

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 04/09/2026
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents were free of any significant medication errors for 2 (Resident #1 and Resident #7) of 5 residents reviewed for medication errors. 1. The facility failed to ensure LVN A did not administer Resident #1's morning dose of IV Vancomycin (an antibiotic) before obtaining a Vancomycin trough (blood is collected and sent to the laboratory to determine if the Resident's Vancomycin level is therapeutic, too high, or too low) level on 04/08/26. 2. The facility failed to ensure MA D administered Resident #7's morning (8:00 am) dose of Amlodipine (blood pressure lowering medication) on 9 (03/03/26, 03/05/26, 03/13/26, 03/17/26, 03/18/26, 03/29/26, 03/30/26, 04/01/26 and 04/05/26) of 25 opportunities between 03/01/26 and 04/09/26 when her blood pressure was within the required parameters for administration per the physician's orders.3. The facility failed to ensure MA D administered Resident #7's morning (8:00 am) dose of Carvedilol (blood pressure and pulse lowering medication) on 9 (03/03/26, 03/05/26, 03/13/26, 03/17/26, 03/18/26, 03/29/26, 03/30/26, 04/01/26 and 04/05/26) of 25 opportunities between 03/01/26 and 04/09/26 when her blood pressure and pulse were within the required parameters for administration per the physician's orders.4. The facility failed to ensure MA D administered Resident #7's morning (8:00 am) dose of Losartan Potassium (blood pressure lowering medication) on 9 (03/03/26, 03/05/26, 03/13/26, 03/17/26, 03/18/26, 03/29/26, 03/30/26, 04/01/26 and 04/05/26) of 25 opportunities between 03/01/26 and 04/09/26 when her blood pressure was within the required parameters for administration per the physician's orders.5. The facility failed to ensure MA J administered Resident #7's morning (8:00 am) dose of Amlodipine on 3 (03/10/26, 03/21/26 and 03/22/26) of 12 opportunities between 03/01/26 and 04/09/26 when her blood pressure was within the required parameters for administration per the physician's orders.6. The facility failed to ensure MA J administered Resident #7's morning (8:00 am) dose of Carvedilol (blood pressure and pulse lowering medication) on 3 (03/10/26, 03/21/26 and 03/22/26) of 12 opportunities between 03/01/26 and 04/09/26 when her blood pressure and pulse were within the required parameters for administration per the physician's orders.7. The facility failed to ensure MA J administered Resident #7's early evening (5:00 pm) dose of Carvedilol (blood pressure and pulse lowering medication) on 5 (03/04/26, 03/10/26, 03/11/26, 03/27/26 and 03/30/26) of 18 opportunities between 03/01/26 and 04/09/26 when her blood pressure and pulse were within the required parameters for administration per the physician's orders.8. The facility failed to ensure MA J administered Resident #7's morning (8:00 am) dose of Losartan Potassium (blood pressure lowering medication) on 3 (03/10/26, 03/21/26 and 03/22/26) of 12 opportunities between 03/01/26 and 04/09/26 when her blood pressure was within the required parameters for administration per the physician's orders.9. The facility failed to ensure MA J administered Resident #7's bedtime (9:00 pm) dose of Losartan Potassium (blood pressure lowering medication) on 5 (03/04/26, 03/10/26, 03/11/26, 03/24/26 and 03/30/26) of 15 opportunities between 03/01/26 and 04/09/26 when her blood pressure was within the required parameters for administration per the physician's orders.10. The facility failed to ensure LVN K administered Resident #7's early evening (5:00 pm) dose of Carvedilol (blood pressure and pulse lowering medication) on 2 (03/01/26 and 03/14/26) of 4 opportunities between 03/01/26 and (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
---	-------	-----------

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 04/09/2026
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>04/09/26 when her blood pressure and pulse were within the required parameters for administration per the physician's orders.11. The facility failed to ensure LVN K administered Resident #7's bedtime (9:00 pm) dose of Losartan Potassium (blood pressure lowering medication) on 2 (03/01/26 and 03/14/26) of 7 opportunities between 03/01/26 and 04/09/26 when her blood pressure was within the required parameters for administration per the physician's orders.12. The facility failed to ensure LVN L administered Resident #7's early evening (5:00 pm) dose of Carvedilol (blood pressure and pulse lowering medication) on 1 (03/16/26) of 4 opportunities between 03/01/26 and 04/09/26 when her blood pressure and pulse were within the required parameters for administration per the physician's orders.13. The facility failed to ensure LVN L administered Resident #7's bedtime (9:00 pm) dose of Losartan Potassium (blood pressure lowering medication) on 1 (03/16/26) of 4 opportunities between 03/01/26 and 04/09/26 when her blood pressure and pulse were within the required parameters for administration per the physician's orders.These failures could place residents at an increased risk for complications, exacerbation of symptoms and disease process, and potential hospitalization.The findings included:Record review of Resident #1's admission record reflected an [AGE] year-old female initially admitted to the facility on [DATE] with most recent admission [DATE]. Her relevant diagnoses included acute respiratory failure with hypoxia (the inability of the respiratory system to maintain an adequate blood oxygen level to preserve normal organ function), tracheostomy (a hole made through the front of the neck into the windpipe when medical conditions make the use of a breathing machine, also known as a ventilator, necessary for an extended period of time), and ventilator associated pneumonia (a lung infection that develops in a person who is on a ventilator when bacteria gets into the lungs and causes an infection).Record review of Resident #1's quarterly MDS dated [DATE] reflected no BIMS score, as she was unable to speak. Her Cognitive Skills for Daily Decision Making score was 3 which indicated severe impairment and she never or rarely made decisions.Record review of Resident #1's care plan dated 04/16/25 reflected the focus: At risk for infection or recurrent/chronic infection related to compromised medical condition: respiratory failure. Chronic infection noted: ESBL (Extended-Spectrum Beta Lactamase- multidrug resistant germs that produce enzymes that break down many common antibiotics) site: Sputum. 