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	02/05/2025

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** 48278 Based on observation, 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 are identified in the comprehensive assessment and described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #187) of 8 residents reviewed for care plans. The facility failed to include oxygen treatment in Resident #187's comprehensive care plan. This deficient practice could affect residents who received oxygen and could result in residents receiving incorrect or inadequate oxygen support and could result in a decline in health. Findings Included: Record Review of Resident #187's face sheet, dated 02/05/2025, revealed a [AGE] year-old male admitted on [DATE], and original admitted on 10/25/2024 with pertinent diagnoses of Pneumonia, Encephalopathy (damage or disease that affects the brain), History of Transient Ischemic Attack (mini stroke) and Cerebral Infarction (stroke), Chronic Kidney Disease Stage 3 (kidneys have mild to moderate damage, and they are less able to filter waste and fluid out of your blood), and Major Depressive Disorder. Record review of Resident #187's MDS assessment, dated 01/12/2025, a BIMS score of 05 revealed the resident's cognition was severely impaired. Record Review of Resident #187's physician's order summary dated 02/02/2025 revealed no oxygen order. During an observation on 02/02/2025 at 11:55 a.m., Resident #187 was lying in his bed with head of the bed elevated and had on a nasal cannula with the oxygen concentrator set at 1.5 liters per minute. During an interview on 02/02/2025 at 11:57 a.m. with Resident #187 ' s was lying in his bed with head of the bed elevated. His family member was at bedside, stated that Resident #187 has being using oxygen via NC every day since before he was readmitted to the facility. (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	During an interview with LVN B on 02/02/2025 at 12:02 p.m., stated that MDS was responsible for care planning. She stated the oxygen needed to be care planned because staff need to know Resident #187 was on oxygen and we do not want the resident to desaturate (blood oxygen levels drop below normal range). During an interview on 02/02/2025 at 05:07 p.m. the DON stated that the staff knew Resident #187 was on oxygen. She stated a possible negative outcome of the oxygen not being care planned was that the care plan tells you what the resident was supposed to be on. The DON stated the care plan of the resident revolves around the resident's needs. She stated if they have no physician order for oxygen then care planning will be overlooked. During an interview on 02/02/2025 at 05:25 p.m. MDS stated he was responsible for writing care plans for the whole facility. He stated that he did not get the physician order for the oxygen. MDS stated that what he care plans gets administered. He stated that once he gets the order, he checks that it had been followed through and formulate a care plan. The negative outcome of not having the oxygen care planned was that staff was not going to follow through with it and would not evaluate if effective. He stated that oxygen was considered a medication and if not following orders, the patient would desaturate for not having oxygen. Record review of facility policy titled Care Plans and date revised January 2023 revealed the following: The community develops a comprehensive care plan for each resident that includes measurable objectives to meet a resident medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. 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 ability, needs, medical condition, preventative measure.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based on observation, interviews, and record review, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice for 2 of 18 (Resident #187, Resident #78) residents reviewed for respiratory care. 1. The facility failed to ensure Resident #187 had an oxygen sign posted on their door to alert everyone that they were on oxygen and failed to obtain a physician's order prior to providing oxygen therapy for Resident #187. 2. The facility failed to obtain a physician's order prior to providing oxygen therapy for Resident #78. This deficient practice could place residents who receive respiratory care at risk for developing respiratory complications, make others unaware oxygen was in use, and of receiving inappropriate and inadequate care. The findings included: Record Review of Resident #187's face sheet, dated 02/05/2025, revealed a [AGE] year-old male admitted on [DATE], and original admitted on 10/25/2024 with pertinent diagnoses of Pneumonia, Encephalopathy (damage or disease that affects the brain), History of Transient Ischemic Attack (mini stroke) and Cerebral Infarction (stroke), Chronic Kidney Disease Stage 3 (kidneys have mild to moderate damage, and they are less able to filter waste and fluid out of your blood), and Major Depressive Disorder. Record review of Resident #187's MDS