract). Staff were seen passing by the room and looking in Resident #116's room while RN K was administering medication. RN K was having a difficult time administering medication via G-tube. He then went back out of the room a second time to get a new syringe. He then went back into Resident #116's room to continue with his medication administration and once again left the door and curtain open. In an interview on 02/10/2026 at 4:57 p.m., RN K stated that he was to close the door and the curtain before doing any care with Resident #116. He stated that he got nervous and forgot. RN K stated that he should have provided the resident with privacy. He stated that he had been trained on resident privacy and dignity. In an interview on 02/11/2026 at 10:50 a.m., ADON L stated that staff should provide privacy anytime they administer medications. She stated that all staff had been trained. ADON L stated that staff should close the door, the curtain, and close the blinds when providing care. She stated that this was important to provide privacy. In an interview on 02/11/2026 at 11:10 a.m., the DON stated that RN K should have closed the door and the curtain prior to administering medication to Resident #116. She stated that staff should provide privacy when providing care due to at times being exposed. The DON stated that in-services for privacy and dignity are done frequently. Record review of the facility's policy, Promoting/Maintaining Resident Dignity dated 01/13/23, revealed Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances residents quality of life by recognizing each residents individuality. Compliance Guidelines: All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. 12. Maintain resident privacy. Record review of the facility's policy, Enteral Tube Medication Administration revised date 10/01/19, revealed Procedure: Establish the privacy of the patient.		

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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 observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet resident's mental and psychosocial needs, for 1 Residents (Resident#73) of 3 residents reviewed for care plans. The facility did not develop and implement a comprehensive person-centered care plan to address Resident#73's behaviors. These failures could residents at risk for their mental and psychosocial needs not being met. The findings included: Record review of Resident#73's face sheet, dated 2/9/26, revealed Resident #73 was 66 years-old male and was initially admitted to the facility on [DATE]. Resident#73's diagnoses included: Muscle Weakness, Hemiplegia and Hemiparesis following cerebral infraction affecting right dominant side (long-term weakness or paralysis on the right side of the body caused by a previous stroke affecting the brain's dominant hemisphere). Record review of Resident#73's Quarterly MDS assessment, dated 12/2/25, revealed Resident#73 had moderate cognitive impairment; was able to make self-understood; and was usually able to understand others. Record review of Resident #73's Comprehensive care plans dated 5/30/22 revealed no focus, goals or interventions/tasks related to Resident#73's behavioral issues, refusing using the plate guard while eating. Record review of Resident#73's Order Summary dated 2/9/26 revealed May use Sippy Cup and Plate Guard with meals. During an observation on 2/9/26 at 1:00 p.m., Resident #73 was in the dining room without the plate guard. During an interview on 2/9/26 at 1:01 p.m., Resident #73 stated that he did not want to use the plate guard. During an interview on 2/9/26 at 1:04 p.m., CNA I stated that Resident #73 refused to use the plate guard. She stated nurses were aware of Resident #72 refusing to use the plate guard. During an interview on 2/11/26 at 10:09 a.m., LVN C stated that he had seen Resident #73 refusing to use the plate guard. LVN C said when Resident #73 refused to use the plate guard they should have informed DON about the refusal to update the care plan. LVN C said that there was not a negative outcome for refused to use the plate guard because Resident #73 eat good without the plate guard. LVN C said that he should have called the doctor to get an alternative resolution, like occupational therapy for Resident #73. During an interview on 2/11/26 at 1:55 p.m., MDS nurse stated that nurses, ADONs and DON were responsible for updating the care plans. She said that she was not aware of Resident #73 refusing to use the plate guard. During an interview on 2/11/26 at 2:15 p.m., the DON said Resident #73 had refused to use the plate guard. DON said that MDS nurses and all nurses were responsible for updating the care plan. DON said that when a resident refused using the plate guard should have been care planned and nurse should have informed the doctor about the refusing. DON said that the negative outcome was that nurses and aides were not following the doctor's order. Record review of the facility's policy on, Comprehensive Care Plans, with an implemented date 10/24/2022, revealed: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident's rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #10) of 6 residents reviewed for administration. The facility failed to ensure Resident #10 had an order for EBP (refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloved use during high contact resident care activities). This failure could place residents at risk of not receiving nursing services by adequately trained nurses and could result in a decline in health. The findings included: Record review of Resident #10's admission record dated 02/09/26, reflected a [AGE] year-old male with and adm date of 12/14/24 and an initial admission date of 12/07/24. His relevant diagnoses included vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, damaging brain tissue), Parkinsonism (a clinical syndrome characterized by motor dysfunction) and age-related physical debility (general physical deterioration, frailty, or senile asthenia). Record review of Resident #10's quarterly MDS assessment dated [DATE] reflected a BIMS score of 99, which indicated his cognition was severely impaired. His active diagnoses included a wound infection (other than foot). Record review of the Resident #10's quarterly care plan assessment dated [DATE] reflected a problem [Resident #10] (stage 3) pressure ulcer (sacrum) r/t immobility, incontinence. Date initiated 02/04/26. His interventions in part included cleanse coccyx with Daikin's 0.125 pat dry pack with moist collagen sheets/powder and adaptic pack green foam and cover with drapes @125MMHG. There was no mention of EBP. Record review of Resident #10's order summary reflected no order for EBP. He had an order that reflected cleanse coccyx with Daikins 0.125 skin prep peri wound pat dry pack with moist collagen sheets or powder and adaptic pack green foam and cover with drapes @ 125MMHG as needed for stage 3 pressure injury date ordered 02/05/26. In an interview on 02/09/26 at 5:00 p.m., LVN A said Resident #10 had a stage 3 ulcer to the sacral area that was covered with a wound vacuum. He said Resident #10 did not need to be under EBP because his wound was not open and was contained. LVN A said during peri-care, CNAs followed the facility's protocol and wore gloves. He said there was a possibility the wound vacuum could come off during peri-care and at that point the CNAs would notify the charge nurse. He said there were no negative outcomes to Resident #10 or other residents if he was not under EBP. LVN A said it was the responsibility of the facility's wound care nurse to treat Resident #10's wound and obtain an order for EBP if one was needed. In an interview on 02/09/26 at 5:06 p.m., ADON B said Resident #10 had one wound to his sacrum. She said Resident #10's was not required to be under EBP because his wound was not open, it was contained and had a wound vacuum. She said CNAs wore gloves during peri-care and that was sufficient. ADON A said if the vacuum came off during peri-care, the CNAs knew to notify the charge nurse. ADON A said there were no negative outcomes to Resident #10 not being under EBP. She said there was no EBP order because one was not needed. In an interview on 02/10/26 at 10:00 a.m., the Wound Care Nurse said it was his responsibility to complete wound care to residents. He said if a resident required to be under EBP, he would notify their doctor to obtain an order. He said Resident #10 had a stage 3 ulcer to his sacral area and had a wound vacuum to help it heal faster. He said he was not aware; Resident #10 was required to be under EBP since his wound was contained. The Wound Care Nurse said a negative outcome Resident #10 not being under EBP could be cross contamination. In an interview on 02/10/26 at 2:13 p.m., the DON stated Resident #10 had a wound vacuum applied to a stage 3 sacral wound. She said, his wound was open and covered but nonetheless, he needed to be under EBP. She said she was not sure why he was under EBP. The DON said a negative outcome to Resident #10 not being under EBP would be possibly an infection. Record review of the facility's Enhanced Barrier (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Precautions policy dated 11/24/25 reflected:Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definition: enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organism that employs targeted gown and gloves use during high contact resident care activities. Policy Explanation and Compliance Guidelines:2. Initiation of Enhance Barrier Precautions:b. An order for an enhanced barrier precautions will be obtained for residents with any of the following:i. wounds (e.g., chronic wounds such as pressure ulcers.)		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure nurse staffing data was posted daily and readily accessible to residents and visitors with all required information for 3 of 3 days reviewed (02/7/26, 02/8/26, and 02/9/26) for nurse staffing posting. The facility failed to post the daily staffing information in a prominent place on 02/7/26, 02/8/26, and 02/9/26. This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts. Findings included: Upon observation during entrance to the facility on [DATE] at 8:39 am, State Surveyor observed a clear frame on the right side of the extended care nurses station, on the wall next to the dining area of the transitional care displaying name of facility and the total number of CNAs, LVNs, and RNs dated 02/6/26. An interview on 02/11/26 at 2:20 p.m., DON said she was in charge of posting the daily staff information. She said she would make sure the daily staff information were posted by 8:30 am on a daily basis. She said the negative outcome for not posting the staff information would be we would not have communication between residents/visitors and staff. An interview on 02/11/26 at 2:45 p.m., the Administrator said it was the responsibility of the DON to post the nursing staffing information. She said the daily postings should be up by 8:30 a.m. She said there were no negative outcome for not having the staff information posted just miscommunication between residents and staff. Record review of the facility's Nurse Staffing Posting Information policy dated 10/2022 reflected: Policy:It is the policy of this facility to make nurse staff information readily available in a readable format to residents and visitors at any given time. Policy explanation and compliance guidelines:1. The nurse staffing sheet will be posted on a daily basis and will contain the following informationb. the current date		