

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Country Meadows Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3301 Park Row Blvd Corsicana, TX 75110	

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 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide doctor's orders for the resident's immediate care at the time the resident was admitted.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents had physician's orders for the resident's immediate care for one (Resident #3) of six residents observed for physician orders for oxygen.</p> <p>The facility failed to provide physician orders for Resident #3, while resident was on oxygen 2 liters via nasal cannula.</p> <p>These failures could place the residents at risk of not receiving necessary care and services that could result to worsen condition.</p> <p>Findings included:</p> <p>Review of Resident #3's Face Sheet dated 08/27/2024 reflected that resident was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Relevant diagnoses included pleural effusion (fluid accumulation around the lungs), muscle weakness, dyspnea (the sensation of difficult or uncomfortable breathing), and hypertension (elevated blood pressure).</p> <p>Review of Resident #3's MDS assessment dated [DATE] reflected that Resident #3 had an intact cognition with a BIMS score of 15.</p> <p>Review of Resident #3's Comprehensive Care Plan dated 08/11/2024 reflected no documentation of Resident#3 oxygen therapy use.</p> <p>Review of Resident #3's Physician's Order on 08/10/2024 reflected no physician orders for continuous and/or as needed oxygen supplement. Review revealed no physician order for when to change the cannula and oxygen tubing. Review of Resident #3's Physician's Order on 08/10/2024 reflected no physician orders to keep the oxygen cannula and tubing in a bag when not in use. Review revealed no physician orders for when to change the humidifier. Review of Resident #3's Physician's Order on 08/10/2024 reflected no physician's order to wash filters from oxygen concentrator. Review revealed no physician order for what to assess, like redness to nares (openings of the nose where the prongs of the cannula are inserted).</p> <p>(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
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<p>F 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 08/26/2024 at 02:27 PM, revealed that Resident #3 was sitting at the edge of the bed, receiving oxygen supplement via nasal cannula. It was also observed that Resident #3 had an oxygen concentrator at the side of the bed. The oxygen concentrator was on with the setting of 2 liter/minute. Resident #3 confirmed that she used oxygen whenever she had breathing difficulty since her admission to the facility two weeks ago.</p> <p>Interview and observation with LVN E on 08/26/2024 at 02:33 PM, she stated she did not know resident was on oxygen or supposed to have oxygen. LVN E went to Resident #3's room to make sure she was using oxygen supplement therapy. LVN B started to search her computer and then stated that she could not find the order for oxygen. LVN B acknowledged that the order for oxygen supplement for Resident #3 was not on the eMAR (electronic medication administration record). LVN B said that it was important to have a physician's order to know what to do, what to assess, and what was the treatment plan. LVN B added that this would put the resident at risk of not having the medications, treatments, and services they needed. She further stated the nurse admitting resident was responsible in transcribing the physician orders upon resident's admission, and the nurse caring for the resident should review the admission order against the order in the residents' electronic system.</p> <p>Interview with the DON on 08/28/2024 at 9:30 AM, the DON stated there should be physician orders on everything done for the resident. The DON said that physician orders served as verification that the resident was assessed, the medical issues were addressed, and the needed treatments or medications were ordered. The DON further added that without those orders, the staff would not know the needed care and the needed treatment. The DON said that the charge nurse is the one responsible in transcribing the physician orders upon admission or when there was a new order from the physician. The DON said that the expectation is for the staff to ensure that physician orders are transcribed to residents' electronic system during admission. The DON concluded, she was new to the facility, been here for one week, and stated moving forward, she will be checking residents' electronic chart to make sure their orders had been transcribed completely during admission process.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560</p> <p>Based on observation, interview, and record review, the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #18) of 6 residents reviewed for quality of life.</p> <p>The facility failed to ensure Resident #18 had her fingernails and facial hair trimmed.</p> <p>This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #18's Quarterly MDS assessment dated [DATE] reflected Resident #18 was an [AGE] year-old female with initial admitted to the facility on [DATE]. Resident #18's relevant diagnoses included Anemia, Hypertension, Renal insufficiency, hyperlipidemia, anxiety disorder, senile degeneration of brain, severe stage bilateral Glaucoma. Resident #18 needed substantial assistance for bathing and needed setup assistance with ADLs. Resident #18 had BIMS of 7, which indicated severe cognitive impairment.