

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/29/2026
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)		
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 interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes 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 (Resident #1) of 3 residents reviewed for care plans, in that: The facility failed to ensure Resident #1's care plan dated 11/20/17 reflected her Enhanced Barrier precautions due to pressure injury to left gluteus. This failure could place residents in the facility at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs. The Findings included: Record review of Resident #1's electronic face sheet, dated 07/29/2026, reflected a [AGE] year-old female who was originally admitted to the facility on [DATE]. Her diagnoses included Cerebral infarction (a type of ischemic stroke that occurs when a blocked or narrowed blood vessel cuts off blood flow to a region of the brain), muscle wasting and atrophy (the shrinking and loss of muscle tissue), Type 2 diabetes (is a chronic condition where your body either resists the effects of insulin or doesn't produce enough of it to regulate blood sugar properly). Record review of Resident #1's comprehensive person-centered care plan, dated 11/20/2017, did not reflect the Enhanced Barrier Precautions. Record review of Resident #1's 07/29/2026 Physician order sheet report reflected, Treatment Orders: Santyl External Ointment 250 UNIT/GM Apply to Pressure injury Left Glut topically one time a day for Pressure injury Left Gluteus stage 2 Cleanse Pressure injury Left Gluteus stage 2 with dakins solution, pat dry with gauze, apply Santyl and gentamicin ointment, cover with bordered foam dressing, every shift until resolved with a start date 06/11/2026. Record review of Resident #1's quarterly MDS dated [DATE] revealed:Section M- Skin ConditionsUnhealed Pressure Ulcers/Injuries YES During an interview on 07/29/26 at 4:46 p.m., MDS C nurse stated the care plan should have been updated when and by whomever received the order for the Enhanced Barrier Precautions. MDS nurse stated if the care plan was not updated it could affect the nurses by not being able to give the care that Resident #1 needed. MDS nurse stated that he was responsible to update the care plan and did not know that Enhanced Barrier Precautions were needed for wounds. During an interview on 07/29/26 at 4:27 p.m. the DON stated the care plan had to be updated to give Resident #1 the best care and to verify if the interventions were effective. The DON stated that EBP should have been on the care plan. The DON stated the care plan had to be updated as soon as possible to give the best care to Resident #1. The DON stated Resident #1 was at risk of not receiving the proper care that he required. The DON stated that the care plan was a way of communication between staff. Record review of facility's policy titled Care Plan Development, Review, and Update policy with a revised date January, 2026 reflected:Policy:The community will develop and maintain a (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensive, interdisciplinary, person-centered care plan for each resident. the care plan will include measurable objectives, appropriate interventions, and resident-directed goals designed to support the resident's highest practicable physical, mental, and psychosocial well-being .		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, interviews, and record review, the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles for 1 (wound care cart) of 7 medication carts. The facility failed to ensure that the wound care cart was secured and locked when it was left unattended by LVN B. This failure could place residents at risk of injury to other residents if medication left unsecured were consumed. Findings included: During an observation on 07/29/2026 from 04:36 PM revealed the wound care medication cart was left unlocked on 200 hallway. During the observation LVN B came out of the room and surveyor informed her wound care medication cart was unlocked and the LVN B secured the cart by locking it. During an interview on 07/29/2026 at 04:36 PM with LVN B revealed she was responsible for the wound care medication cart that was left unlocked. She stated he was expected to lock the wound care medication cart when she walked away from it. She stated if it was left unlocked then a resident could open a drawer and take anything that was not for them. She stated he had left the cart unlocked because she just forgot. During an interview on 07/29/2026 at 07:18 PM with the DON stated her expectation of staff when they walk away from the medication cart was to lock it. DON stated that all staff were responsible for locking and monitoring the medication carts. DON stated that the negative outcome for leaving the cart unlocked was that a resident or visitor could grab the medication from the cart, and it could harm them. Record review of facility policy Medication Cart Use & Storage with a revised date January,2023 revealed Security: The medication cart and its storage bins should be kept closed, secured and/or in the line of sight when not in use.		

