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	12/31/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to formulate an advance directive for 1 (Resident #1) of 3 residents reviewed for Advance Directives. The facility failed to ensure Resident #1's OOH-DNR was completed. The OOH-DNR form did not have the physician's signature. This failure could affect all residents who have implemented Advance Directives and established their choice not to be resuscitated at risk of receiving CPR against their wishes. The findings were: Record review of Resident #1 face sheet dated [DATE] revealed an [AGE] year-old female admitted to facility on [DATE] with diagnosis of Diabetes Mellitus type 1 (a chronic autoimmune disease where the immune system mistakenly destroys the insulin-producing beta cells in the pancreas, leading to little or no insulin production, causing high blood sugar), Muscle wasting and atrophy, dehydration (your body doesn't have enough water and fluids to function properly). Resident #1's electronic face sheet reflected Code Status: DNR. Record Review of Resident #1 comprehensive care plan dated [DATE] revealed Resident #1 advanced directives/care choices/ code status with interventions: code status: DNR. Record review of Resident #1's MDS assessment dated [DATE] reflected he scored a 5 on his BIMS which reflected severely cognitively impaired. Record review of Resident #1's physician order dated [DATE] reflected ***Code Status: ***DNR*** Record review of Resident #1's OOH-DNR form undated reflected the form was not signed by the attending physician below section E, Physician's Statement: I am the attending physician of the above noted person and have noted the existence of this order in the person's medical records. I direct health care professionals acting in our-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation. It also revealed the physician did not sign section F, All persons who have signed above must sign below, acknowledging that this document has been properly completed. During an interview on [DATE] at 9:43am ADON stated that the DNR form was discussed upon admission. She stated residents who were DNR should have a completed and signed by all parties, the OOH DNR. She stated all parties were residents or family, witnesses, and the doctor. ADON stated DNR form was signed by the family and the order was placed in the Resident #1's electronic record. She stated that the DNR status of a resident was located on the electronic system for resident's records. ADON stated if it showed DNR on the electronic system for resident's records that meant the OOH DNR form had been verified and completed. During an interview on [DATE] at 11:50 a.m., Social Services stated that he was the one responsible for completing the OOH DNR form. He stated that upon admission, he informed the resident and/or family of their rights regarding the DNR status. If it was confirmed for the resident to be DNR, he provided them with the form, and obtained their signatures, and the doctor ' s signature. He stated that the OOH DNR form should be signed by the doctor as soon as possible. He stated that it was important for the OOH DNR form to be signed by the doctor because it makes the document official, a legal document that all parties signs. The Social Services stated the DNR was not complete until the doctor signed it. During an interview [DATE] at 2:00 pm with DON stated that the social worker was responsible for completing the OOH DNR form. She stated the facility explains the document and if they say yes that they want to be DNR, the facility would obtain the resident/RP and witnesses signatures. DON said that she got a verbal order from the MD and that was why the code status was changed to DNR. DON said that there was not a negative outcome because she had the verbal order. Record review of the facility's Advanced Directives policy date reviewed/revised [DATE], revealed the Advance directive implementation: the IDT should honor the care decision expressed and initiate the advance directive by initiating the out of hospital Do Not Resuscitate (OOH DNR) form and should obtain the medical provider/physician's signature as per the OOH DNR form instructions.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure parenteral care and services were administered consistent with professional standards of practice for 1 of 3 residents reviewed for intravenous fluids. (Resident #1) The facility failed on 12/29/2025 to ensure the dressing on Resident #1's peripheral intravenous line (a short flexible tube inserted into the vein to administer fluids and medications) was dated and initialed. This failure could place residents at risk of not receiving the appropriate IV care and services. Findings included: Record review of Resident #1 face sheet dated 12/31/2025 revealed an [AGE] year-old female admitted to facility on 12/11/2025 with diagnosis of Diabetes Mellitus type 1 (a chronic autoimmune disease where the immune system mistakenly destroys the insulin-producing beta cells in the pancreas, leading to little or no insulin production, causing high blood sugar), Muscle wasting and atrophy, dehydration (your body doesn't have enough water and fluids to function properly). Record Review of Resident #1 comprehensive care plan dated 12/26/2025 revealed Resident #1 is at risk for complications