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	01/13/2026

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure each resident had the right to access personal and medical records pertaining to himself or herself within 24 hours and allow the resident to obtain a copy of the records or any portions thereof upon request for 1of 4 residents (Resident #1) reviewed for resident rights. The facility failed to provide a copy of Resident #1's medical records to Resident #1's RP after requesting the records on 10/15/25. This failure could place residents at risk of not having access to records when requested. The findings included: Record review of Resident #1's face sheet, dated 01/13/26, revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and discharged on 08/29/25 with diagnoses that included: unspecified dementia (decline in thinking skills and causing issues with memory, planning, focus and mood), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, type 2 diabetes mellitus (high blood sugar) without complications and acute pain due to trauma. Record review of Resident #1's discharge MDS assessment, dated 08/29/25, revealed Resident #1 had a BIMS score of 09, indicating moderate cognitive impairment. Record review of Resident #1's care plan with an initiation date of 08/11/25 reflected a focus of I have impaired cognitive function/dementia or impaired thought process r/t (Dementia). Record review of authorization to disclose protected health information form completed and signed by Resident #1's RP reflected it was signed on 10/15/25. During an interview with Medical Records LVN on 01/08/26 at 2:51 pm, she stated the RP for Resident #1 requested records on 10/15/25. The Medical Records LVN stated she sent the request to her supervisor, the Health Information Management Director on 10/15/25. The Medical Records LVN stated the Health Information Management Director let her know that she would communicate with the family of Resident #1 because it takes long to get those documents since they were requesting all of the records. During a telephone interview with the Health Information Management Director on 01/08/26 at 3:20 pm, she stated on 11/06/25 she sent the Medical Records LVN an email that she had finished getting the records requested by Resident #1's family and was going to be sending them out. The Health Information Management Director stated she would send records via secure email and stated usually the person receiving them would have to confirm when they were received and she would get a confirmation receipt via email. The Health Information Management Director reviewed her email and did not have any records of her sending any email with Resident #1's requested records and stated she did not have any confirmation receipts received. The Health Information Management Director stated she thought she had sent out the records that were requested for Resident #1 but stated she had a number of record requests coming in and that time and was unable to find any records of the requested records for Resident #1 being sent in her email. During an interview with the Medical Records LVN on 01/13/26 at 2:24 pm, stated the Health Information Management Director was responsible for sending out the requested records to Resident#1's RP and stated when records such as a medication list or profile were (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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requested she would get it cleared from the Health Information Management Director and then she would provide the medical records to the resident or RP. The Medical Records LVN stated but due to Resident #1's family requesting the entire chart the Health Information Management Director had spoken to her when they were almost ready and they had agreed that the Health Information Management Director would email the requested records to Resident #1's RP. The Medical Record LVN was not sure how long she had to send out requested records and stated she would need to review the facility policy but stated they usually sent them timely. The Medical Records LVN stated she felt she followed the facility policy in this situation and stated she received an email from the Health Information Management Director on 01/11/26 that the requested records had been sent to the family for Resident #1. The Medical Records LVN stated she did not know why the records were not sent out on time. The Medical Records LVN stated she received informal training when she started her position as medical records but stated it was something that was verbal. The Medical Records LVN stated not sending out records in the allotted time frame could have negative out come because information was requested and they did not get it on time. On 01/13/26 at 3:25 pm, the Health Information Management Director was attempted to be reached via phone for follow up questions however the call was unsuccessful and a voicemail was left with no response. Record review of signed position agreement for Medical Records Manager by the Medical Records LVN on 08/16/24 stated, 3. Retrieve/Request medical records promptly upon request by authorized individuals Record review of facility policy titled, Medical Records with a revised date of January 2023 stated, 2. The resident has the right to access all records pertaining to his or her care and stay in the nursing home, including current medical records. The community allows access to all of the residents records upon receipt of an oral request followed with a signed, written request by an authorized representative within 24 hours (excluding weekends and holidays). An oral request is sufficient to produce the current record for review only. Under the section titled, Purchase of medical record it contained verbiage stating, After receipt of records for inspection, the resident may purchase copies at a cost not to exceed the state copying fees for photocopies. Requests will be granted in two working days.