</p> <p>Review of Resident #18's Comprehensive Care Plan revised on 10/27/2023 reflected, problem: [Resident #18] has an ADL self-care performance deficit related to disease processes - Glaucoma, cataract, hyperlipidemia, Hypertension, Anemia, Osteoporosis, & senile degeneration of the brain. Goal: Resident will maintain grooming hygiene with verbal cues. Resident will maintain/improve upper extremity/lower extremity dressing with modified independence. The resident will maintain current level of function with all ADL's and self-care with as much independence as possible through the review date. Interventions: BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. BATHING/SHOWERING: The resident requires physical help limited to transfer assistance by 1 staff with showering scheduled three times weekly and as necessary. BED MOBILITY: The resident is able to move to and from lying position, turn herself in the bed, with the supervision and set up help of one staff member. DRESSING: Allow sufficient time for dressing and undressing. DRESSING: The resident requires set up help with the supervision of one staff member to dress. EATING: The resident requires set up assistance and supervision of one staff member to eat. PERSONAL HYGIENE: The resident requires limited assistance of one staff member to assist with personal hygiene and oral care. TRANSFER: The resident is able to transfer with set up help and supervision of one staff member.</p> <p>In an observation and interview on 8/26/24 at 11:33 AM, with Resident #18 revealed she had 0.5-0.75 inch of facial hair on her chin. Resident #18s fingernails were at least 1-1.25 inches in length and were chipped. Resident #18 stated that she would like her fingernails to be clipped and did not preferred long nails. She also stated that she did not have a razor to trim her facial hair and added that she could not see very well to take care of the facial hair. She stated that the nursing staff did not offer to trim nails or shave her facial hair.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 8/26/24 at 1:33 PM, LVN D stated that both CNAs and LVNs were responsible for providing ADLs that included nailcare and facial trimming. He stated if a resident had diagnoses of diabetes (high blood glucose), only nurses were allowed to trim resident's nails. He stated that nailcare and facial hair trimming should be done on shower days and as needed. He stated that he had not had a chance to visit with Resident#18 at the time of interview and will check on her. He stated that the risk for not performing nailcare was increased risk of infection as well as skin break down and risk of not shaving facial hair could lead to dignity concerns.</p> <p>In another interview on 08/26/24 at 03:37 PM, LVN D stated that he clipped Resident #18's fingernails and shaved facial hair on her chin He stated that it may have been overlooked by the nursing staff who worked on Friday 8/23/24 since Resident #18 was Monday-Wednesday-Friday bath schedule.</p> <p>In an interview on 8/27/24 at 11:08 AM, CNA B stated that she worked the morning shift across multiple halls. She stated she was aware of Resident #18's ADL needs. She stated both CNAs and LVNs were responsible for providing ADL care to the resident. She stated the risk for not performing nailcare can lead to skin breakdowns and not shaving facial hair can lead to dignity concerns.</p> <p>In an interview on 08/27/24 at 03:24 PM, the ADON stated that she has worked since in the facility since last 6 months. She stated that her expectation was that nursing staff should be providing ADL care to residents on shower days and as needed. She stated that both CNAs and LVNs were responsible for providing nail care and shaving facial hair. She stated as the ADON of the facility , she conducted daily rounds on all residents to ensure ADLS were carried out. She said risk to residents for not performing nail care was skin tears and infection . She added risk to residents for not shaving facial hair especially in female resident was loss of dignity.</p> <p>In an interview on 08/28/24 at 09:20 AM, the DON stated she had started working in the facility as the DON about a week ago and was getting to know the residents. She stated her expectation was ADLs such as nail care and hair trimming were offered to residents on shower days and as needed. She stated both CNAs and LVNs were responsible for providing ADL care. As the DON in the facility, she planned to round the residents daily to ensure resident's ADL needs were met adequately. She stated that long, chipped nails could lead to wounds, skin tears and possibly infection She stated that risk to residents with not trimming facial hair could lead to dignity concerns.</p> <p>Record Review of the facility policy titled Activities of Daily Living (ADLs) dated 5/26/2023 reflected, Policy:</p> <p>The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; 2. Transfer and ambulation; 3.Toileting; 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560</p> <p>Based on observation, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen in that:</p> <p>The facility failed to ensure expired milk in the walk-in refrigerator was discarded in a timely manner.</p> <p>These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination.</p> <p>Findings included:</p> <p>In an observation on [DATE] at 10:02 AM, revealed one-gallon of milk that was half-filled had best-by date of [DATE] in the facility's walk- in refrigerator.