STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675105	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing and Rehabilitation	1900 N Frances St Terrell, TX 75160

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observations, interviews, and record review, the facility failed to notify residents or their representatives on how to file a grievance or complaint in an anonymous manner for The facility failed to notify residents or their representatives either individually or through prominent postings throughout the facility on how to file a grievance or complaint in an anonymous manner for 1 of 1 facilities reviewed. This failure could place residents at risk of not filing a grievance without the fear of discrimination, reprisal, retribution, and their right to anonymously file their grievance. Findings included:Interview on 08/12/2025 at 2:00PM with six residents during the confidential Resident Council revealed the residents were unaware where grievance forms were located. The residents stated that they did not know how to anonymously file a grievance.Observation of the common areas throughout the facility on 08/12/25 at 2:45PM revealed no grievance forms or a container to place the grievances. Interview on 08/13/25 at 6:20PM, the Activities Director said if anyone wanted to fill out a grievance they go to the Activities Director to get a form. Activities Director revealed she was not sure where else the residents would get a grievance form because she had the forms. The Activities Director revealed if a resident was able to get ahold of a grievance form and wanted to turn it in, they could turn it into the head nurse, same if the Activities Director was not on-site. Activities Director revealed if the resident could not fill out a grievance it would cause mental issues for the resident. Interview on 08/15/2025 at 10:45am with the DON revealed grievances are filled out in the EMR. The Activities Director distributed forms to residents and assisted to fill out the form, if needed. The Activities Directed gave the completed grievance forms to staff, unspecified, to enter in the electronic medical records. The DON revealed she did not know who specifically the Grievance Official was at the facility. DON revealed she was sure where and how to turn in grievances . Review of the facility's policy titled, Grievances dated 11/2/2016 revealed, Procedure1. The facility will notify residents on how to file a grievance orally, in writing, or anonymouslywith postings in prominent locations.2. The grievance official of this facility is the administrator or their designee. The grievance official will: Oversee the grievance process Receive and track grievances to their conclusionReview of the Resident's Rights subsection Grievances revealed, The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The facility must make information on how to file a grievance or complaint available to the resident.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675105	A. Building B. Wing	08/15/2025

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents were free from abuse for 1 (Resident #7) of 6 Residents reviewed for abuse.The facility failed to protect Resident #7 from verbal abuse when Resident #16 made mocking statements and gestures regarding Resident #7's personal hygiene, the Administrator, LVN B, DON and Social Worker were aware of the verbal abuse. The verbal abuse led to Resident #7 being fearful, avoiding Resident #16 and Resident #7's withdrawal from former social patterns in refusing to go to the dining room and activities. An IJ was identified on 08/14/25. The IJ template was provided to the facility on [DATE] at 10:13AM. While the IJ was removed on 08/15/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because the facility was continuing to monitor the implementation and effectiveness of their Plan of RemovalThis failure could result in residents becoming fearful, refusing to go to the dining room, or participate in activities. Findings included: Record review of Resident #7's face sheet, dated 05/28/25, reflected the resident was a [AGE] year-old male, who admitted [DATE] with diagnoses of paranoid schizophrenia (a chronic mental health condition characterized by disruptions in thought, perception, and behavior). Record review of Resident #7's MDS dated [DATE] revealed he had a BIMS score of 10 indicating he had moderate cognitive impairment. Record review of Residents #7's care plan dated 4/23/2025 revealed he was on antipsychotic medications for diagnosis of paranoid schizophrenia. Interventions included administration of medication as ordered.Record review of Resident #16's face sheet, dated 08/01/25, revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses of depressive, dementia with other behavioral episodes.Record review of Resident# 16's MDS, dated [DATE], revealed he had a BIMS score of 6 indicating severe cognitive impairment.Record review of Resident #16's care plan, dated 08/19/24 and revised 08/12/25, revealed the resident had potential to demonstrate verbally abusive behavior, ineffective coping skills, and yelled loudly at staff, and called them names. Interventions included providing positive feedback for good behavior, assessing, and anticipating the resident's needs. During an interview on 08/12/25 at 12:30PM, Resident# 7 revealed he was scared of what Resident #16 would do to him based on past incidents when Resident #16 pinched his nose, yelled Resident #7 smelled, and followed him around.During an observation on 08/12/2025 at 12:30PM, it revealed the two resident room (Resident #7 and Resident #16) were in proximity/on the same hall/next door to one another. Resident #7 was well groomed, no body odor, or other smells noted. In an interview on 08/12/25 at 12:33PM Administrator revealed he was aware of a previous incident when Resident #7 reported to him Resident #16 said Resident#7 smelled. The administrator stated that he notified the social worker, and the social worker spoke to Resident #7 and Resident #16, and everything seemed to be okay. In an interview on 08/12/2025 at 4:45PM LVN B revealed that Resident #16 and Resident #7 did not like each other. LVN B stated that Resident #16 was the aggressor, he said mean things to people, especially the staff. Resident #7 kept to himself and avoided Resident #16. LVN B stated that he had been in serviced on abuse and neglect. He said the last in service was last pay day on 08/12/2025. He stated that the administrator and the DON were aware of the two Residents not getting along. In an interview on 08/12/25 at 2:58PM the DON revealed she was aware of an incident where that Regional nurse notified the DON that Resident #7 verbalized Resident#16 was holding his own nose yelling that Resident #7 smelled. The DON stated that she spoke with Resident #7 and Resident #16. The DON stated that Resident #16 denied the incident, and Resident #7 acted like nothing happened. No further interventions were implemented. Record review of Grievance, progress notes, social services notes for the dates of 04/01/25 through 08/15/25 reflected no documentation of the incident and interventions for Resident #7 or Resident #16.In an interview on 08/13/2025 at 11:20AM Social Worker revealed a few weeks ago, the Administrator notified her that Resident #7 reported that Resident #16 told Resident #7 that Resident #7 smelled. The Social Worker stated that she spoke with Resident #16 about him being mean to other residents and he denied it, but Resident #7 said that it did happen. Social Worker stated that she talked to both parties and Resident #7 said he was satisfied that she had talked to Resident #16. Social Worker stated that there was not follow up because it was just a passing conversation, and she did not realize that it was going to be a major issue. Social Worker stated Resident #7 was upset enough to bring it up. Social Worker stated that Resident #7 did not appear to have any psychosocial effects, but he must have been upset enough to report it to the administrator'. Social Worker stated that Resident #7's base