assessment, dated 01/12/2025, a BIMS score of 05 revealed the resident's cognition was severely impaired. Record review of Resident #187's active orders, dated 02/02/2025, revealed no order for oxygen. Record review of Resident #187's care plan, dated 01/22/2025, revealed no oxygen care planned. During an observation and interview on 02/02/2025 at 11:55 a.m., Resident #187 was lying on a bed and had on a nasal cannula with the oxygen concentrator set at 1.5 liters per minute. No sign was on the outside of Resident #187's door to indicate he had oxygen in use in the room. During an interview on 02/02/2025 at 11:57 a.m. with Resident #187's family member, stated that Resident #187 has being using oxygen via NC every day since before he was readmitted to the facility. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/02/2025 at 12:02 p.m., with LVN B stated she was Resident #187's nurse. LVN B stated the nurses are responsible for posting the oxygen sign on the outside of the resident's rooms for all residents who have oxygen. She stated Resident #187 had oxygen in use via NC and should have a sign but did not. LVN B stated, if someone does not know the resident, they do not know where to look or how to identify the resident's needs for oxygen and for example, it can cause a fire. The oxygen sign was an extra identifier. LVN B revealed she could not find a physician order in Resident 187's chart. She stated he had been using oxygen since before he went out to the hospital. LVN B further stated she assumed the physician order was in place. During an interview on 02/02/2025 at 12:14 p.m., the ADON stated residents with oxygen should have signs posted so people know they are on oxygen. She stated the floor nurses are responsible for posting the O2 sign. During an interview on 02/02/2025 at 5:07 p.m. the DON stated the nurses and nurse managers were responsible for posting the O2 sign on the resident's door who are on oxygen. The DON stated the O2 sign alerts the staff that the resident is on oxygen. 2.Record review of Resident #78's Physician's Orders revealed Resident #78 was an [AGE] year-old female admitted to the facility on [DATE] and was readmitted on [DATE] with diagnosis of other cerebral infarction due to occlusion or stenosis of small artery (a type of stroke where a small blood vessel in the brain becomes blocked or narrowed, leading to brain tissue infarction (tissue death) due to lack of blood supply), metabolic encephalopathy (a brain dysfunction that occurs when there's an imbalance of chemicals in the blood), and acute on chronic systolic (congestive) heart failure (a sudden worsening of symptoms in a person who already has a pre-existing chronic condition of systolic [left ventricle] heart failure). Physician's orders did not reveal an existing order for oxygen. Record review of Resident #78's quarterly MDS dated [DATE] indicated Resident #78 had severe cognitive impairment and Section O. C1. Oxygen therapy was not checked. During an observation and interview on 02/02/25 at 1:17 p.m. Resident #78 was observed lying in bed with the head of bed raised slightly and Resident #78 with O2 via nasal cannula. The FM said Resident #78 was admitted to the facility since the end of August. The FM said Resident #78 had been in and out of the hospital since admission. The FM said she was on O2 continuous at 2 liters per minute since she returned from the hospital. Observation of O2 concentrator revealed it was set at 2 Lpm. During an interview on 02/03/2025 at 3:57 p.m., LVN F said any nurse type in a physician's order in the resident's electronic record. LVN F said he did not know why the order for oxygen for Resident #78 was not included in the resident's physician's orders. LVN F said physician's orders were needed for the use of oxygen. During an interview on 02/02/2025 at 05:07 p.m. the DON stated the nurses who got the orders were the ones who were responsible for entering the orders. She stated that medical records help with checking that the orders were in. She does not know how this was missed. She stated physician order should have been in place. The DON stated she already spoke to the doctor and obtained the order. A policy regarding physician's orders to treat residents was requested on 02/02/2025 at 5:15 pm. The DON stated she did not have a physician order policy and provided me with the Professional Standard of Care, date revised January 2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Oxygen Administration, revised date January 2023, revealed Assess the resident's room to determine if the environment is safe for oxygen administration. Record review of the facility's policy titled Oxygen Administration, revised date January 2023, revealed Compliance Guidelines A resident receives oxygen therapy when there is an order by a physician. Procedure #3. Obtain physician orders for oxygen administration.