4/8/26- Droplet isolation due to Acinetobacter Baumannii (bacteria that can cause infections in the blood, urinary tract, lungs (pneumonia) or wound which typically occur in healthcare settings) initiated 04/16/25 and revised on 04/08/26. Interventions included: enhanced barrier precautions as clinically indicated and administer medication and/or antibiotic as per MD orders, initiated 04/16/25. The care plan also reflected the focuses: tracheostomy related to dysphagia (difficulty swallowing) and ventilator dependent related to respiratory failure initiated 04/16/25. Interventions included: Administer medications and treatments as ordered/indicated, obtain labs and diagnostic studies as indicated and report abnormal findings to physician initiated on 04/17/25. Record review of Resident #1's order summary report reflected the following orders: VANCOMYCIN, TROUGH ** SCHEDULED 4/8/2026; Auto-Send 4/7/2026 8:00 PM** one time only related to Ventilator Associated Pneumonia ordered on 04/07/26 to start on 04/08/26. Vancomycin HCl Intravenous Solution Reconstituted 1 GM. Use 1 gram intravenously every 12 hours for Ventilator Associated Pneumonia for 14 Days ordered on 04/04/26 to start on 04/05/26.Record review of Resident #1's MAR (Medication Administration Record) on 04/08/26 at 4:05 pm reflected LVN A administered Resident #1's 8:00 am Vancomycin dose on 04/08/26.Record review of Resident #1's Results tab in her EMR (Electronic Medical Record) on 04/08/26 at 4:14 pm reflected she did not have a Vancomycin trough level pending or resulted. Record review of the facility's laboratory logbook on 04/08/26 at 4:40 pm reflected Resident #1's blood draw order for her Vancomycin trough level was not done by the laboratory technician on 04/08/26.In an interview on 04/08/26 at 4:32 pm, the ADON stated she was not sure exactly how long before the next dose a Vancomycin trough was to be drawn. She stated Resident #1 started receiving the Vancomycin on 04/05/26 at 8:00 am. The ADON stated the order for the Vancomycin trough was for 04/08/26 but she did not know the time. She stated the lab tech usually went to the facility to (continued on next page)</p>		

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 04/09/2026
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>draw labs around 7:00 am and they knew to do labs because the EMR order was linked to the laboratory. She stated she did not know if the Vancomycin trough was drawn, she would have to go check the logbook. The ADON stated Vancomycin troughs were drawn to ensure the Vancomycin level was within the therapeutic range. If it was not within the range, the nurse would contact the provider to either hold or possibly adjust the dosage. She stated if the Vancomycin level was too high and the Vancomycin was given it could damage the kidneys and if it was too low, the resident was not getting the proper dose to treat the infection. The ADON checked the lab logbook, and it appeared the Vancomycin trough level was not collected. She called the lab and was told they were short on lab technicians, so they did not send anyone to the facility that morning (04/08/26). The ADON contacted the provider and ordered a STAT Vancomycin level to be drawn at 7:00 pm on 04/08/26. The ADON stated if the nurse noticed the lab was not drawn, they called the lab to find out what happened, then contacted the provider for orders or changes. She stated the nurses could not draw their own labs because they did not have the supplies to draw labs or the equipment to result them. She stated one of the night shift nurses printed out the pending labs and put them in the logbook. The ADON stated she was responsible for making sure the labs were done. She stated she was busy on 04/08/26 and simply forgot. She stated the lab did not automatically call the facility if they were not able to send a tech out to draw labs. The ADON stated the lab technician told her it would take about an hour to result a Vancomycin trough level. In an interview on 04/09/26 at 10:23 am the ADON stated Resident #1's Vancomycin trough got drawn around 7:00 pm on 04/08/26, but the provider cancelled the Vancomycin order before the lab had resulted, so the test was cancelled. She stated the Vancomycin was cancelled because the provider got the sputum culture results and changed the antibiotics. She stated Resident #1 received her 8:00 am Vancomycin dose on 04/08/26 even though the trough was not drawn. The ADON stated the nurse should not have administered the Vancomycin on 04/08/26 because the trough had not been drawn. In an interview on 04/09/26 at 3:10 pm, LVN A stated she knew if blood was supposed to be collected on a resident through pass down report and it showed up on the orders tab in the EMR. She stated if the lab work was drawn, it showed up under results. She stated she did not recall if Resident #1 had any labs pending on 04/08/26. She stated Resident #1 had labs drawn weekly and probably needed a Vancomycin trough drawn. She stated she spoke to NP I who told her the troughs were done after every 4th dose for Resident #1. LVN A stated Vancomycin troughs were done to see if the level was too high or too low. It was important to know if it was too high or too low for dosage adjustments. LVN A stated if the Vancomycin trough level was too high it could cause kidney damage. She stated the Vancomycin trough lab did not show up in the orders tab that she recalled on the morning of 04/08/26. She stated she did not remember when the last in-service was over following up on lab results. LVN A stated night shift printed out the lab manifest and put it in the logbook, then when the lab technician came in, they got the lab orders from the book and that was how they knew what labs to draw on what resident. LVN A stated she did not usually mess with that book unless she ordered a STAT lab, then she printed it out and put it in the book. In an interview on 04/09/26 at 4:04 pm, NP I stated she cancelled Resident #1's Vancomycin administration because it was not effective against her [NAME] (Ventilator Associated Pneumonia). She stated she normally checked vancomycin trough levels before the 4th dose of Vancomycin. She stated it was important to check Vancomycin levels to ensure the kidneys were not damaged and if the Vancomycin level was too high, the dose or timing were adjusted. NP I stated if the Vancomycin trough was not checked, it could lead to altered mental status and kidney damage if it was too high and if it was too low, it would not be effective and could lead to antibiotic resistance. She stated when she had a resident on any antibiotics or medications that required monitoring, she checked the resident's medical records to see the laboratory results. NP I stated the facility was supposed to contact her to let her know if the blood was not drawn for some reason. She stated she and the primary NP for Resident #1 were working together in another facility on 04/08/26 so she knew he was not notified the Vancomycin trough level was not drawn on 04/08/26. In an interview on 04/09/26 (continued on next page)</p>		