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	675105	A. Building B. Wing	08/15/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	675105	A. Building B. Wing	08/15/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, and record review, the facility failed to maintain an environment as free of accident hazards as is possible for 3 of 3 areas (1 shower room, and 1 wooden cabinet inside of the shower room and exterior/interior front door), reviewed for accidents and hazards. 1. The facility failed to ensure that the exterior door to the Shower Room in the facility's Secured Unit was locked and secured.2. The facility failed to ensure that the Master lock on the wooden cabinet inside the Shower Room in the facility's Secured Unit was locked and secured.3. The facility failed to ensure that Resident #7 was supervised and did not have access to the Nurses Station and access the red button to open the front door. These failures could place residents at risk of accidents, injury, elopement, and consuming hazardous products. Findings Include:Record review of Resident #7's admission face sheet dated 08/13/25 reflected he was a [AGE] year-old male was originally admitted to the facility on [DATE] and readmitted on [DATE] with active diagnoses that included: paranoid schizophrenia, hallucinations, psychotic disorder without hallucinations due to known physiological condition, brief psychotic disorder, major depressive disorder, single episode (unspecified), anxiety, unspecified intellectual disabilities, mild intellectual disabilities, and unspecified symptoms and signs involving cognitive functions and awareness . Record review of Resident #7's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 11 indicating that he had moderate cognitive impairment. Resident #7's MDS Assessment reflected that he had active diagnoses of anxiety, psychotic disorder, and schizophrenia. Resident #7 was prescribed narcotic medications for antipsychotic (type of drug used to treat symptoms of psychosis), antidepressant (prescription medicines to treat depression), and anticonvulsant (medication used to prevent or control seizures). Record review of Resident #7's Care Plan dated 03/26/2025 reflected, Focus:[Resident #7] has ID and is PASRR positive.Date Initiated: 04/08/2021Revision on: 07/17/2025Focus:[Resident #7] has episodes of delirium where he believes the FBI, space crafts, or other bizarre things are happening to him.Date Initiated: 04/15/2021Revision on: 04/01/2024Focus:[Resident #7] often believes that the state will take him away, that the facility management are wanting to get rid of him, or that workers here at the facility no longer like him. At times he is easily redirected with positive redirection but there's times that this belief is firmly held until resident has forgotten the subject.Date Initiated: 06/29/2022Revision on: 07/05/2022Focus:[Resident #7] has a dx of intellectual disability.Date Initiated: 09/09/2022Revision on: 09/09/2022Focus: [Resident #7] has impaired visual function d/t cataracts.Date Initiated: 03/02/2022Revision on: 09/09/2022Focus:[Resident #7] has mood problem r/t Disease Process schizophrenia.Date Initiated: 07/15/2025Revision on: 07/15/2025Focus:[Resident #7] has a dx of depression.Date Initiated: 09/09/2022Revision on: 04/23/2024Focus:[Resident #7] wanders aimlessly. Does not attempt or want to leave facility. [Resident #7] likes to sit in chairs in front of the facility outdoors, will walk to side of building where he keeps cans. [Resident #7] educated that if he does choose to leave the property to notify nurses.Date Initiated: 06/03/2021Revision on: 04/19/2023Focus:[Resident #7] is resistive to care r/t psych dx.Date Initiated: 06/04/2021Revision on: 07/26/2022 Focus:[Resident #7] is making verbal threats. Claims to take a roll of quarters and hit Someone.Date Initiated: 11/22/2022Revision on: 11/22/2022Focus:[Resident #7] needs out of room social, spiritual, and stimulus activities and mentalstimulation. [Resident #7] enjoys have small, odd jobs around the facility, such as helping clean, putting supplies away, ETC.Date Initiated: 04/22/2022Revision on: 04/27/2023Focus:[Resident #7] requires anti-psychotic medications for dx of paranoid schizophrenia.Date Initiated: 03/02/2021 Revision on: 04/23/2024Focus:[Resident #7] requires antidepressant medication.Date Initiated: 11/03/2023Revision on: 11/03/2023Observation in the facility's Secured Unit on 08/12/25 at 10:50 AM, revealed the exterior door of the Shower Room was ajar and was unlocked and unsecured. The exterior door to the Shower Room had a touch pad lock. Upon entry into the Shower Room, there was a wooden cabinet with a Master Lock for a lock, but the lock was unsecured on the wooden cabinet. There was a key hanging from a chain beside the wooden cabinet that can be used to unlock the Master Lock on the wooden cabinet. Inside of the wooden cabinet were the following items: 1 open bottle of cleanser, one 128 fl. oz. container labeled, Spray Cleanser, 1 container of deodorant, 2 bottles of mouthwash, 1 unsealed package of twin-size razors, and 1 roll of toilet paper. On the top of the wooden cabinet, there was 1 gallon container labeled, Shampoo & Body Wash. On the floor there was 1 - 1 gallon container labeled, Shampoo & Body Wash. The storage rack contained several undergarments, towels, 2 bottles of mouthwash (1 bottle was open), 1 deodorant, 1 opened