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26141 Based on observation, interview, and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standard or food service safety for 1 of 1 kitchen reviewed for food service safety. The facility failed to ensure all food items were labeled and dated in the freezer, and a bag of French toast was open to air and was unlabeled and undated. This failure could place residents at risk of foodborne illnesses. The findings included: An observation of the facility freezer on [DATE] at 11:05 a.m. revealed an open to air bag with five slices of French toast that was unlabeled and undated. In an interview on [DATE] at 11:10 a.m., [NAME] A said she did not have any idea of how long the bag of French toast had been in the freezer, but she would throw it out. [NAME] A said they have been trained to label and date all items in the refrigerator and freezer. She said it is important to label and date all food items because they will know if the food is expired and if left too long and opened it could be contaminated or the food will not taste good. [NAME] A said she did not remember when the last time they had an in-service on labeling and dating food items. In an interview on [DATE] the DM said all dietary employees know to label and date all items in the refrigerator, freezer, and pantry. The DM said all staff are responsible for labeling and dating food items. Record review of facility's policy titled Policy: Food Storage revised: [DATE], revealed: To ensure that all food served by the facility is of good quality and safe for consumption, all foods will be stored according to the state, federal and US Food Codes and HACCP guidelines. . 3. Freezers .e. Store frozen foods in moisture-proof wrap or containers that are labeled and dated.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47828 Based on interviews and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #1) of 2 residents by 4 of 4 nurses (LVN B, LVN D, LVN E, and LVN F) reviewed for accuracy and completeness of clinical records. The facility failed to ensure LVN B, LVN D, LVN E, and LVN F correctly completed Resident #1's nuero checks between 05/30/24 and 06/01/24. This failure could place residents at risk for not receiving nursing services by adequately trained nurses and could result in a decline in health. Findings included: Record review of Resident #1's admission sheet, dated 02/03/25 , reflected a [AGE] year-old female admitted on [DATE], an original admitted [DATE] and a discharge date of [DATE]. Resident #1's relevant diagnoses included end stage renal failure (the final stage of chronic kidney disease) , muscle weakness, history of falling, fracture of pelvis, and fracture of T-11-T-12 vertebra (a break in the vertebrae located at the T11 and T12 levels of the spine). Record review of Resident #1's MDS assessment dated [DATE], reflected BIMS score question not answered, which indicated resident was not able to answer questions. Record review of Resident #1's care plan dated 05/27/24, reflected had a history of falls related to pubic symphysis, non-displaced right sacral bone fracture, L-1 vertebral, compression fracture and T-12 vertebral (a pelvic injury where the joint connecting the pubic bones is not displaced, but there is a fracture in the right sacral bone that is also isn't shifted out of place). Record review of Resident #1's physician's orders indicated she was not on blood thinners. Record review of Resident #1's progress notes dated 05/29/24 at 5:00 a.m., authored by LVN G reflected, [Resident #1] noted laying supine on floor next to bed, bed noted on lowest position with call light within reach but not in use. [Resident #1] states she was reaching for snacks that were on bedside table and she slid off bed. Head to toe completed no visible injuries noted. [Resident #1] was assisted back to bed x2 assistance and was provided with bedside table near her. [Resident #1] is alert and oriented X3 no change in LOC [Doctor] was notified, no new orders were given. Neuro checks were initiated per facility protocol. RP aware. Record review of Resident #1's nuero checks on her electronic medical record dated 05/29/24 reflected only 4 checks (from 5:00 a.m. to 5:45 a.m.) had been completed and signed on 05/29/24 by LVN G. Record review of Resident #1's, 2nd nuero checks on her electronic medical record initiated on 05/29/24 reflected a total of 24 neuro checks from 05/29/24 at 5:00 a.m. through 06/01/24 at 3:45 a.m. The intervals of the neuro checks were as followed: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Number 1-4 were 15-minute checks Number 5-8 were 30-minute checks Number 9-12 were 60-minute checks Number 13-16 were 2-hour checks Number 17-18 were 4-hour checks Number 19-24 were 8-hour checks LVN D failed to enter new vital signs for neuro checks 5-14 and 19. LVN E failed to enter new vital signs for neuro checks 15 and 16. LVN B failed to enter new vital signs for neuro check 22. LVN F failed to enter new vital signs for neuro check 23. Neuro checks number 5, 6,7,8,9,10,11,12,13,14,15,16,19,22, and 23 had the same blood pressure readings of 108/50, temperature of 97.5, most recent pulse of 76, and more recent