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 04/09/2026
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>at 12:00 pm, the DON stated Vancomycin level blood work was important to track the Vancomycin levels that were in the resident's system. She stated the levels were needed to see if the medication needed to be titrated or discontinued. The DON stated, If the medication levels were not being tested, we would have no way to know what the level was. The DON stated the physician was notified to see what he wanted to do if the Vancomycin level was too low or too high. She stated if the Vancomycin level was too high, it could cause toxicity, but she did not know what could happen if it was too low. Record review of Resident #7's admission record reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her relevant diagnoses included hypertension (high blood pressure), cerebral infarction (stroke), aphasia following cerebral infarction (an impairment in the ability to read, write, and speak), dysphagia following cerebral infarction (difficulty swallowing), and other sequelae of cerebral infarction (a variety of medical, musculoskeletal, and psychosocial complications following a stroke).Record review of Resident #7's quarterly MDS dated [DATE] reflected a BIMS score of 15 which indicated she was cognitively intact. Record review of Resident #7's care plan dated 04/05/24 reflected a focus of heart disease with a risk for complications such as chest pain, shortness of breath, edema, and high blood pressure. The interventions included administer medications as ordered by the physician and monitor vital signs as indicated and report abnormal findings to physician as indicated, initiated on 05/16/25.Record review of Resident #7's order summary report on 04/09/26 reflected the following orders for anti-hypertensive (blood pressure lowering) and pulse lowering medications:Amlodipine Besylate Oral Tablet 10 MG. Give 1 tablet by mouth one time a day for HTN (High Blood Pressure). Hold if SBP (systolic blood pressure-the top number in blood pressure) is less than 100 and notify Nurse/MD (Medical Doctor). Ordered on 12/31/25.Carvedilol Oral Tablet 12.5 MG. Give 1 tablet by mouth two times a day (8:00 am and 5:00 pm) for HTN. Hold if SBP less than 100, pulse less than 60 and notify Nurse/MD. Ordered on 12/31/25.Losartan Potassium Oral Tablet 50 MG (Losartan Potassium) Give 1 tablet by mouth two times a day (8:00 am and 9:00 pm) for hypertension. Hold if SBP less than 100 Notify Nurse/MD. Ordered on 06/11/24.Record review of Resident #7's March 2026 and April 2026 MARs reflected the following:03/01/26, Morning, MA D documented BP 107/56, Pulse 64 and 3= Held: BP outside parameters for Amlodipine, Carvedilol and Losartan.03/01/26, Evening and Bedtime, LVN K documented BP 126/56, Pulse 63 and 3= Held: BP outside parameters for Carvedilol and Losartan Potassium.03/04/26, Evening and Bedtime, MA J documented BP 120/54, Pulse 60 and 3= Held: BP outside parameters for Carvedilol and Losartan Potassium.03/05/26, Morning, MA D documented BP 107/56, Pulse 65and 3= Held: BP outside parameters for Amlodipine, Carvedilol and Losartan Potassium.03/10/26, Morning, MA J documented BP 104/56, Pulse 70 and 3= Held: BP outside parameters for Amlodipine, Carvedilol and Losartan Potassium.03/10/26, Evening and Bedtime, MA J documented BP 126/56, Pulse 64 and 3= Held: BP outside parameters for Carvedilol and Losartan Potassium.03/11/26, Evening and Bedtime, MA J documented BP 124/54, Pulse 66 and 3= Held: BP outside parameters for Carvedilol and Losartan Potassium.03/13/26, Morning, MA D documented BP 103/50, Pulse 68 and 3= Held: BP outside parameters for Amlodipine, Carvedilol and Losartan.03/14/26, Evening and Bedtime, LVN K documented BP 103/55, Pulse 65 and 3= Held: BP outside parameters for Carvedilol and Losartan Potassium.03/16/26, Evening and Bedtime, LVN L documented BP 115/53, Pulse 60 and 3= Held: BP outside parameters for Carvedilol and Losartan Potassium.03/17/26, Morning, MA D documented BP 123/50, Pulse 64 and 3= Held: BP outside parameters for Amlodipine, Carvedilol and Losartan Potassium.03/18/26, Morning, MA D documented BP 104/54, Pulse 60 and 3= Held: BP outside parameters for Amlodipine, Carvedilol and Losartan Potassium.03/21/26, Morning, MA J documented BP 108/56, Pulse 66 and 3= Held: BP outside parameters for Amlodipine, Carvedilol and Losartan Potassium.03/22/26, Morning, MA J documented BP 106/50, Pulse 64 and 3= Held: BP outside parameters for Amlodipine, Carvedilol and Losartan Potassium.03/24/26, Bedtime, MA J documented BP 124/54, Pulse 58 and 3= Held: BP outside parameters for Losartan Potassium.03/27/26, Evening, MA J documented BP 114/50, Pulse 68 and (continued on next page)</p>		

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 04/09/2026