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	675105	A. Building B. Wing	08/15/2025

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 one (Resident #2) of four residents reviewed for medication administration.The facility failed to ensure LVN A administered each medication separately via Resident #2's g-tube per physician's orderThis failure could place residents at risk for potential significant medication interactions such as medication-medication or medication-food interactions.Findings included:Record review of Resident #2's Quarterly MDS Assessment, dated 07/19/25, reflected the Resident was a [AGE] year-old male, had a BIMs score of 8 indicating he was moderately cognitively impaired. The Resident had diagnoses which included dysphagia (difficulty swallowing foods and liquids), Cerebrovascular accident (a disruption of blood flow to the brain, leading to brain cell damage). Record review of Resident #2's Comprehensive Care Plan, revised 07/16/25, reflected [Resident# 2] requires tube feeding swallowing difficulty r/t CVA. Facility interventions included: The Resident is dependent with tube feeding and water flushes. See MD orders for current feeding orders. Monitor/document/report to MD PRN: Aspiration- fever, SOB, Tube dislodged, Infection at tube site, Self-extubation, Tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, Constipation or fecal impaction, Diarrhea, Nausea/vomiting, Dehydration.Record review of Resident #2's physician orders reflected: Enteral Feed Order every shift check G/T placement prior to administration of meds and hanging enteral feedings Verbal Active 04/11/2025 04/12/2025. Enteral Feed Order every shift Check gastric residual volume. Hold feeding for 1 hour____ and notify physician for residual greater than ____60ml_. Verbal Active 04/11/2025 04/12/2025 Enteral Feed Order every shift Flush enteral tube with 30ml water pre/post medication administration and 10 ml water between each medication Verbal Active 04/15/2025 04/15/2025.An observation on 08/13/25 at 8:46 AM revealed Resident #2 had enteral feeding Isosource 1.5 Cal infusing via G tube at 75ml/hr. LVN L performed hand hygiene and donned clean gloves. LVN L verified and pulled Resident #2's medications per MAR. The medications included: Eliquis 5mg 1 tablet, Folic Acid 1mg 1 tablet, Multivitamin with minerals 1 tablet, Chewable aspirin 81mg 1 tablet, Baclofen 10MG 1 tablet, Thiamin 100mg 1 tablet. LVN L put all the tablets in one pill pouch and crushed all the medications together, then she put the crushed medication in an 8-ounce cup and filled the cup with water. LVN L removed gloves, sanitized her hands, donned clean gloves, and went into the Resident's room. LVN L stopped the G Tube feeding. LVN L checked for G Tube placement, and then she checked for residual with none noted. LVN L did not flush the G Tube before administering the medication. LVN L administered the medication using a syringe then after administering the medication LVN L flushed the G Tube with 60 cc of water. In interview on 08/13/25 at 8:56 AM revealed LVN L knew that G tube medication was not supposed to be crushed and given together, but she stated that she crushed them together because the medications were mostly vitamins and that she had spoken to NP Q and NP Q was okay with her crushing the medication. LVN L stated that she was aware that she was supposed to flush the G Tube before administering medication, but she did not because there was no residual. She stated that flushing the G Tube before administering medication was important to get food out of the way and to prevent medication food interaction. She stated that cocktailing medication can result in medication interaction that can harm the resident or be ineffective. She stated she had been in-serviced on medication administration to include G tube administration a few weeks ago.An interview on 08/13/25 at 1:41 PM, the DON revealed all G- tube medications were not to be cocktailed unless there was a physician's order. The DON stated that before administering medication, nurses should check and follow the physician orders. The DON stated the policy was to check for placement, check for residual, flush before medication administration, and flush after medication administration. The DON stated staff had been in-serviced on G tube medication and management. The inservice was done 8/13/2025. The DON stated the risk to the resident was interaction of medication that might not be safe to administer at the same time. The Resident could experience side effects such and nausea, vomiting, and diarrhea. In an interview on 08/14/2025 at 10:28AM, NP Q revealed that G tube medication should not be cocktailed unless there was a physician order. She stated she had not given an order to cocktail Resident #2's medication. She stated the policy was to check for placement, check for residual the flush before administering medication. NP Q stated the nurse should flush with water between medications then flush after completing medication administration. NP Q stated that cocktailing medications

