STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676414	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid Valley Nursing & Rehabilitation	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)
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** 45737 Based on interviews and record review, the facility failed to develop and implement a person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 4 residents (Resident #1) reviewed for comprehensive care plans. The facility did not include Resident #1's pruritis (itchy skin) and behavior of itching and scratching on care plan. This failure could place residents at risk for not receiving appropriate treatment and services. The findings included: Record review of Resident #1's face sheet, dated 03/07/25, revealed the resident was a [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: type 2 diabetes mellitus (high blood sugar) without complications, malignant neoplasm of bladder (bladder cancer or cancerous tumor that develops in bladder), unspecified, acute respiratory failure with hypoxia, dysphagia, oral pharyngeal phase (swallowing disorder that affects the muscles and nerves in the mouth, throat and upper esophagus), and nontraumatic intracranial hemorrhage (bleeding within the brain that occurs without head injury), unspecified. Record review of Resident #1's quarterly MDS assessment, dated 01/31/25, revealed Resident #1 had a BIMS score of 15, indicating he was cognitively intact. Record review of Resident #1's nursing notes from 01/23/25 revealed, CARE PLAN MEETING: IDT met with patient in his room .expressed concerns regarding itching to his skin, Nursing informed, MD aware. Record review of Resident #1's notes from 01/31/25 documented by PA stated, Dermatology referral to [MD] Record review of Resident #1's order summary report reflected an active order to refer to dermatology for DX: Pruritus with an order date of 01/31/25. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan with an initiation date of 07/26/24 included a focus of Admission/Readmission Care Plan; I may be at risk for: self-care, deficits, skin concerns, pain, infection & nutritional/hydration concerns and emotional distress with an initiation date of 07/26/24 and interventions of, 1. Administer medication, care & treatments as per MD recommendation . 4. Monitor vital signs and health conditions as indicated,. Further review of care plan did not include any verbiage related to pruritus or Resident #1's behavior of itching. During an interview with Resident #1 on 03/06/25 at 1:12pm he stated he previously use to be itchy all over his body and was scratching his whole body before. Resident #1 stated they were using creams and it helped fix his issue and stated it had gotten better and he did not itch anymore. During an interview and observation with the Treatment Nurse on 03/07/25 at 3:38pm she stated the DON or MDS nurse was responsible for completing and updating resident care plans, she was unaware of how often resident care plans were updated or completed. The Treatment Nurse stated Resident #1 had dry, itchy skin, pruritus, and behaviors such as itching and scratching, and stated he had this on and off since he had been at the facility. The Treatment Nurse stated residents skin conditions such as dry, itchy skin, pruritus, and behaviors such as itching and scratching should be on the care plan. The Treatment Nurse stated she did not personally attend any meetings and did not know how the MDS nurse was notified of any skin conditions or behaviors identified on residents. The Treatment Nurse reviewed Resident #1's care plan and stated there was nothing on there related to Resident #1 having pruritus, dry, itchy skin, having behaviors of itching or scratching. The Treatment Nurse stated the care plan she reviewed only included a general focus on skin assessment and that Resident #1 was at high risk for skin break down. The Treatment Nurse was unable to answer why Resident #1's care plan did not reflect his related skin conditions/behaviors. The Treatment Nurse stated it was important that the care plan reflected any skin changes or related behaviors so that everyone would know and because it was the process of caring for the resident, and stated they had to know what was being done and resolved at all times. The Treatment Nurse stated not accurately reflecting residents skin changes, condition and behaviors on the care plans could negatively impact them because they would not be providing the care, they needed for the resident's quality of care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation with the MDS nurse on 03/07/25 at 4:59p.m., he stated he was responsible for completing and updating the care plans and stated they should be updated upon admission and when a resident had a change in medication, treatment, orders or any assessments. The MDS nurse stated residents skin conditions such as dry, itchy skin, pruritus and behaviors such as itching and scratching should be on the resident's care plan. The MDS nurse stated he was notified of any skin conditions or behaviors identified on residents during morning meetings, by nurses reporting any treatment, reviewing new orders daily and stated he also shared an office with the Treatment Nurse. The MDS nurse stated Resident #1 had pruritus, itchy, dry skin and behaviors of itching and scratching and stated they had a care plan meeting with him and he referred it to nursing and had told them about getting a consult with a skin doctor so they could know what was going on. The MDS nurse stated Resident #1 would keep scratching with a back scratcher he had and stated he provided him health education on not scratching for prevention. MDS nurse stated he had noted Resident #1 with those skin conditions and behaviors since Resident #1 had been at the facility. The MDS nurse reviewed Resident #1's care plan and stated there was nothing on there related to Resident #1 having pruritus or having behaviors or itching or scratching. The MDS nurse could not recall and was not sure why Resident #1's care plan did not reflect his related skin conditions/behaviors. The MDS nurse stated it was important that the care plan reflected any skin changes or related behaviors so that treatment would be followed. The MDS nurse stated he had been trained over completing or updating resident care plan by his regional but did not remember when. The MDS nurse stated he had reviewed the facility policy related to accurate and updated care plans but could not recall the exact policy, the MDS nurse stated he had followed the facility related policy. The MDS nurse stated he monitored and oversaw care plans to ensure they accurately reflected residents skin changes, conditions, and behaviors. The MDS nurse stated not accurately reflecting residents skin changes, condition and behaviors on the care plans could negatively impact them because treatment would not be followed and there would be no continuity of care and you won't be able to evaluate the effective of treatment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation with the DON on 03/07/25 at 5:37p.m., she stated usually the MDS nurse was responsible for completing and updating the care plans and stated any of her nurse managers and herself could also do it. The DON stated care plans were completed and updated daily because the MDS nurse would print out any new orders and if something was coming up they would discuss it in their morning meetings. The DON stated the MDS was notified of any skin condition or behaviors during the morning meeting and should identify them himself when reviewing the orders and documentation. The DON stated residents skin conditions such as dry, itchy skin, pruritus and behaviors such as itching and scratching should be on the residents care plan if they are current and should be resolved when done. The DON stated Resident #1 did not currently have anything. The DON stated Resident #1 was scratching but did not know if he had a diagnosis of pruritus and stated he currently did not have anything active, The DON stated Resident #1 has had this on and off since admission. The DON reviewed Resident #1's care plan and stated there was nothing on there related to pruritus. The DON stated she was unable to say why Resident #1's care plan did not reflect his related skin conditions/behaviors and stated the only thing she could think of was because he did not currently have any treatment in place. The DON stated it was important that the care plan reflected any skin changes or related behaviors because it was part of their assessment and care plans had to be personalized to the residents and whatever they are going through. The DON stated her and the MDS nurse had trained over completing or updating resident care plans but did not know by who or when. The DON stated the facility policy related to accurate and updated care plans stated care plans had to be updated and personalized to the residents. The DON stated in this situation she thought they had followed the facility policy. The DON stated the MDS nurse, herself or any nurse mangers monitored and oversaw care plans to ensure they accurately reflected residents skin changes, conditions and behaviors. The DON stated she did not think not accurately reflecting residents skin changes, condition and behaviors on the care plans would have negatively impacted residents. The DON stated she thought they did everything they could for Resident #1 and stated he got treatment in house and will still be done as needed for Resident #1. Record review of licensed nurse competencies checklist dated 04/10/24 revealed the DON checked off as met under the general section for Kardex/Plan of Care. Record review of licensed nurse competencies checklist dated 05/06/24 revealed the Treatment Nurse checked off as met under the general section for Kardex/Plan of Care. Record review of licensed nurse competencies checklist dated 02/02/24 revealed the MDS nurse was checked off as met under the general section for Kardex/Plan of Care. Record review of facility policy titled Care Plans with an implemented date of February 2017 and a revised date of January 2023 included a section titled, Guidelines: .Care Plans that included the following verbiage: The Care plan should be reflective of the identified problem or risk, a measurable outcome objective and appropriate intervention/interventions in relation to the identified problem or risk outcome objective, and the resident's ability, needs, medical condition, preventive measure.