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>3= Held: BP outside parameters for Carvedilol.03/29/26, Morning, MA D documented BP 120/56, Pulse 60 and 3= Held: BP outside parameters for Amlodipine, Carvedilol and Losartan Potassium.03/30/36, Morning, MA D documented BP 112/53, Pulse 60 and 3= Held: BP outside parameters for Amlodipine, Carvedilol and Losartan Potassium.03/30/26, Evening and Bedtime, MA J documented BP 130/54, Pulse 62 and 3= Held: BP outside parameters for Carvedilol and Losartan Potassium.04/01/26, Morning, MA D documented BP 107/50, Pulse 61 and 3= Held: BP outside parameters for Amlodipine, Carvedilol and Losartan Potassium.04/05/26, Morning, MA D documented BP 116/54, Pulse 61 and 3= Held: BP outside parameters for Amlodipine, Carvedilol and Losartan Potassium.In an interview on 04/09/26 at 8:25 am, MA D stated she did not administer the medications because Resident #7's blood pressure was outside of the parameters for administration. MA D stated Resident #7's diastolic blood pressure (the bottom number) was below 60, so she held the medication. When MA D checked Resident #7's orders and blister packs for the medication orders, she stated the hold parameters only included the systolic blood pressure (the top number) and the pulse. MA D stated on her computer, further down in the order, it sated to hold if systolic blood pressure was below 110 and diastolic blood pressure was below 60. MA D stated she told the nurse she held the medication and about the conflicting hold parameters. MA D stated if a blood pressure medication was not administered according to the physician's orders, it could cause the resident's blood pressure to go up which could cause a stroke. She stated in-services on medication administration were usually once a month and the last one was approximately 2 1/2 weeks ago and covered notification to the nurse for non-administration for refusal or vital signs outside of parameters as well as other medication administration topics. In an interview on 04/09/26 at 9:38 am, LVN E stated when MA D notified her that Resident #7's blood pressure medications were held, she checked the Losartan, Amlodipine, and Carvedilol orders and they all only said hold if systolic blood pressure was below 100. She added that Carvedilol also had a hold parameter of pulse below 60. She stated the MA notified her and she contacted the doctor to clarify the hold parameters. LVN E stated MA D should not have held the blood pressure medications, as the order stated to hold if systolic blood pressure was below 100 and did not have a hold parameter for the diastolic number. She stated if anti-hypertensive medications were held when they should have been given, it could cause the resident's blood pressure to go high and cause the resident to get a headache or a stroke. LVN E stated in-services on medication administration were every 1-3 months and she did not recall when the last one was.In an interview on 04/09/26 at 10:15 am, Resident #7 stated she did recall a few times in the past month when the nurse told her that her blood pressure was a little bit low and did not administer her blood pressure medications but did not recall having any symptoms of high blood pressure on those days. In an interview on 04/09/26 at 10:23 am, the ADON stated the old hold parameters were in the pharmacy comments area of the chart and were not part of the administration order. The ADON stated the pharmacy did not completely remove the previous hold parameters on Resident #7's anti-hypertensive medications when the physician updated the orders with new parameters, so it could appear there were 2 sets of hold parameters if the order screen was expanded to show the pharmacy information. She stated the pharmacy information shown was part of the original provider's order and should have been removed when the provider updated the order. She stated she did not know how long that information had been there. She stated MA D should not have held Resident #7's blood pressure medications because her vital signs were not outside of parameters to give them, per the physician's order. She stated LVN E called the doctor and administered the medications after she got clarification on the orders. The ADON stated if there were conflicting or confusing hold parameters for a medication, the nurse notified the pharmacy to remove the old parameters and updated the orders. The ADON stated if a blood pressure medication was held when it should have given, it could cause the blood pressure to go up which could lead to high blood pressure, hypertensive crisis, stroke, hospitalization, or even death. She stated in-services on medication administration were quarterly and as needed and the last one was within the last 2-3 weeks. She stated the DON did annual check offs (continued on next page)</p>		

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 04/09/2026
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>with the nurses and MAs for medication administration. In an interview on 04/09/26 at 12:00 pm, the DON stated Resident #7's blood pressure medications were given after LVN E contacted the nurse practitioner. She stated if there were conflicting orders, the nurse should contact the provider to clarify the order. The DON stated if a blood pressure medication was held when it should have been given, it could cause the resident's blood pressure to be too high which could lead to stroke. The DON stated medication administration was observed by the pharmacist monthly and as needed and medication aides had medication administration check-offs done every year. The DON stated medication administration in-services were done every 3 months and as needed and the last in-service was last month. Record review of the facility's Medication Administration Policy dated March 2019 and revised January 2024 reflected in part: Compliance Guidelines: Resident medications are administered in an accurate, safe, timely, and sanitary manner. RESPONSIBLE DISCIPLINES: Licensed Nurses, C.M.A.s 2. Verify the medication label against the medication sheet for accuracy of drug frequency, duration, strength, and route. a. The nurse/medication aide shall be responsible to read and follow precautionary or instructions on prescription labels. b. If the label and medication sheet are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders shall be checked for the correct dosage schedule. 5. If applicable and/or prescribed, take vital signs or tests prior to administration of the dose. 6. Administer medications as ordered by the physician.</p>		

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 04/09/2026