associated with intravenous therapy related to peripheral line, with interventions frequently monitor/check IV access site upon each care encounter, careful when providing care & look for s/s of infection or infiltration (abnormalities) such as redness, swelling, puffiness, pain, discomfort, tenderness, drainage, warm to touch at or near the site. If any abnormalities are noted, then promptly notify Nurse /MD/NP. Record review of Resident #1's MDS assessment dated [DATE] reflected he scored a 5 on his BIMS which reflected severely cognitively impaired. During an observation on 12/29/2025 at 9:30 am Resident # 1 had a peripheral intravenous lock covered with a transparent dressing with no date and no initials on her right hand. There were no signs or symptoms of infection or infiltration noted at the IV site. During an interview on 12/29/25 at 9:25 a.m. LVN A stated she was the nurse for Resident #1. She stated that the nurse who initiated the IV was responsible for labeling the dressing with the date of placement and initials. LVN A stated that it was important to label the IV site to know when the IV was placed or the last time it was changed. She stated that if the IV was changed within the ordered time, then it could cause an infection. She stated that the last time he had checked the resident's IV site was this morning, at the beginning of his shift. LVN A stated that the IV site should be checked at every shift. The site was to be checked for any signs of infection, the date and signature on the dressing, and check that the saline lock cap was in place. She stated he could not recall when the last training was he had received on IV administration. LVN A stated the resident had a peripheral IV lock on her right hand covered with a transparent dressing that was not labeled or dated. In an interview on 12/31/25 at 2:00 p.m., the DON stated she did not know why the dressing label had not been dated and initialed. The DON stated that the nurse that had inserted the IV should have dated and initialed the dressing that was over the IV site. The DON searched through orders on their computer system to verify who had placed the IV, however, she was able to find the progress note indicating placement. The DON stated that labeling the insertion site dressing was taught in nursing school and every nurse should have known to label it. She stated that the negative outcome of not labeling the dressing was that it could go over the recommended standard time of every 72 hours and could cause infection. She stated that IV administration class was done annually and as needed. Record review of facility policy named IV Policies and Procedures Manual revealed: Procedure: 12. With sterile tape, secure the catheter and apply dressings. Label appropriately.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals used in the facility were stored in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 3 residents (Resident #1) reviewed for medication storage. The facility did not ensure a medication named Normal Saline flush was not stored at the bedside for Resident #1 on 12/29/2025. This failure could place all residents at risk of misuse of medication and decreased quality of life. Findings included: Record review of Resident #1 face sheet dated 12/31/2025 revealed an [AGE] year-old female admitted to facility on 12/11/2025 with diagnosis of Diabetes Mellitus type 1 (a chronic autoimmune disease where the immune system mistakenly destroys the insulin-producing beta cells in the pancreas, leading to little or no insulin production, causing high blood sugar), Muscle wasting and atrophy, dehydration (your body doesn't have enough water and fluids to function properly). Record review of Resident #1's MDS assessment dated [DATE] reflected he scored a 5 on his BIMS which reflected severely cognitively impaired. Record Review of Resident #1 comprehensive care plan dated 12/26/2025 revealed Resident #1 is at risk for complications associated with intravenous therapy related to peripheral line, with interventions frequently monitor/check IV access site upon each care encounter, careful when providing care & look for s/s of infection or infiltration (abnormalities) such as redness, swelling, puffiness, pain, discomfort, tenderness, drainage, warm to touch at or near the site. If any abnormalities are noted, then promptly notify Nurse /MD/NP.During an observation and interview on 12/29/2025 at 9:30 am Resident # 1 was observed with a normal saline flush on his television stand. She stated the nurse left the normal saline flush on top of the television stand. During an interview on 12/29/2025 at 9:35am with LVN A said no resident should have medications or the normal saline flush at their bedside. She said a resident could take the normal saline, other residents or visitors. She said residents could have an allergic reaction or the normal saline flush could get contaminated. During an interview 12/31/2025 at 2:00 pm with DON said no resident should have medication of any kind at their bedside. She said another resident could go in the room and take the medication. She said Resident #1 could get an adverse reaction. Record Review of facility policy titled Medication Cart Use and Storage revealed: Security: the medication cart and its storage should be kept closed, secured and/or in the line of sight when not in use.