</p> <p>In an interview with the Dietary Manager on [DATE] at 10:06 AM, revealed she conducted morning walk-in rounds every Monday to check for expired products since new inventory was delivered every Tuesday. She further added she had forgotten to conduct her morning rounds on Monday, [DATE]. She stated that the use-by date on the milk gallon was [DATE] and the milk should have been discarded within three days of use-by date per the facility policy. She also stated that she was not aware if the expired gallon of milk was served to the residents and added she will discard the gallon of milk immediately after the interview. She said the facility utilizes use by date on dairy products to determine their shelf-life. She stated risk to residents if served expired food product was increased chances of food borne illness.</p> <p>In an interview with [NAME] A on [DATE] at 12:55 PM, revealed he was working as a cook in the facility for one year. He stated that Cooks, Dietary aides, and the Dietary Manager were responsible for ensuring expired food items were discarded. He stated that, as a cook, he always checked the expiry date on the foods before using the food item. He stated if he had seen the expired gallon of milk in the walk-in refrigerator, he would have promptly thrown it away. He said the risk of using or serving expired food or dairy items could make the residents sick.</p> <p>Record review of the facility policy titled Refrigerators, Coolers and Freezers dated [DATE], reflected, 2. Dispose of all outdated [NAME] and discard all leftover items greater than 72 hours old .</p> <p>Review of FDA food code dated 2022 reflected, . (K) Disposition of Expired Product at Retail .Processed reduced oxygen foods that exceed the use-by date or manufacturer's pull date cannot be sold in any form and must be disposed of in a proper manner .</p>		

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<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** 47690</p> <p>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 one (Resident #42) of six residents observed for infection control.</p> <p>CNA B failed to perform hand hygiene between glove changes, and when she went from dirty to clean during incontinence care for Resident #42.</p> <p>These failures placed residents at risk for spread of infection through cross-contamination.</p> <p>Findings included:</p> <p>Record review of Resident #42's face sheet dated 08/27/2024 reflected she was [AGE] years old female. She was originally admitted to the facility on [DATE] and readmitted on [DATE]. She was admitted with the diagnoses of diabetes mellitus, hypertension (high blood pressure), morbid obesity.</p> <p>Review of Resident#42's MDS assessment dated [DATE] reflected Resident#42 had an intact cognition with a BIMS score of 15. The review further reflected the resident was totally dependent on staff for toileting hygiene and shower/bathing.</p> <p>Review of Resident #42's Care Plan initiated 08/12/2024 reflected the resident was incontinent of bowel and bladder. Resident#42 had an ADL (activity of daily living) self-care performance deficit related to physical limitation and the intervention was for the resident to be assisted by staff for incontinent care.</p> <p>Observation 08/26/2024 at 09:56 AM revealed CNA B entered Resident # 42's room and told the resident she was here to get her up off the bedside commode and clean her buttocks area. CNA B helped Resident#42 to a standing position with Resident#42 using a four wheels walker, cleaned Resident#42's buttocks area using one wipe per stroke. CNA B helped Resident#42 to sit down on her wheelchair. CNA B removed her gloves and proceeded to gather Resident#42's clean gown, clean brief, and socks without any form of hand hygiene. CNA B took Resident#42 to the shower room and got Resident#42's shampoo and body wash from a sack in the shower room. CNA B pulled gloves from her pocket, put them on and proceeded to shower Resident#42. After showering Resident #42, CNA B helped her put on her clothes. CNA B changed gloves without any form of hand hygiene. CNA B took the resident back to her room. CNA B removed her gloves and washed her hands before exiting the room.</p> <p>Interview with CNA B on 08/26/24 at 10:29 AM revealed she was supposed to perform hand hygiene after removing gloves, and before getting Resident#42's bathing supplies for shower. She stated had hand sanitizer in her pocket to use every time she changed gloves and forgot to use it. She stated she had training on hand hygiene, and that she was supposed to wash hands for 20 seconds before entering resident's room and after contact with resident. CNA B stated she was to perform hand hygiene between changing gloves. She stated the risk to residents' was developing infection. CNA B stated she had been in serviced on hand hygiene not long ago by performing hand hygiene in front of the ADON.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the ADON on 08/27/2024 at 2:22 PM revealed she expected staff to wash hands before entering resident's room, and after contact with resident. She stated staff was supposed to perform hand hygiene every time they removed gloves, and before putting on clean gloves. She further stated staff were trained to change gloves with hand hygiene when they went from dirty to clean task, and after care was completed. The ADON stated it was her responsibility to make sure staff were following proper hand hygiene during residents' care. She stated the risk to residents' was developing infection.</p> <p>Review of the facility's policy titled Hand Hygiene revised October 12, 2022, reflected, . Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves .</p>