

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 04/11/2025
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident who was incontinent of bladder received the appropriate treatment and services to prevent urinary tract infections for one of two (Resident#2) residents reviewed for catheter care.</p> <p>The facility failed to ensure CNA A used the proper wiping technique when providing perineal/in continent care to Resident #2. CNA A reused wipes when cleaning the urethral opening of Resident #2's penis and provided incontinence care with Resident #2 standing.</p> <p>This deficient practice could place residents with catheters at risk of infection and decline in health.</p> <p>The findings included:</p> <p>Record review of Resident #2's face sheet, dated 04/11/25, revealed the resident was an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: hematuria (blood in the urine), benign prostatic hyperplasia (nonmalignant enlargement of prostate gland) without lower urinary tract symptoms, retention of urine (inability to empty all the urine from the bladder), and urinary tract infection (infection that affects part of the urinary tract).</p> <p>Record review of Resident #2's quarterly MDS assessment, dated 01/26/25, revealed Resident #2 had a BIMS score of 00, indicating his cognition was severely impaired. Resident #2's section H - bladder and bowel reflected Resident #2 had an indwelling catheter.</p> <p>Record review of Resident #2's care plan with an initiated date of 08/14/23 reflected a focus of, I require a foley catheter (F20 [French tubing size] 30cc [inflation amount] balloon) DX [diagnosis] obstructive uropathy (blockage that prevents urine from flowing normally through the urinary system). Interventions included, Catheter Care every shift and as indicated.</p> <p>Record review of Resident #2's active physician's orders on 04/11/25 revealed an order for Foley catheter care with perineal wipes and/or soap and water Q SHIFT and PRN with a frequency of every shift and scheduled every day with a start date of 12/21/24 and end date of indefinite.</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
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation RN Surveyor completed an observation of perineal care/incontinent care completed by CNA A and CNA B on Resident #2 on 04/11/25 at 10:05am. CNA A was observed placing Resident #2's wheelchair near a grab bar in the restroom. Resident #2 grabbed the bar with both hands and was assisted to standing by CNAs A and B. During observation of care RN surveyor observed CNA A wipe the top of Resident #2's penis 3 times reusing the same wipe each time. RN Surveyor noted Resident #2 was tired of standing, holding on to the grab bar and was asked if he was okay and if anything was bothering or hurting him. Resident #2 stated in Spanish, Si me molesta [NAME] lo aguantó, which when translated to English means, yes, it bothers me but I put up with it. During this time RN Surveyor observed Resident #2's catheter tubing appeared to hang due to gravity. CNA A stated she had always provided incontinence care with Resident #2 standing. CNA A was observed returning to Resident #2's head of penis and wiped 2 more times reusing the same wipe each time.</p> <p>During an interview with CNA A on 04/11/25 at 12:15pm she stated she had last been trained or in-serviced over incontinent care for a male resident with a Foley catheter in November or December of 2024. CNA A stated CNA C provided the training for catheter care. CNA A stated she had been trained to wipe once and throw the wipe away after. CNA A stated she did not recall reusing any wipes when providing incontinent care to Resident #2 and stated she should not have done that. CNA A stated reusing a wipe could contaminate the area she was providing care to and could cause the resident to get an infection. CNA A stated it was important to provide the correct care because it could cause infection. CNA A stated they normally stood Resident #2 when providing perineal care. CNA A was not sure why it was done in standing but stated it has always been done that way.</p> <p>During an interview with the DON on 04/11/25 at 3:15pm she stated staff were trained over perineal care annually and during random check offs. The DON stated when staff completed check offs it included residents with foley catheters. The DON stated CNA C was in charge of the trainings and she would observe. The DON stated if staff used wipes, it was usually the same steps as when using a wash cloth which was to fold and use another side. The DON stated staff could use the same wipe as long as they folded it and used a clean side. The DON stated she thought this was the process. The DON stated she was not the one who did the training, and she would just observe the training and was not sure if that was how CNA A was trained. The DON stated if the proper technique was not used residents could develop a buildup of bacteria or a bacterial infection.</p> <p>During an interview on 04/11/25 at 3:57pm with CNA C she stated she provided the aides monthly training over catheter care with males. CNA C stated aides were trained to use a new wipe for every swipe. CNA C stated when using a washcloth, you are able to fold it but not when using a wipe. CNA C stated she had trained CNA A over this exact procedure and had previously observed her and had not seen her use an incorrect wipe technique. CNA C stated you wanted to use one wipe per swipe because it was infection control. CNA C stated you wouldn't want the resident to be standing during catheter care and stated the best thing to do was to do it in bed because you're able to see from that angle. CNA C stated having Resident #2 stand and using the same wipe was not the correct procedure. CNA C stated it was important to use the correct technique because it could impact residents by causing rashes, fungus or urinary tract infections. CNA C stated she kept herself up to date on techniques by looking and learning techniques online and trained herself that way.</p> <p>During a follow up interview with the DON on 04/11/25 at 4:18pm she stated when she looked up CNA A's technique used during perineal care it stated her technique was okay, but stated CNA C stated it was not. The DON stated that CNA A should have provided the care to Resident #2 while he was laying down as it would have made the procedure easier.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of CNA A's trainings revealed she had completed a training titled, performing perineal care for a male patient on 12/27/24.</p> <p>Record review of CNA A's trainings revealed she had completed a training titled, CNA - Urinary catheter care on 10/16/24.</p> <p>During a follow up interview with the DON on 04/11/25 at 6:13pm the DON stated they didn't use the [NAME] for their catheter care and stated they used the Texas curriculum for nurse aides in long term care facilities that was provided by health and human services.</p> <p>Record review of CNA A's competency checklist dated 04/30/24, reflected under section titled, PERSONAL CARE, CNA A was checked off as met for Pericare [perineal]/incontinent male and Foley cath [catheter] care male.</p> <p>Record review of undated facility document titled Indwelling catheter care (daily cleansing) stated While the CDC (Centers of Disease Control) does not endorse routine meatal cleansing (urethral opening), this community does conduct daily and as needed (PRN) indwelling catheter cleansing. There was also verbiage that stated, This standard servers to override the [NAME] textbook requirement for sterile technique. Clean technique will be used for cleansing care. The policy did not include a reference or definition of the clean technique and did not include verbiage related to reusing wipes or only using each wipe once per swipe.</p> <p>Record review of the Texas curriculum for nurse aides in long term care facilities dated March 2024 included a section titled 2.7.5 Procedural Guideline #22 - Catheter Care which included steps to Lower head of bed and position the resident on his or her back but did not include verbiage regarding the use of wipes and only mentioned the use of a wash cloth.</p>