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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** 45737 Based on observation, 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 of 4 residents (Resident #1) reviewed for medical records accuracy, in that: The facility failed to document Resident #1's physician ordered weekly total body skin assessment. 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. The findings included: Record review of Resident #1's face sheet, dated 03/07/25, revealed the resident was a [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: type 2 diabetes mellitus (high blood sugar) without complications, malignant neoplasm of bladder (bladder cancer or cancerous tumor that develops in bladder), unspecified, acute respiratory failure with hypoxia, dysphagia, oral pharyngeal phase (swallowing disorder that affects the muscles and nerves in the mouth, throat and upper esophagus), and nontraumatic intracranial hemorrhage (bleeding within the brain that occurs without head injury), unspecified. Record review of Resident #1's quarterly MDS assessment, dated 01/31/25, revealed Resident #1 had a BIMS score of 15, indicating he was cognitively intact. Record review of Resident #1's care plan with an initiation date of 07/26/24included a focus of Admission/Readmission Care Plan; I may be at risk for: self-care, deficits, skin concerns, pain, infection & nutritional/hydration concerns and emotional distress with an initiation date of 07/26/24 and interventions of, 1. Administer medication, care & treatments as per MD recommendation . 4. Monitor vital signs and health conditions as indicated,. Record review of Resident #1's active physician's orders revealed orders to Complete the [electronic documentation software] skin & wound - Total Body Skin Assessment, with a frequency of every day shift every Mon (Monday) for Skin Integrity with a start date of 08/12/24 and end date of indefinite. Record review of Resident #1's total body assessment revealed Resident #1's last total body skin assessment was completed on 02/19/25. Record review of Resident #1's February 2025 TAR reflected his order for total body skin assessment on 02/24/25 had been signed off by the ADON. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation with the Treatment Nurse on 03/07/25 at 3:38pm she stated she was responsible for completing skin assessments and completed them every Monday and Tuesday. The Treatment Nurse reviewed Resident #1's physician orders and stated he had orders for weekly body audits on Mondays. The Treatment Nurse stated after 02/19/25 Resident #1's next skin assessment would have been due on 02/26/25. The Treatment Nurse stated she was not working from 02/13/25-03/03/25 and stated during that time the DON would have had to delegate somebody to complete the skin assessments or she would have made herself responsible for completing the skin assessments. The Treatment Nurse stated she did not know who completed the skin assessment on 02/26/25 for Resident #1 but she stated she was able to see it on her end. Treatment Nurse reviewed the copy of Resident #1's assessments retrieved on 03/05/25 by Surveyor A and stated the last skin assessment she saw was on 02/19/25 and did not know why there was not one documented on 02/26/25. The Treatment Nurse stated during the time of Resident #1's missed skin assessment he did not have any skin break down and was just monitored for any itchiness. The Treatment Nurse stated it was important to follow physician orders and complete and document residents skin assessments weekly to make sure there was no skin breakdown and stated her goal was to keep residents free of wounds. The Treatment Nurse did not know what the facility policy stated in regard to following physician orders and documenting skin assessments, she stated she had not been trained over completing and documenting skin assessments. The Treatment Nurse stated the DON would monitor her skin assessments to ensure completion and documented had been completed. The Treatment Nurse stated not completing and documenting skin assessment could negatively impact residents because it was not done. During an interview and observation on 03/07/25 at 5:37 p.m., with the DON she stated the Treatment Nurse was responsible for completing the skin assessment but stated she was responsible for the previous 2 weeks because the Treatment Nurse was out, the DON did not recall the exact dates the Treatment Nurse was out. The DON reviewed Resident #1's physician orders and stated he had orders for weekly skin assessments. The DON reviewed Resident #1's list of assessments from 03/05/25 and confirmed the last skin assessment completed was on 02/19/25 and stated the following date for a skin assessment for Resident #1 was on 02/26/25. The DON stated she was responsible for completing the skin assessment for Resident #1 on 02/19/25 and 02/26/25. The DON stated she did complete the skin assessment on 02/26/25 and her ADON signed the MAR but did not complete the skin assessment form, the DON stated the forms do not tell you much. The DON stated she did not complete the skin assessment form because it just got passed her and she must have forgot. The DON stated Resident #1 did not have any skin issues during the time his skin assessment was not documented. The DON stated it was important to follow physician orders and complete and document skin assessments because they have to make sure they are checking residents and to prevent anything or catch something the was not being done. The DON stated the facility policy regarding following physician orders and documenting skin assessments stated if they found a wound, they had to complete a different assessment with the measurements of the wound and the notifications made. The DON stated the facility did follow this policy. The DON stated she had been trained over completing and documenting skin assessments but did not know by who and stated she was trained during in services via [video conferencing platforms]. The DON Stated she monitored and oversaw the skin assessment to ensure completion and documentation had been completed during their daily meetings. The DON stated if they don't do their weekly audits there was no negative impact on the residents and stated they sign off on the MAR and if there's anything new, they will document and call the MD so there's no negative impact. Record review of licensed nurse competencies checklist dated 04/10/24 revealed the DON was checked off as met under the general assessment section of skin, hair, nails, and under the evaluation/notification/documentation section on admission orders and physician orders. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of licensed nurse competencies checklist dated 05/06/24 revealed the Treatment Nurse was checked off as met under the general assessment section of skin, hair, nails, and under the evaluation/notification/documentation section on admission orders and physician orders. Record review of facility policy titled, Skin and Wound Prevention and Management with am implemented date of 03/14/29 and revised date of January 2023 included verbiage under the section titled Guideline: that reflected, 1 A licensed nurse should at least weekly conduct a routine skin assessment/evaluation in order to identify new pressure injuries or other types of skin concerns. The licensed nurse should document the results of weekly skin checks in the resident's medical record.