respiration of 17.0 and dated 05/30/24. An observation and interview on 02/05/25 at 11:00 a.m., LVN B said when a resident required neuro checks, their vital signs needed to be rechecked at each interval. She said when she conducted neuro checks, she would write the resident's vitals on my notepad and at a later time, she would transfer the information to the resident's medical electronic record. LVN B was observed as she checked Resident #1's electronic medical record and said recalled conducting a neuro check on Resident #1 on 05/31/24 at 11:45 a.m. She said answered all the questions and rechecked her vitals at that time, and all were within normal range. LVN B said she must have forgotten to enter Resident #1's vitals on her electronic medical record and that was the reason the vitals that showed were dated 05/30/24. She said the neuro checks were standard protocol for residents who fell . She said Resident #1's neuro check was normal. LVN B said a negative outcome for not documenting the correct vital signs could be her doctor would not be getting an accurate account of her vitals. An observation and interview on 02/05/25 at 11:17 a.m., LVN E was observed as she checked Resident #1's electronic medical record and said she had conducted a neuro check on her on 05/29/24 at 5:45 p.m. and 05/29/24 at 7:45 p.m., and both were normal. She said she had answered all questions and had rechecked Resident #1's vitals both times but had no explanation as to why the vitals showed a future date of 05/30/24. LVN E said the negative outcome for Resident #1 were that the correct vitals were not recorded. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 02/05/25 at 3:30 p.m., LVN F said when he conducted neuro checks, he would write the resident's vitals on paper and at a later time, she would transfer the information to the resident's medical electronic record. LVN F was observed as he checked Resident #1's electronic medical record and said he had conducted a neuro check on 05/31/24 at 11:45 a.m. He said he remembered he answered all the questions and had rechecked Resident #1's vitals but must have forgotten to enter her new vital readings that that was the reason the date on the vitals had 05/30/24. An observation and interview on 02/05/24 at 4:00 p.m., The DON was observed as she checked Resident #1's electronic medical record. The DON said Resident #1 had sustained a fall on 05/29/24 with no injuries. The DON said neuro checks had been initiated by LVN G. The [NAME] said the only explanation she could think of as to why there were two neuro check assessments done was because something went wrong on the first one and a new nuero check assessment had to be initiated. The DON said she was not sure why the vitals for neuro check number 5, 6,7,8,9,10,11,12,13,14,15,16,19,22, and 23 had the same blood pressure readings of 108/50, temperature of 97.5, most recent pulse of 76, and more recent respiration of 17.0 and dated 05/30/24. The DON said nursing staff conducted nuero checks, they were supposed to answer all questions and recheck all vitals. She said the date they are done and the date on the vitals should match. The DON said she did not know what had happened. The DON said there were no negative effects on Resident #1 as she had not sustained any injuries due to the fall. Record review of facility's policy on Professional Standard of Care, dated February 2017 and revised in January 2024 reflected: Compliance Guidelines: The community provides services tat meet professional standards of quality and are provided by appropriately qualified persons (e.g., licensed, certified). Compliance with Professional Standards of Care Nursing: e) Nurses should conduct assessments or evaluations and document within the medical record in the following instances: 1. admission, re-admission and as clinically indicated 3. when exceptions are identified

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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** 48278 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 2 of 8 residents (Residents #3 and #81) reviewed for infection control in that: 1. The facility failed to ensure LVN C followed the Enhanced Barrier Precautions (EBP) when she did not wear a gown while administering medication via G-tube for Resident #3. 2. The facility failed to inform visitors that Resident #81 was on contact precautions. 3. The facility failed to ensure that Resident #81 had a CONTACT precaution sign at the door. These failures could place residents at risk for cross contamination and the spread of infection. Finding included: 1. Record review of Resident #3's face sheet dated 02/03/2025 revealed she was a [AGE] year-old female with an admitted [DATE], and with pertinent diagnoses which included: Gastrostomy status (presence of a surgically created opening into stomach used to provide nutritional support), Alzheimer ' s Disease, Dysphagia (difficulty swallowing), Hypertension (high blood pressure). Record review of Resident #3's Comprehensive Care Plan dated 01/10/2025 revealed at risk for infection or recurrent/chronic infection r/t compromised medical condition. Interventions: Enhanced Barrier Precautions practices as clinically indicated. Record review of Resident #3's Physician Order Summary dated 02/03/2025 revealed EBP precaution when in contact with peg tube. Observation on 02/03/2025 at 01:31 p.m. revealed LVN C did not wear a gown, only gloves to administer a medication via Resident #3 ' s G-tube. There was an Enhanced Barrier Precautions (EBP) sign posted on Resident #3 ' s door, PPE supplies available outside the room. During an interview on 02/03/2025 at 01:45 p.m. with LVN C, stated that she was nervous and forgot to put on the gown when administering the medication via G-tube to Resident #3. She stated Resident #3 was on Enhanced Barrier Precautions, she turned and looked at the EBP sign posted on Resident #3's door. LVN C stated she was to be wearing a gown and gloves when doing patient care on any resident who was on EBP. She stated EBP was recommended for residents who have an entrance, like for example a G-tube and/or a foley catheter. The negative outcome of not wearing a gown when administering medication via G tube was exposing Resident #3 to infection. She had EBP in service done about a month ago. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/03/2025 at 04:54 p.m., the DON stated that Enhanced Barrier Precautions should be used when staff comes into contact with residents who have a G-tube, foley catheter, and wound drainage. The DON stated LVN C was supposed to be wearing a gown and gloves when administering medication via a G-tube to Resident #3. She stated this was to help prevent the spread of infection. The DON stated that she had training in infection control, and enhanced barrier precaution done a couple days ago. Record review of the facility policy titled Infection Prevention and Control date reviewed April 2024 revealed Enhanced Barrier Precautions (EBP) maybe implemented as an infection control intervention designed to reduce transmission of resistant organisms. The use of PPE, such as gown and glove use during high contact resident care activities. EBP may be indicated as a recommendation by the CDC (when Contact Precautions do not otherwise apply) for residents with the following: Wounds or indwelling medical devices, regardless of MDRO colonization status; EBP requires the use of gowns and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Indwelling medical devices (e.g. central line, urinary catheter, feeding tube) regardless of MDRO colonization status. 2. Record review of Resident #81's face sheet, dated 02/2/2025, revealed the resident was a [AGE] year-old male and an admitted [DATE] and initially admitted [DATE] with diagnoses that included: ESBL in the urine (Extended-Spectrum Beta-Lactamases. It refers to a group of enzymes produced by certain bacteria that make them resistant to a wide range of antibiotics). Record review of Resident #81's admission MDS assessment, dated 01/30/2025, revealed was in progress. Record review of Resident #81's comprehensive care plan, dated 12/17/2024, revealed was in progress. Observation on 02/2/2025 at 12:56 p.m. revealed there was not a sign posted on Resident #81's door, was inside the room with resident without wearing PPE. PPE was available outside the residents room and the hazardous bins were inside the room. Interview on 02/2/2025 at 12:56 p.m. Resident#81's said that she was never informed about the infection was contagious and that she visited Resident #81 every day and never used PPE. Interview on 02/2/2025 at 1:10 p.m. with LVN C confirmed Resident #81 was on contact precautions due to ESBL in the urine. LVN C stated that nurses are in charge to place the signs at the door and to inform visitors about the infection. LVN C said that it is crucial to inform visitors to prevent the spread of the infection. Interview on 02/4/2025 at 12:45 p.m. with the DON confirmed visitors should have put on a gown when entering Resident #81's room. The DON said that the sign at the door alerts visitors and staff about the infection and the sign helped with the prevention and spread of infection. The DON said that all staff oversaw checking that the signs were at the door. The DON said that all staff were in charge to ensure visitors were wearing PPE inside the room. DON said that all staff was responsible to make sure there was PPE available to staff and visitors. (continued on next page)

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	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid Valley Nursing & Rehabilitation	601 N Mile 2 West Mercedes, TX 78570

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, titled Infection Prevention and Control, revised 04/2024, revealed The infection prevention and control program are a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. Contact Precautions may be implemented for a resident known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or patient-care items in the resident's environment. 50487