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 4 residents (Resident #2) reviewed for respiratory care. The facility failed to ensure Resident #2's behavior of removal of nasal cannula and non-compliance with oxygen was care planned. This deficient practice could place residents at an increased risk of developing respiratory complications and a decreased quality of care. The findings included: Record review of Resident #2's face sheet, dated 01/10/26, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] and discharged on 01/07/26 with diagnoses that included: unspecified dementia (decline in thinking skills and causing issues with memory, planning, focus and mood), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, type 2 diabetes mellitus (high blood sugar) without complications and unspecified combined systolic (congestive) and diastolic (congestive) heart failure (the heart has difficulty with both emptying and filling properly), chronic pulmonary edema (build up of fluid in the lungs) and paroxysmal atrial fibrillation (fast, irregular heartbeat that last a few hours or days) Record review of the 5 day MDS assessment, dated 12/14/25, revealed Resident #2 had a BIMS score of 14, indicating she was cognitively intact. Record review of physician orders reflected Resident #2 had an order for continuous oxygen 2 liters per nasal cannula with an order date of 12/09/25. Record review of Resident #2's care plan with an initiation date of 12/10/25 reflected a focus of Oxygen Therapy r/t CHF with intervention to Administer oxygen per MD orders with an initiation date of 12/30/25. There was no verbiage related to Resident #2 removing her oxygen, or non-compliance with oxygen therapy. During an interview with LVN A on 01/13/26 at 1:55 pm, she stated Resident #2 would occasionally remove her oxygen and stated the nurses and respiratory therapist would have to place the oxygen back on Resident #2 when they would be notified by the aides during their rounds or when they would round on Resident #2. During an interview with CNA B on 01/12/26 at 5:41 pm, she stated Resident #2 would remove her oxygen and stated staff would put it back on her all the time and Resident #2 would remove it. During an interview with LVN C on 01/12/26 at 4:50 pm, she stated Resident #2 would remove her oxygen constantly and she would always have to fix it for her. During an interview with RT D on 01/13/26 at 1:48 pm, she stated Resident #2 was always taking off her oxygen and stated they were constantly checking on her to make sure she had it on. RT D stated staff was aware of her removing her oxygen because she would get report to make sure to check Resident #2 because she had a tendency to remove the cannula. During an interview and record review with MDS nurse E on 01/13/26 at 3:45 pm, he stated Resident #2 had orders in place for continuous oxygen and stated staff said Resident #2 would remove her oxygen sometimes but not all the time and they would have to remind her that she needed it. MDS nurse E stated staff was aware of this behavior because they were the ones who reported it. MDS nurse E stated Resident #2 had no negative impact due to removing her oxygen. MDS nurse E stated Resident #2's behavior of removing her oxygen should have been on her care plan. MDS nurse E reviewed Resident #2's care plan and stated her behavior of removing it was not on her care plan. MDS nurse E stated it was not on there because the behavior was not reported since her readmission from the hospital and stated he was responsible for putting behaviors on the care plan and for reviewing the care plans to ensure behaviors were included and stated he updated the care plan based on any reports of behaviors or on review dates and stated he was still reviewing the care plan. MDS nurse E stated it was (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	important to have behaviors such as removing oxygen on the care plan because if the patient had an order for oxygen its like a medication and they need to be complaint because for Resident #2 she had a diagnoses of congestive heart failure and needed the oxygen because if she was non complaint and her oxygen saturation dropped it could cause hypoxia or respiratory failure. MDS nurse E stated the facility policy stated behaviors should be documented on the care plan and stated he followed the facility policy in this situation. During an interview with the DON on 01/13/26 at 4:38 p.m., she stated Resident #2 had continuous orders for oxygen. The DON stated when Resident #2 was first admitted to the facility she would constantly remove her oxygen and stated since her most recent readmission in December 2025 she was not aware if she was still removing it and stated there was no recent documentation of her removing it either and clarified if Resident #2 was still non complaint with her oxygen then she was not aware. The DON stated staff was aware that Resident #2 would remove her oxygen because staff had to monitor her. The DON stated Resident #2 had no negative impact due to removing her oxygen and stated her oxygen saturation was always good. The DON stated Resident #2's behavior of removing her oxygen should have been on her care plan. The DON stated it was not on her most recent care plan because they had no reports of her being non complaint after her last hospital visit in December of 2025. The DON stated anyone could update the care plan but stated for the most part it was MDS nurse E. The DON stated it was important to have those behaviors on the care plan so that staff are aware and because it was a part of their plan of care to see what behaviors the residents had. The DON stated MDS nurse E reviewed the care plan to ensure behaviors were included and stated he did them quarterly and if there were any changes then he could input things at any time. The DON stated she did not think the facility policy stated anything regarding behaviors. The DON stated MDS nurse E had been trained by his consultants over the care plan and what to put on the care plan. The DON stated there was no negative impact to resident due to not including her behavior on the care plan because she was complaint with her oxygen. Record review of facility training dated 07/18/24 included topics of comprehensive care plans and acute care plans and reflected MDS nurse E had received the training. Record review of facility policy titled, Oxygen Administration with a revised date of January 2023 and implementation date of 03/14/19 and policy titled, Care Plans did not have any verbiage related to documentation of behaviors on residents care plan.