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 4 residents (Residents #6), reviewed for pharmaceutical services, in that: The facility failed to ensure Resident #6's physician's ordered Midodrine was correct. This failure could place residents at risk for not receiving medication as ordered. The findings included: Record review of Resident #6's admission record, dated 04/09/26, a [AGE] year-old male with an admit date of 04/06/26 and an initial admission date of 01/27/26. His relevant diagnoses included end stage renal disease (permanent, irreversible kidney failure where kidneys can no longer function on their own), dependence on renal dialysis (a life sustaining chronic need for hemodialysis or peritoneal dialysis due to end-stage renal disease), and hypotension (low blood pressure). Record review of Resident #6's Medicare-5 day MDS assessment, dated 03/14/26, reflected he had a BIMS score of 15, which indicated his cognition was intact. Record review of Resident #6's dated 03/10/26, reflected a: Focus: [Resident #6] have ESRD (end stage renal disease) and require dialysis treatments. I am at risk for increase, SOB, chest pain, increased or decreased blood pressure, itchy skin, nausea/vomiting, loose stools, dehydration, and infected/malfunctioning access site. Dialysis on MWF 7:30 am, date initiated/revised 03/10/26. Interventions: in part included give medications as ordered by my physician, date initiated 03/10/26. Record review of Resident #6's physician's order summary dated 04/09/26, reflected: Midodrine HCl Oral tablet 5 MG (Midodrine HCl), give 1 tablet by mouth one time a day every Mon, Wed, Fri for hypotension on dialysis days-send to dialysis. Hold if SBP is less than 140 notify nurse/MD. Start date: 04/08/2026. Record review of Resident #6's April 2026 Medication Administration Record reflected, Midodrine HCl Oral Tablet 5 MG was not administered on 04/08/26 and a code 3 was entered. Code 3 indicated medication was held: BP outside parameters. In a telephone interview on 04/09/26 at 11:18 a.m. NP G said Resident #6 was one of his residents. He said he had ordered Midodrine HCl oral tablet 5 mg to Resident #6 to help increase his blood pressure while in dialysis. He said the nursing facility was to send the medication to the dialysis center in case Resident #6's blood pressure dropped. This surveyor read Resident #6's active order for Midodrine HCl oral tablet 5 mg to NP G and he said the parameter to hold if systolic blood pressure less than 140 was not correct. NP G said the order should not have any parameters and regardless of his blood pressure the medication should have been sent with him to the dialysis clinic. NP G said a negative outcome to Resident #6 would be if the nursing facility followed the parameters on his Midodrine order, they would not send the medication with him to the dialysis clinic if his systolic blood pressure was outside the prescribed parameters, which could result in a further drop while being dialyzed. In an interview on 04/08/26 at 11:31 a.m., the DON said Resident #6 had been readmitted on [DATE] after being in the hospital. She said Resident #6 was a dialysis patient and his dialysis days were Mondays, Wednesdays, and Fridays. She said Resident #6 had an order of Midodrine and it was to be sent with him to the dialysis clinic in case his blood pressure dropped. The DON said the dialysis clinic where Resident #6 went to did not have medications on hand to administer. She said per the dialysis clinic request and per Resident #6's order a Midodrine pill should be sent to the clinic in case Resident #6's blood pressure dropped. She said the facility maintained an ongoing communication with the dialysis clinic regarding Resident #6. She said before Resident #6 left the facility on his scheduled dialysis days, a Midodrine pill would be placed in a plastic bag, labeled with his name, route, indication, and dose and attached to the dialysis communication sheet. The DON said the communication sheet was to be given to the EMS personnel and they in turn would hand deliver it to the facility. She said at no time did Resident #6 handle the medication. She said if Resident #6 did not require his Midodrine medication, the dialysis clinic would discard it. The DON said the (continued on next page)</p>		

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 04/09/2026
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>dialysis clinic would indicate on the dialysis communication sheet whether or not Resident #6 required his Midodrine medication on that day. The DON said Resident #6's Midodrine order with a start date of 04/08/26 was not correct, she said it should not have had any parameters. The DON said LVN F followed the order as it read of being held if Resident #6's SBP was below 140. She said the facility had not sent a Midodrine pill with Resident #6 when he went to dialysis today (04/08/26). The DON said there were no negative outcomes to Resident #6 having an incorrect Midodrine order. In a telephone interview on 04/08/26 at 3:25 p.m., Dialysis RN H said Resident #6 was one of their patients. He said Resident #6 would receive dialysis on Mondays, Wednesdays, and Fridays. He said the nursing facility would send a Midodrine pill labeled with Resident #6's name, dose, indication, route, and frequency in a plastic bag stapled to his dialysis communication sheet. He said if Resident #6's blood pressure dropped; he would be administered Midodrine. Dialysis RN H said at no time would Resident #6 handle the Midodrine pill. He said EMS personnel would hand deliver the medication to a facility's nurse and they would keep it in case Resident #6 required it. In an interview on 04/08/26 at 3:45 p.m., Resident #6 said he had just returned from dialysis and did not want to be interviewed. He said he was tired and just wanted to go back to sleep. Record review of Resident #6's Dialysis Communication form post treatment dated 04/08/26 reflected: Patient with asymptomatic hypotension during treatment, please send Midodrine with pt. In a telephone interview on 04/08/26 at 5:20 p.m., LVN F said she had worked the overnight shift (10:00 p.m. to 6:00 a.m.) on 04/07/26. She said she had been assigned to Resident #6's hall and she had cared for him during her shift. She said Resident #6 was a dialysis patient and was scheduled dialysis on Mondays, Wednesdays, and Fridays. She said she had checked his blood pressure on 04/08/26 at 4:00 a.m. and it was outside the ordered parameter. She said she had not administered Resident #6 Midodrine and had not prepared it to be sent to the dialysis clinic. She said she used code 3 which indicated it was held due to blood pressure outside parameter. This surveyor read Resident #6's Midodrine order to LVN and she said the parameters were not correct. She said the parameter should have read if SBP was greater not less than 140. She said she had not notified her DON nor had called Resident #6's NP to get clarification. She said the negative outcome for Resident #6 would be that his blood pressure could drop while in dialysis and without the Midodrine medication, dialysis would need to stop. In an interview on 04/09/26 at 3:00 p.m., Resident #6 said he was scheduled to go to dialysis on Mondays, Wednesdays, and Fridays in the morning. He said while in dialysis there had been times his blood pressure dropped. Resident #6 said the nursing facility would send a blood pressure medication in an envelope to the dialysis clinic in case his blood pressure would drop. He said the envelope was given to the EMS personnel and they would hand it over to a nurse at the dialysis clinic. Resident #6 said he had never handled the medication himself. He said if his blood pressure would drop, a dialysis clinic nurse would ask him if he wanted to take the pill. Resident #6 said if he did not require the pill the dialysis clinic stayed with it. Resident #6 said he had not had any complication while being dialyzed on 04/08/26 and was able to complete his treatment. Record review of the facility's Medication Administration policy revised on January 2024 reflected: Compliance guidelines: Resident medications are administered in an accurate, safe, timely, and sanitary manner. 2. Verify the medication label against the medication sheet for accuracy of drug frequency, duration, strength, and route. The nurse/medication aide shall be responsible to read and follow precautionary or instructions on prescription labels. If the label and medication sheet are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders shall be checked for the correct dosage schedule. Report any discrepancies to the pharmacy. Do not administer the medication until the discrepancy is resolved.</p>		

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 04/09/2026
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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure its medication error rate was not five percent or greater. The medication error rate was 8.11% based on 3 errors out of 37 opportunities for 1 (Resident #7) of 5 residents observed for medication administration. The facility failed to ensure MA D administered Resident #7's 3 anti-hypertensive medications (Amlodipine Besylate, Carvedilol, and Losartan Potassium) when her blood pressure was within parameters for administration per the physician's orders. This failure could place residents at risk for not receiving the intended therapeutic effects of their medications and could contribute to possible adverse reactions. The findings included: Record review of Resident #7's admission record reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her relevant diagnoses included hypertension (high blood pressure), cerebral infarction (stroke), aphasia following cerebral infarction (an impairment in the ability to read, write, and speak), dysphagia following cerebral infarction (difficulty swallowing), and other sequelae of cerebral infarction (a variety of medical, musculoskeletal, and psychosocial complications following a stroke). Record review of Resident #7's quarterly MDS dated [DATE] reflected a BIMS score of 15 which indicated she was cognitively intact. Record review of Resident #7's care plan dated 04/05/24 reflected a focus of heart disease with a risk for complications such as chest pain, shortness of breath, edema (fluid retention causing swelling), and high blood pressure. The interventions included to administer medications as ordered by the physician and monitor vital signs as indicated and report abnormal findings to physician as indicated, initiated on 05/16/25. Record review of Resident #7's order summary report on 04/09/26 reflected the following orders for anti-hypertensive (lowering blood pressure) medications: Amlodipine Besylate Oral Tablet 10 MG. Give 1 tablet by mouth one time a day for HTN (high blood pressure). Hold if SBP (systolic blood pressure- the top number in blood pressure) is less than 100 and notify Nurse/MD (Medical doctor). Ordered on 12/31/25. Carvedilol Oral Tablet 12.5 MG. Give 1 tablet by mouth two times a day for HTN. Hold if SBP less than 100, pulse less than 60 and notify Nurse/MD. Ordered on 12/31/25. Losartan Potassium Oral Tablet 50 MG (Losartan Potassium) Give 1 tablet by mouth two times a day for hypertension. Hold if SBP less than 100 and Notify Nurse/MD. Ordered on 06/11/24. During an observation on 04/09/26 at 8:11 am, Resident #7's blood pressure was 122/53 and her pulse was 64. MA D did not administer Resident #7's Amlodipine Besylate, Carvedilol, or Losartan Potassium as ordered by the physician. In an interview on 04/09/26 at 8:25 am, MA D stated she did not administer the medications because Resident #7's blood pressure was outside of the parameters for administration. MA D stated Resident #7's diastolic blood pressure (the bottom number) was below 60, so she held the medication. When MA D checked Resident #7's orders and blister packs for the medication orders, she stated the hold parameters only included the systolic blood pressure (the top number) and the pulse. MA D stated on her computer, further down in the order, it stated to hold if the systolic blood pressure was below 110 and diastolic blood pressure was below 60. MA D stated she told the nurse she held the medication and about the conflicting hold parameters. MA D stated if a blood pressure medication was not administered according to the physician's orders, it could cause the resident's blood pressure to go up which could cause a stroke. She stated in-services on medication administration were usually once a month and the last one was approximately 2 1/2 weeks ago and covered notification to the nurse for non-administration for refusal or vital signs outside of parameters as well as other medication administration topics. In an interview on 04/09/26 at 9:38 am, LVN E stated when MA D notified her that Resident #7's blood pressure medications were held, she checked the Losartan, Amlodipine, and Carvedilol orders and they all only said hold if systolic blood pressure was below 100. She added that Carvedilol also had a hold parameter of pulse below 60. She stated the MA notified her and she contacted the doctor to clarify the hold parameters. LVN E stated MA D should not have held the blood pressure medications, (continued on next page)</p>		

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 04/09/2026
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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>as the order stated to hold if systolic blood pressure was below 100 and did not have a hold parameter for the diastolic number. She stated if anti-hypertensive medications were held when they should have been given, it could cause the resident's blood pressure to go high and cause the resident to get a headache or a stroke. LVN E stated in-services on medication administration were every 1-3 months and she did not recall when the last one was. In an interview on 04/09/26 at 10:15 am, Resident #7 stated she did recall a few times in the past month when the nurse told her that her blood pressure was a little bit low and did not administer her blood pressure medications but did not recall having any symptoms of high blood pressure on those days. In an interview on 04/09/26 at 10:23 am, the ADON stated the old hold parameters were in the pharmacy comments area and were not part of the administration order. The ADON stated the pharmacy did not completely remove the previous hold parameters on Resident #7's anti-hypertensive medications when the physician updated the orders with new parameters, so it could appear there were 2 sets of hold parameters if the order screen was expanded to show the pharmacy information. She stated MA D should not have held Resident #7's blood pressure medications because her vital signs were not outside of parameters to give them, per the physician's order. She stated LVN E called the doctor and administered the medications after she got clarification on the orders. The ADON stated if there were conflicting or confusing hold parameters for a medication, the nurse notified the pharmacy to remove the old parameters and updated the orders. The ADON stated if a blood pressure medication was held when it should have been given, it could cause the blood pressure to go up which could lead to high blood pressure, hypertensive crisis, stroke, hospitalization, or even death. She stated in-services on medication administration were quarterly and as needed and the last one was within the last 2-3 weeks. She stated the DON did annual check offs with the nurses and MAs for medication administration. In an interview on 04/09/26 at 12:00 pm, the DON stated Resident #7's blood pressure medications were given after LVN E contacted the nurse practitioner. She stated if there were conflicting orders, the nurse should contact the provider to clarify the order. The DON stated if a blood pressure medication was held when it should have been given, it could cause the resident's blood pressure to be too high which could lead to stroke. The DON stated medication administration was observed by the pharmacist monthly and as needed and medication aides had medication administration check-offs done every year. The DON stated medication administration in-services were done every 3 months and as needed and the last in-service was last month. Record review of the facility's Medication Administration Policy dated March 2019 and revised January 2024 reflected in part: Compliance Guidelines: Resident medications are administered in an accurate, safe, timely, and sanitary manner. RESPONSIBLE DISCIPLINES: Licensed Nurses, C.M.A.s 2. Verify the medication label against the medication sheet for accuracy of drug frequency, duration, strength, and route. a. The nurse/medication aide shall be responsible to read and follow precautionary or instructions on prescription labels. b. If the label and medication sheet are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders shall be checked for the correct dosage schedule. 5. If applicable and/or prescribed, take vital signs or tests prior to administration of the dose. 6. Administer medications as ordered by the physician.</p>		

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 04/09/2026
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)		
<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on observation, interview and record review the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption for 1 (Resident #43) of 3 resident refrigerators reviewed for refrigerator sanitation. The facility failed to ensure Resident #43's personal refrigerator was maintained. Resident #43's personal refrigerator had 3 small individual cups of pudding that were expired as well as a half-eaten carrot cupcake that did not have an open or expiration date. This failure could place residents who store food items in resident refrigerators, at risk of cross-contamination and food-borne illnesses if consumed. Findings were: Record review of Resident #43's admission Record dated 04/09/26 revealed a [AGE] year-old male with diagnoses of Alzheimer's Disease Unspecified (brain disorder causing decline in memory, thinking, and daily functioning), Essential (Primary) Hypertension (high blood pressure), Gastro-Esophageal Reflux Disease without Esophagitis (heartburn), Hyperlipidemia (high levels of fats such as cholesterol), and Cognitive communication deficit (difficulty communicating, such as listening, speaking). Record review of Resident #43's Quarterly MDS assessment dated [DATE] revealed the resident had a BIMS of 5 which indicated severe cognitive impairment. In an observation on 04/07/26 at 9:01 am of Resident #43's personal refrigerator revealed 3 small sealed individual cups of pudding with an expired date of 12/10/25 as well as a half-eaten carrot cupcake that did not have an open or expiration date. In an observation on 04/07/26 at 9:02 am the Resident Refrigerator and Freezer Temperature Log that had been pinned on the wall next Resident #43's refrigerator revealed the refrigerator had last been checked on 04/07/26 in the AM. In an interview on 04/07/26 at 9:02 am Resident #43 stated he did not know when the food items were brought. In an interview on 04/07/26 at 11:52 am Housekeeper A stated she had been in charge of checking resident's personal refrigerators when she cleaned their rooms. She said she had checked Resident #43's refrigerator earlier in the morning and had made sure the temperature was correct. She said she had not checked the dates on the food that had been stored in there. Housekeeper A said she had not been told to check for expiration dates on the food items. She said a resident could get sick if they ate food that was expired. In an interview on 04/07/26 at 2:46 pm the Housekeeping Supervisor said housekeeping staff was responsible for checking residents personal refrigerators. She said they were told to check the temperatures, expiration dates and also to label the open date. The Housekeeping Supervisor said a resident could get ill, not feel well if they ate food that was expired. In an interview on 04/10/26 at 4:00 pm the ADM said housekeeping checked the residents' personal refrigerators. He said they were checked every day. He said expiration dates should be checked. The ADM said depending on the date of expiration of the food, it may cause stomach discomfort. Record review of the facility's policy Outside Foods revised date September 2025 revealed; Compliance Guidelines: 2. The outside food should be labeled with the Resident's name and date. 3. Proper food handling should be used once outside food is brought into the facility.</p>		

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 04/09/2026
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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, and to help prevent the development and transmission of communicable diseases and infections for two (Resident #14 and Resident #82) of 6 residents reviewed for infection control practices. 1. The facility failed to ensure MA D performed hand hygiene for at least 20 seconds before she administered Resident #14's medication.2. The facility failed to ensure MA D performed hand hygiene for at least 20 seconds before and after she administered Resident #82's medication.This failure could place residents at risk for healthcare associated cross-contamination and infections.Findings included:Record review of Resident #14's admission record reflected an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included unspecified dementia (loss of memory, language, problem solving and other thinking abilities which significantly impair a person's ability to perform daily activities), paroxysmal atrial fibrillation (irregular, often fast heartbeat that comes and goes on its own), type 2 diabetes mellitus (chronic condition that happens when blood sugar levels are persistently high which can lead to heart disease, kidney disease, and stroke), hyperlipidemia (high cholesterol), essential (primary) hypertension (high blood pressure), and cognitive communication deficit (difficulty with communication).Record review of Resident #14's quarterly MDS dated [DATE] reflected a BIMS score of 3 which indicated he had severe cognitive impairment.Record review of Resident #82's admission record reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included fracture of right patella (broken kneecap), 03/30/26. Her diagnoses included fracture of right patella (broken kneecap), type 2 diabetes mellitus (chronic condition that happens when blood sugar levels are persistently high which can lead to heart disease, kidney disease, and stroke), hyperlipidemia (high cholesterol), essential (primary) hypertension (high blood pressure), and long term (current) use of anticoagulants (blood thinning medication).Record review of Resident #82's admission MDS dated [DATE] reflected a BIMS score of 15 which indicated she was cognitively intact. Observation on 04/09/26 at 8:41 am reflected MA D scrubbed her hands for 8 seconds before she administered medication to Resident #14. Observation on 04/09/26 at 9:14 am reflected MA D scrubbed her hands for 8 seconds before she administered medication to Resident #82.Observation on 04/09/26 at 9:19 am reflected MA D scrubbed her hands for 11 seconds after she administered medication to Resident #82.In an interview on 04/09/26 at 9:30 am MA D stated hands were washed for 30-35 seconds and it was for the scrub time, not the total time. She stated she usually sang the happy birthday song to herself, but she was not counting just scrub time when she was being timed, she was counting total time. MA D stated if hands were not washed properly, it could lead to spread of infection to other residents. She stated they were in-serviced on hand washing everyday. She stated in-services on infection control were once a month, and the last one was within the last 2 weeks. In an interview on 04/09/26 at 10:23 am the ADON stated in-services on infection control were done quarterly and as needed. She stated hand washing scrub time was supposed to be at least 20 seconds and if hand washing was not done properly it could lead to spread of germs and cause other residents to get sick. In an interview on 04/09/26 at 12:00 pm, the DON stated infection control was in-serviced all the time. She stated hand washing was observed on random staff every month. The DON stated if hands were not washed correctly, it could cause the spread of germs which could lead to illness for other residents. Record review of the facility's Infection Prevention and Control Policy dated 03/13/19 and revised April 2024 reflected in part:Compliance Guidelines:The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance program.Staff Responsibilities:Includes all staff to include direct and indirect care functions, contracted staff, consultants, volunteers, others who provide care and services to (continued on next page)</p>		

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 04/09/2026
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>residents on behalf of the community, and students in the community's nurse aid training programs or from an affiliated academic institution.1. Coordination/ Oversight/ Educatione. Staff will receive training on the community's infection prevention and control program to include but not limited to preventative measures. 2. Policies and Proceduresa. Policies and procedures are utilized as the standards of the infection prevention and control program.9. Prevention of Infection3. Educating staff and ensuring that they adhere to proper techniques and procedures.6. Educating staff and ensuring that they adhere to proper infection prevention and control practices when performing resident care activities as it pertains to his/ her role responsibilities and situation.14. DefinitionsHand washing refers to washing hands with soap and water.Record review of the facility's Infection Prevention and Control Policy did not reflect specific hand washing procedures.www. cdc.gov guidelines reflected: The CDC provides a clear, five-step process for effective handwashing with soap and water. Here are the steps to follow:1. Wet your hands with clean, running water (warm or cold).2. Apply soap and lather your hands by rubbing them together.3. Scrub your hands for at least 20 seconds, ensuring all areas are covered.4. Rinse your hands well under clean, running water.5. Dry your hands using a clean towel or an air dryer.</p>		