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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 that were complete and accurate in accordance with accepted professional standards and practices for 2 of 3 residents (Resident #1 and Resident #2) whose clinical records were reviewed for accuracy, in that: 1. The facility failed to have a physician order for the Enhanced Barrier Precautions for Resident #1.2. The facility failed to document in Resident #2's medical record when Resident #2 got orders for Moisture-Associated Skin Damage. This failure could affect residents whose records are maintained by the facility and could place them at risk for errors in care. Findings include: 1. Record review of Resident #1's electronic face sheet, dated 07/29/2026, reflected a [AGE] year-old female who was originally admitted to the facility on [DATE]. Her diagnoses included Cerebral infarction (a type of ischemic stroke that occurs when a blocked or narrowed blood vessel cuts off blood flow to a region of the brain), muscle wasting and atrophy (the shrinking and loss of muscle tissue), Type 2 diabetes (is a chronic condition where your body either resists the effects of insulin or doesn't produce enough of it to regulate blood sugar properly). Record review of Resident #1's comprehensive person-centered care plan, dated 11/20/2017, did not reflected the Enhanced Barrier Precautions. Record review of Resident #1's 07/29/2026 Physician order sheet report reflected, Treatment Orders: Santyl External Ointment 250 UNIT/GM Apply to Pressure injury Left Glut topically one time a day for Pressure injury Left Gluteus stage 2 Cleanse Pressure injury Left Gluteus stage 2 with dakins solution, pat dry with gauze, apply Santyl and gentamicin ointment, cover with bordered foam dressing, every shift until resolved with a start date 06/29/2026. Record review of Resident #1's Order summary dated 7/29/26 did not reflect any EBP orders on 07/28/26 order was put in the electronic chart on 07/29/26. Record review of Resident #1's quarterly MDS dated [DATE] revealed:Section M- Skin ConditionsUnhealed Pressure Ulcers/Injuries YES 2. Record review Resident #2's face sheet dated 07/29/26 revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus (a chronic condition where the body either doesn't produce enough insulin or doesn't use insulin effectively, leading to high blood sugar levels), Muscle wasting and atrophy (the shrinking and loss of muscle tissue). Record review of Resident #2's care plan dated 04/21/2021 reflected a focus area that Resident #2 had had fragile skin and she was at risk for skin injury. Goal: will have intact skin, free of redness, blisters or discoloration by/through review date. Record review of Resident #2's quarterly MDS assessment, dated 07/10/26 reflected Section M- Skin ConditionsRisk for developing Pressure Ulcers/Injuries YES. During an interview on 7/29/26 at 09:00 a.m., the WCN stated that she called the wound care doctor and notified him that Resident #2 had a rash to her groin area and to her buttocks. The WCN stated that the wound care doctor ordered two creams to be administered to Resident #2. The WCN stated that the order was Calmoseptine External Ointment 0.44-20.6 % Apply to MASD buttock topically every shift for MASD buttock both Cleanse MASD buttock both with dakins solution, pat dry with gauze, apply Calmoseptine with Lotrisone leave open to air every shift, until resolved. The WCN stated that she forgot to document the new orders that she got from the wound care doctor in Resident #2 electronic chart. The WCN stated that if she did not document it meant it never happened. The WCN stated that she forgot to document. The WCN stated that she called the wound care doctor on 06/29/2026. During an interview on 07/29/26 at 4:46 p.m., MDS C nurse stated the care plan should have been updated when and by whomever received the order for the Enhanced Barrier Precautions. The MDS nurse stated if the care plan was not (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	updated because the order was not put in Resident #1's electronic chart. MDS C nurse stated that it could affect the nurses by not being able to give the care that Resident #1 needed. During a phone interview on 7/29/26 at 5:20pm the Wound care Doctor stated that he gave the order to the WCN on 6/29/26 for Resident #2. The Wound care Doctor stated that he had constant communication with nurses and DON. The Wound care Doctor stated that he did not see a negative outcome for not documenting. During an interview on 07/29/2026 at 05:27 p.m., the DON stated that the nurse that got the order was in charge of documenting in Resident #2's electronic chart. The DON stated that she did not think there was a negative outcome. Record review of the facility's policy titled Professional Standard of Care with revised date January,2024 reflected .e. nurses should conduct assessments or evaluations and document within the medical record in the following instances		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to establish and 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 1 of 3 residents (Resident #1) reviewed for infection control. The facility failed to ensure LVN A performed proper hand hygiene for at least 20 seconds during wound care for Resident #1 on 07/28/26. This failure could place residents at risk of infections, healthcare associated with cross contamination, and the spread of infection. Findings include: Record review of Resident #1's electronic face sheet, dated 07/29/2026, reflected a [AGE] year-old female who was originally admitted to the facility on [DATE]. Her diagnoses included Cerebral infarction (a type of ischemic stroke that occurs when a blocked or narrowed blood vessel cuts off blood flow to a region of the brain), muscle wasting and atrophy (the shrinking and loss of muscle tissue), Type 2 diabetes (is a chronic condition where your body either resists the effects of insulin or doesn't produce enough of it to regulate blood sugar properly). Record review of Resident #1's comprehensive person-centered care plan, dated 11/20/2017, reflected Focus [Resident #1] has a an ADL self-care performance deficit r/t Limit Mobility, Impaired balance. Interventions: The resident requires assistance by 1 staff to turn and reposition in bed as necessary. Record review of Resident #1's 07/29/2026 Physician order sheet report reflected, Treatment Orders: Santyl External Ointment 250 UNIT/GM Apply to Pressure injury Left Glut topically one time a day for Pressure injury Left Gluteus stage 2 Cleanse Pressure injury Left Gluteus stage 2 with dakins solution, pat dry with gauze, apply Santyl and gentamicin ointment, cover with bordered foam dressing, every shift until resolved. During an observation on 07/28/26 at 02:10 p.m.Both nurse and cna washed hands before treatment and after treatment was completed. They both donned PPE properly. They both sanitized hands in between glove changes. Old dressing was labeled and did not have drainage. No odor or drainage noted coming from wound. LVN A performed wound care following doctors order correctly. Dressing applied was dated and initialed. LVN A lathered her hands for 9 sec. During an interview on 07/28/2026 at 02:05 p.m., LVN A stated she should have lathered her hands for at least 20 seconds. LVN A stated that she sang the happy birthday song once. LVN A stated that she thought she lathered her hands for at least 20 seconds. LVN A stated the potential negative outcome was infection. During an interview on 07/29/2026 at 4:00 p.m., the DON stated the proper handwashing was to lather hands for at least 20 seconds. The DON stated if LVN A did not lather her hands for at least 20 seconds this would put Resident #1 at risk for infections. Record review of the facility's policy titled Hand Hygiene with an implemented date January 2023 reflected: This facility considers hand hygiene the primary means to prevent the spread of infections. Review of the Center for Disease Control and Prevention website, (https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html), Know when to clean your hands:1. Wet hands with water.2. Apply the manufacturer recommended amount of product to your hands.3. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers.4. Rinse hands with water and use disposable towels to dry. Use a towel to turn off the faucet.5. Avoid using hot water to prevent drying of the skin.Note: Other entities recommend cleaning hands with soap and water for at least 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times and scrubbing hands and fingers with soap.		