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 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 administration of Resident #1's physician ordered acetaminophen on 08/26/25. This failure 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 01/13/26, revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and discharged on 08/29/25 with diagnoses that included: unspecified dementia (decline in thinking skills and causing issues with memory, planning, focus and mood), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, type 2 diabetes mellitus (high blood sugar) without complications and acute pain due to trauma. Record review of Resident #1's discharge MDS assessment, dated 08/29/25, revealed Resident #1 had a BIMS score of 09, indicating moderate cognitive impairment. The pain management section reflected resident had received scheduled pain medication regimen in the last 5 days and also received PRN pain medication or was offered and declined. Resident #1's pain frequency on his MDS reflected he had rarely or not at all experienced pain or hurt over the last 5 days. Record review of Resident #1's care plan with an initiation date of 08/11/25 reflected a focus of I am at risk for experiencing discomfort or pain r/t: Immobility with intervention of, Administer my medication to relieve my pain as recommended by my doctor. both with an initiation date of 08/12/25. Record review of nurses note completed by LVN A on 08/26/25 at 2:10 pm stated Resident #1 complained of back pain after a fall and was provided PRN acetaminophen. Record review of Resident #1's physician's orders revealed orders for, Acetaminophen Oral Tablet (Acetaminophen) Give 650 mg by mouth every 6 hours as needed for pain Not to exceed 3000 mg in a 24 period, with a start date of 08/26/25. Record review of Resident #1's August 2025 medication administration record reflected his order for Acetaminophen Oral Tablet (Acetaminophen) Give 650 mg by mouth every 6 hours as needed for pain Not to exceed 3000 mg in a 24 period was started on 08/26/25 at 3:15pm and did not have any signature on the medication administration record from LVN A to indicted medication was administered as stated on nurses note on 08/26/25. During a telephone interview with LVN A on 01/13/25 at 1:55 pm, she stated she did not recall Resident #1 but stated if she was working at time medication was administered then she would have been responsible for documenting it on the MAR and stated it was important to document administered medications on the MAR because they had to follow exact time frames and if it was not documented then the following nurses may not know that it was given. LVN A stated she probably forgot to click it as administered on the MAR. LVN A stated she had previously been trained on documentation of medication administration but did not recall an exact date or who provided the training. LVN A stated the DON and ADON were responsible for reviewing the MAR to ensure documentation was accurate and complete. LVN A stated the facility policy for medication administration stated they should sign the MAR after they administer medication and stated she did follow that policy. LVN A stated not completing documentation of administered medications could negatively impact residents because the following nurses may not know that the medication has already been given and that could be harmful to a resident. During an interview with the DON on 01/13/26 at 4:38 pm she stated on 08/26/25 LVN A was responsible for documentation of administered medication. The DON stated on 08/26/25 LVN A documented that she provided PRN acetaminophen to Resident #1 on her nurses note but stated it was not documented on the MAR. The (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	DON stated the administered medication should have been signed off on the MAR. The DON stated she thought LVN A did not sign the MAR because she forgot to. The DON stated it was important to document medication administration so that the person who administered it could know what time It was administered and so the following staff who come in after would be aware of the time it was last administered. The DON stated LVN A had been trained over medication administration. The DON stated during their morning meeting on Monday through Friday the leadership team would review the MARs to ensure they were being signed and stated on the weekends the manager would review it for completion. The DON was not sure exactly what the facility policy stated regarding documentation of medication administration and stated she would need to review it. The DON stated not documenting the administration of medication on the MAR could negatively impact residents because the staff that came in next may not be aware the last time the medication was given. Record review of licensed nurse competencies checklist for LVN A dated 05/05/25 reflected she was checked off as met for Demonstrates understanding and competency of MARS/TARS singing out - compliance of administration as ordered. Record review of facility policy titled, Medication Administration with a revised date of January 2024 did not have any verbiage related to documentation of administered medication in residents MAR.