

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Mid Valley Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 601 N Mile 2 West Mercedes, TX 78570	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737</p> <p>Based on observation, interview and record review, the facility failed to 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 1 of 4 residents (Residents #2), reviewed for pharmaceutical services, in that:</p> <p>The facility failed to ensure Resident #2 had his physician ordered Entresto (medication used for heart failure) available on 03/22/24.</p> <p>This failure could place residents at risk for not receiving medication as ordered.</p> <p>The findings included:</p> <p>Record review of Resident #2's face sheet, dated 04/16/24, revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included: essential (primary) hypertension (Blood pressure that is higher than normal), chronic kidney disease (kidneys are damaged and cant filter blood the way they should), stage 5 (end stage kidney disease), dependence on renal (kidney) dialysis (removing extra fluid and waste products from blood when the kidneys are unable to), atherosclerotic (buildup of plaque causing arteries to narrow and limiting blood flow to heart) heart disease of native coronary artery without angina pectoris (chest pain caused by reduced blood flow to the heart), cardiac arrhythmia (irregular heartbeat), unspecified, type 2 diabetes mellitus (high blood sugar) with unspecified complications and peripheral vascular disease, unspecified (circulatory condition in which narrowed blood vessels reduce blood flow to the limb).</p> <p>Record review of Resident #2's modified Medicare 5-day Minimum Data Set assessment, dated 03/22/24, revealed Resident #2 did not have a BIMS score due to not being assessed.</p> <p>Record review of Resident #2's care plan, retrieved on 04/16/24, revealed Resident #2 had a focus of, I have heart disease. I am at risk for associated cardiac complications and a focus of, I have ESRD (End Stage Kidney Disease) and require dialysis treatments, both with an initiated date of 03/22/24.</p> <p>(continued on next page)</p>

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
-----------------------------------------------------------------------	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Mid Valley Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 601 N Mile 2 West Mercedes, TX 78570	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's physician's orders, retrieved on 04/16/24, revealed an order for Entresto (heart medication that included 2 blood pressure lowering medications sacubitril and valsartan) Oral Tablet 49-51MG (sacubitril- Valsartan) with directions to give 1 tablet by mouth two times a day for heart failure with an order date of 03/22/24 at 3:31am.</p> <p>Record review of Resident #2's March medication administration record revealed CMA A documented Resident #2's blood pressure was 129/59 when checked during in the morning on 03/22/24. There was no option to document the exact time it was taken.</p> <p>Record review of Resident #2's March medication administration record revealed CMA A documented a 9 which indicated, other: nurse verbally informed [reason] for Resident #2's morning dose of Entresto on 03/22/24.</p> <p>Record review of Resident #2's eMAR- medication administration note dated 03/22/24 at 9:50am written by CMA A reflected Entresto was pending.</p> <p>During an interview on 4/15/24 at 3:02pm with LVN B she stated Resident #2's Entresto was not given on 03/22/24 because they did not have it, LVN B stated they had a pyxis (medication storage and dispensing system) and stated Entresto was not there. LVN B also stated Resident #2's diastolic pressure (the pressure as the heart relaxes before the next beat)was 58 or 59 and stated she figured Entresto would not be given. LVN B stated Resident #2 was admitted at midnight on 03/22/24 and stated the pharmacy they used was in San [NAME] and would take until the following evening to get the medication. LVN B stated she though Entresto was a life sustaining medication if I was for heart failure.</p> <p>During observation and interview on 4/15/24 at 3:28pm with LVN B she checked the facility Pyxis (medication storage and dispensing system) for Entresto and stated they did not have Entresto available.</p> <p>During an interview with LVN B on 4/15/24 at 4:00pm she stated missing a dose of Entresto that was used for heart failure was going to cause something.</p> <p>During an interview with CMA A on 04/15/24 at 4:26pm, she stated when a resident did not have a medication available she would write a progress note and notify the nurse who was responsible for notifying the doctor and pharmacy. CMA A stated she told LVN B that the Entresto was not available on 03/22/24. CMA A stated she had not notified the pharmacy or doctor because she was not authorized to and stated the nurse would make those notifications. CMA A stated the doctor and pharmacy should have been notified that the Entresto was not available. CMA A stated she had been trained by the DON over notifying the doctor and pharmacy when medications were not available. CMA A stated If Resident #2 missed a dose of Entresto he would get sick.</p> <p>During an interview with the DON on 04/15/24 at 5:21pm, she provided communication between the ADON and MD C stating MD C would not be speaking with Surveyor D. The DON stated medications had to be input by 8pm because the pharmacy driver would leave to deliver the medication. The DON stated more than likely there would not have been an alternative medication for Entresto and stated this was because they don't usually get an alternate for blood pressure medication. The DON stated Resident #2's did not meet blood pressure parameters.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Mid Valley Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 601 N Mile 2 West Mercedes, TX 78570	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/16/24 at 10:38am with a pharmacy representative, she stated they had received an order for Entresto on 03/22/24 at 3:39am from the facility and stated it was delivered to the facility and signed for on 03/23/24 at 4:19am. The pharmacy representative stated there was no documentation of a request for an alternative medication or any other order for short supply. The pharmacy representative stated Resident #2's order for Entresto did not include any parameters. The pharmacy representative stated Entresto was used to lower blood pressure and if missed would increase blood pressure.</p> <p>During an interview on 04/16/24 at 1:49pm, CMA A was asked how not notifying the doctor of medications being unavailable could negatively impact a resident and she stated that on 03/22/24 Resident #2's blood pressure was not within parameters to administer his blood pressure medication and stated even if they had Entresto available she would not have administered it because it was a blood pressure medication. CMA A stated Entresto would help blood pressure go down and stated if Entresto was not provided it could cause hypertension.</p> <p>During an interview with LVN B on 04/16/24 at 1:59pm she stated she was notified by CMA A that Resident #2 did not have Entresto available on 03/22/24 but did not recall a specific time. LVN B stated nurses were responsible for notifying the doctor when medications were not available and stated she should have notified the doctor that Entresto was not available because they could potentially have found another medication or something equivalent. During a previous interview on 04/15/24 at 4:00pm LVN B did not have a reason why she did not notify the doctor of Entresto not being available for Resident #2. LVN B stated the DON had provided her training over making notifications to the pharmacy and doctor if medications were not available. LVN B stated the DON would check the phone and review what messages had been sent and to who in order to monitor for any notifications that needed to be made to the doctor. LVN B stated not notifying the doctor of medications that were not available couple negatively impact residents in a lot of way.</p> <p>During an interview with the DON on 04/16/24 at 1:28pm, The DON stated she did not recall if she verified that Entresto would be available for the Resident #2 when he admitted and stated she was not sure if the admitting nurse identified Entresto was not available when Resident #2 was admitted . The DON stated when a medication was not available they would try to take out as many medications as they could from the pyxis and stated not all medications were in there and stated if they were then the doctor would need to be notified so that he would be aware that the resident would not be taking Entresto. The DON stated when LVN B was made aware of Resident #2's Entresto not being available she was responsible for notify the doctor and should have notified the doctor. The DON stated she did not believe the doctor would have said anything because Resident #2's blood pressure was not in the parameters for blood pressure medication and stated if blood pressure was below 110/60 it should not be administered. The DON stated she monitored staff were making the appropriate notifications to the doctor by reviewing the medication administration records. The DON stated herself and other nursing manager had provided training to facility staff over notifying the doctor when medications were unavailable. The DON stated the negative impacts of not notifying the doctor when a medication unavailable would depend on the situation and stated in this situation it was better Resident #2 did not receive the medication. The DON stated Entresto was not a life sustaining medication and was used to lower blood pressure.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Mid Valley Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 601 N Mile 2 West Mercedes, TX 78570	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/16/24 at 3:20pm the DON stated she did not have Inservice documentation for CMA A and LVN B that covered making notifications to the doctor and stated she was working on it at that time. At time of exit on 4/16/24 there was no Inservice documentation provided for making notifications to the doctor.</p> <p>Record review of facility policy titled, Pharmacy Services: Provision of Medications and Biologicals with an implementation date of February 2017 and a revised date of November 2023 included verbiage stating, The community is responsible for the timely acquisition and administration of medications and biologicals. A drug, whether prescribed on a routine, emergency, or as-needed basis, must be provided in a timely manner. And The nursing team members will report drug errors and adverse drug reactions to the resident's physician in a timely manner, as warranted by an assessment of the resident's condition, and record them in the resident's record. An incident report must be completed. Medication errors include, but are not limited to, administering the wrong medication, administering at the wrong time, administering the wrong dosage strength, administering by the wrong route, omitting a medication, and/or administering to the wrong resident.</p>		