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	675105	A. Building B. Wing	08/15/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 reviews the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for one medication cart (600 hall) of the facility's two medication carts reviewed for medication storage. The facility failed to ensure that opened insulin pens,1) Lantus 100 unit/ml and 2) Insulin pro 100units/ml were properly labeled and dated before storing in the 600-hall medication cart. This failure could place resident at risk by diminishing the effectiveness, and therapeutic benefits of the medications and/or result in medication error by giving the wrong resident the wrong insulin.The findings included:Observation on [DATE] at 11:03 AM with LVN B on the 600-hallway's medication cart revealed opened insulin pens: 1. Lantus 100 unit/ml and 2. Insulin pro 100 units/ml that had no patients' labels, and no dates indicating when the insulins were open.In an interview on [DATE] at 11:05 AM with LVN B he stated the nurses were responsible for checking all insulin pens and vials had patient labels and open dates. LVN B stated he did not realize the opened insulin pens Lantus 100 unit/ml and insulin pro 100 units/ml did not have labels and open dates. He stated that it was important to date opened insulins because opened insulins expire after 28 days. LVN B stated that the risk to the resident was receiving expired insulin that could cause negative drug effects that could harm the resident. He stated that having insulin in the medication cart that did not have the proper label could result in administering insulin to the wrong resident which may result in hospitalization. He stated that he knew that he was supposed to check and ensure all medications were within date before administering to the residents. LVN B stated that he had been in-serviced on medication storage and dating all opened insulins by online training and the administration. He stated that he would remove the unlabeled and undated insulin from the cart immediately.An interview on [DATE] at 1:47 PM with the DON, revealed that all insulin pens and vials should be labeled, and they should have an open date. She stated that it was the responsibility of every nurse to check the label and open date before administering insulin to a resident. The DON stated insulin was supposed to be dated because it expired 28 days after opening. She stated that failure to have open dates on insulin could result in administrating medication that was expired and could not be effective or that could have negative side effects to the resident. He stated the ADON audited the medication carts as needed, but there was not a set schedule. She stated that the pharmacist audited the medication carts monthly.Review of the facility policy PCU027 - Medication Storage in the Facility Policy reflected that: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to the procedures for medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed.The facility failed to ensure that 1 of 1 dented can was removed from the rack in the dry pantry areaThe facility failed to ensure that Dietary X properly used hair restraints during food preparation. This failure could place residents at risk for food exposed to adulteration or potential contaminants.Findings Included:Observation and interview on 08/12/25 at 9:15 AM, the Dietary Manager stated she had been employed at the facility for four years. The initial tour of the kitchen revealed that in the dry storage area 1 of 1 dented can on the rack with the other canned items, instead of in the area labeled as Dented Cans Only, do not use. Dietary Manager indicated the dented cans were used first. The Dietary Manager repeated a second time what was said about the use of the dented cans. During interview with the Dietary Manager on 08/15/2025 at 2:51pm in the dining room she stated she moved the dented can to a separate location away from the other cans for to be returned to the distributor. Dietary X had been observed on 8/15/25 at 2:57pm not properly using the hair restraint to cover all hair during food preparation. Dietary Manager stated on 8/15/25 at 2:57pm if someone ingested food that had been contaminated, there was a risk they could get an airborne illness and potentially cause harm and sickness. Interview with the Dietary [NAME] on 08/15/2025 at 3:00pm revealed dented food cans had a specific place in the corner and cannot be used but would be returned to the distributer. The Dietary [NAME] revealed dented food cans were not used due to cracks, leaking food, air or insects entering the can, possibly causing harm due to ingesting metal from the can, increase medical issues, possible internal micro cuts, and food poisoning. The Dietary [NAME] stated without the proper use of hair restraints, risks of biological contaminants (the presence of harmful biological agents, such as bacteria, viruses, fungi, parasites, or animal dander, in food, water, air, or on surfaces, which can cause disease, allergic reactions, or pose a risk to health and safety) with the harm of making a resident sick, especially if they already had a compromised immune system along with the overall decline of the quality of the food. Record review of the facilities policy titled Food Storage and Supplies, dated 2012 does not address dented cans. Review of U.S Department of Health and Human Services Food Code, dated 2017, revealed, 3-202.15 Package Integrity reflected: Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants.Review on 8/15/25 at 3:55pm of the U.S. Public Health Service Food Code dated 2017 reflected: .3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (7) Storing damaged, spoiled, or recalled food being held in the food establishment as specified under S 6-404.11; .

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	675105	A. Building B. Wing	08/15/2025

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Country View Nursing and Rehabilitation	1900 N Frances St Terrell, TX 75160

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #2) of 6 residents reviewed for infection control. 1.LVN L failed to don (to put on) PPE prior to performing the high contact resident care activity on a resident who was on enhanced barrier precaution.This failure could place residents at risk for healthcare associated cross contamination and infections.Findings included:Record review of Resident #2's Quarterly MDS Assessment, dated 07/19/25, reflected the resident was a [AGE] year-old male, had a BIMs score of 8 indicating he was moderately cognitively impaired. The resident had diagnoses which included dysphagia (difficulty swallowing foods and liquids), Cerebrovascular accident (a disruption of blood flow to the brain, leading to brain cell damage).Record review of Resident #2's Comprehensive Care Plan, dated 07/16/25, reflected (Residents name) requires tube feeding swallowing difficulty r/t CVA. Facility interventions included: Monitor/document/report to MD PRN: aspiration - fever, SOB, tube dislodged, infection at tube site, self-extubation, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration.Record review of Resident #2's Comprehensive Care Plan, dated 04/25/25, reflected (Residents name) was on enhanced barrier precautions. Facility interventions included: Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity.An observation on 08/13/25 at 8:46 AM, revealed Resident #2's room had an Enhance Barrier Precaution signage outside his room and cart set up with PPE. LVN L performed hand hygiene with sanitizer and entered Resident #2s' room, stopped the G tube feeding, administered medication via feeding tube and restarted the tube feeding Isosource 1.5 Cal . LVN L did not don PPE. An interview on 08/13/25 at 8:56 AM, revealed LVN L knew that Resident #2 was on enhanced barrier precaution, and she should have donned PPE before accessing the resident's (Resident#2) feeding tube. She stated that failure to use PPE could put the resident at risk for infection. She stated that she had been in-serviced on enhanced barrier precautions a few weeks ago.An interview on 08/13/25 at 1:41 PM with the DON revealed that her expectation was the staff should use appropriate PPE while providing care to residents on enhanced barrier precautions. She stated that risk to the patient was MDRO infection. She stated that the staff had been in-serviced on infection control and enhance barrier precautions. The facility policy titled Enhanced Barrier Precautions reflected: Multidrug-resistant organism (MDRO) transmission is common in long term care (LTC) facilities. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities.EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. A single set of PPE cannot be used for more than 1 patient. EBP are indicated for residents with any of the following: Colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply (see MDRO list on page 3); or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP