STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675696	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Village Care	721 W Mulberry Angleton, TX 77515

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45328 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 (CR #1) of 5 residents reviewed for pharmacy services. -The facility failed to ensure CR#1's morphine (opioid pain-relieving medication that usually provides significant pain relief for short term or chronic pain) and Norco (combination of acetaminophen and hydrocodone to relieve moderate to severe pain) medications were not administered too close together to prevent accidental overdose on 01/01/25. An Immediate Jeopardy (IJ) was identified on 02/05/25. The IJ template was provided to the facility on [DATE] at 9:26 a.m. While the IJ was removed on 02/07/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal (POR). This failure could place residents at risk for adverse side effects, overdose, hospitalization , and death. The findings included: Record review of CR #1's Admission Record, dated 01/10/25, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included age-related osteoporosis with current pathological (broken bone) fracture, left femur (thigh bone), asthma (narrowing of the airways), and muscle weakness. Record review of CR #1's MDS Assessment, dated 12/31/24, revealed a BIMS score of 3, indicating severe cognitive impairment. Further review revealed resident was dependent (the assistance of 2 or more helpers was required for the resident to complete the activity) with toileting, shower/bathe, and upper and lower body dressing. Section J - Health Conditions, Pain Management indicated CR #1 received scheduled and PRN pain medication, pain was present, experienced frequently, and resident verbalized intensity as moderate (scale 2) over the last 5 days. (continued on next page)

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
	675696	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Village Care	721 W Mulberry Angleton, TX 77515

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of CR #1's baseline care plan, dated 12/27/24, revealed the resident was alert, cognitively intact, and incontinent. Further review revealed CR #1 was taking psychotropic, antibiotics, anticoagulants, opioids, and black box medications. Record review of CR #1's MAR dated, 01/01/2025-01/31/2025, revealed an order for morphine sulfate oral tablet 15 mg, 1 tablet by mouth every 12 hours for pain (8:00 a.m. and 2000 (8:00 p.m.)), start date 12/30/24, end date 01/03/25. Further review revealed an order for Norco oral tablet, 7.5-325 mg, 1 tablet by mouth three times a day (8:00 a.m. 1300 (1:00 p.m.), and 1800 p.m. (6:00 p.m.)) for pain, start date 12/30/24, end date 01/01/25. On 01/01/25, CR #1 was administered a morphine tablet and Norco tablet at 8:00 a.m. Record review of physician orders, dated 12/30/24, revealed an order for morphine sulfate oral tablet 15 mg, give 1 tablet by mouth every 12 hours for pain, start date 12/30/24. Further review revealed an order for Norco oral tablet 7.5-325 mg (hydrocodone-acetaminophen), give 1 tablet by mouth three times a day for pain, do not exceed 3 GM in 24 hours, start date 12/30/24. Record review of CR #1's progress notes, dated 01/01/25 at 12:20 p.m., revealed upon entering resident room to assist CNA in brief change and repositioning, this nurse [Nurse A] noted resident to be lethargic. Pupils pinpoint and barely reactive, speech unclear, unable to follow commands, respiratory rate decreased. Doctor and 911 called and RP notified. Record review of CR #1's hospital records, report date 01/29/25, revealed resident was given 1 injection and 2 syringes of NARCAN (used to treat an opioid overdose emergency). Further review read in part .ED course as of 01/01/25 .Narcan given helps with RR and now making more noise, gives her name when asked . Narcan ordered with some improvement[,] wore off quickly, will redose .After narcan pt is now yelling call the police and they are drugging me .She was given Narcan by EMS and her symptoms improved. She was recently given morphine for pain which has probably been too strong for the patient .was admitted for acute encephalopathy in setting of accidental narcotics overdose .presented to the hospital for acute encephalopathy in the setting of accidental opiate overdose that resolved while here at the hospital .treated with IV ceftriaxone yet her encephalopathy did not improve .developed acute respiratory failure with hypoxia during hospice admission .pronounced dead at 2:57 PM . Resident was admitted to inpatient hospice care on 01/04/25 and passed away on 01/09/25 from acute toxic encephalopathy. During a telephone interview on 01/10/25 at 10:28 a.m., CR #1's family member said on two separate visits, 12/28 and 12/29, resident was overmedicated, and she asked nurses not to administer anything other than what the hospital had given her and to talk with her before any medication changes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675696	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Village Care	721 W Mulberry Angleton, TX 77515

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 01/10/25 at 1:20 p.m., Nurse A said on the 01/01/25 CR #1 was the same as 12/31/24, refusing care all morning. She said a CNA came to her and told her the resident did not want her brief to be changed by the CNA. She said she thinks it was CNA C that notified her and so she went in the room with CNA C and noticed a change in condition. She said she noticed CR #1 had slurred speech, was lethargic, her pupils were pinpoint, altered mental status, and said that was all she could remember off the top of her head, and that it was noticeable. She said she immediately called Doctor and reported the change of condition, and she gave the order to send the resident to the hospital. She said she called 911 for transport, assessed her vitals, EMS arrived, and once she was leaving with them, she notified the family member and explained her change of condition and that she was going to the hospital. She said the medication aides pass the medications including narcotics. She said the CNA on 01/01/25 was CNA C. She said the resident may have gone out to the hospital sometime after breakfast or lunch. She said she had taken the residents vitals earlier that morning between 6:45 a.m. and breakfast. She said she cannot recall what her vital signs were off the top of her head but if they were not within normal limits for resident, the doctor would have been notified. She said she did not receive any notifications about a change in condition from the CNA before assisting her with the brief changing. She said that she knew with all the medications she got, she was still in pain. On 01/10/25 at 2:00 p.m., a telephone call made to CNA B but received message saying the subscribers number was not in service. On 01/10/25 at 2:18 p.m., a telephone call made to CNA C, but call went unanswered. Left a voicemail requesting a return phone call. During an interview on 01/01/25 at 3:22 p.m., the DON said she knew CR #1 went out to the hospital and was admitted with acute encephalopathy related to UTI, dehydration, acute kidney injury, and they suspected a possible stroke and CT showed some stenosis to the carotid artery but could not completely rule that out. She said Nurse A described the resident as failure to thrive and that she had been refusing to eat and drink and medications at times. She said the Doctor made a recent pain medication adjustment a couple days before the resident went out to the hospital. She said the resident was not seeing a pain management doctor. She said the resident came to the facility because she had a recent hip fracture and was not a surgical candidate. She said she was on hydrocodone, but it was not managing her pain so the Doctor prescribed morphine twice a day and CR #1 could have hydrocodone 3 times a day if she needed it. She said If the pain was not being managed, they notify the doctor and go from there and always try to do things like repositioning and non-medication interventions such as therapy and a hot pack. On 02/04/25 at 10:18 a.m. and 11:24 a.m., called CNA B but at two different numbers provided by the facility but received the following messages: the subscriber you have called is not in service, please check the number and try your call again; your call cannot be completed as dialed please check the number and try again. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675696	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Village Care	721 W Mulberry Angleton, TX 77515

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a telephone interview on 02/04/25 At 12:32 pm, the Doctor said morphine was used for pain management. She said CR #1 had excruciating left hip pain. She said she had started her on Morphine because CR #1 complained of pain score of 10/10. She said Norco was for pain management as well. She said she was on Norco but said Norco was not helping. She said she ordered Morphine Sulfate 15 mg, 1 tablet to be administered by mouth to be schedule for every 12 hours. She said she told them she can also have Norco as needed. Norco was the breakthrough pain medication. She said despite the two medications, CR #1 was still in pain. She said she had a femur fracture and was in a lot of pain. She said Norco was to be administered every 6 hours as needed for pain. She said CR #1 refused food, and care due to pain. She wanted Morphine. She said when a medication was ordered for three times a day, it should be administered at, 8 a.m., 2 p.m., and 9 p.m. bedtime. She said she never writes orders in the Electronic Medication Administration Record (eMAR) the nurses do. She said she sees the orders because she signs any order under her name. She said after you give Morphine, you wait, if the resident was still in pain, then you give the Norco. She said wait for at least 2 hours to administer a second pain medication. She said the consequences of administering two opioids were: constipation, drossiness, altered mental status, pupils' constriction, dizziness, vomiting, nausea, confusion, and changes in pupils. She said the elderly population were frail. Surveyor mentioned that the hospital mentioned accidental opioid overdose, the Dr., said the hospital did not know what they were doing. During an interview on 02/04/25 at 1:38 p.m., the DON said she was not at the facility when CR #1 was transported to the hospital. She said Nurse A told her the resident had a decrease in responsiveness. She said she was not aware of what pain medication CR #1 was taking until after she went out to the hospital. She said Nurse A said she was also concerned that it could be her pain medication. She said she looked at the hospital site and they had encephalopathy, UTI, and dehydration. She said she was not aware of the hospital notes about opiate overdose, but she did call the Doctor to let her know she was transferred to the hospital and what the hospital's notes were at that time. She said Nurse A was concerned it was about the medications because of how she found the resident before she sent her out. She said she did not know CR #1's order for Norco and morphine were together at 8:00 a.m. She said when starting to manage breakthrough pain you start with one and space out the other at least a couple of hours. She said the Doctor ordered the morphine in addition to the Norco because Norco was not helping with pain. During follow-up interview on 02/05/25 at 9:46 a.m., Doctor/Medical Director/Physician said when the EMS comes, to be on the safe side, they will give Narcan even with the slight suspicion of overdose. She said hospital gave Narcan because probably EMS told them. The Doctor said in spite of being on the schedule morphine 2 times a day CR #1 was still needing the Norco because she was still in pain. The Doctor said because CR #1 was yelling and in pain, she thinks that was why they gave it to her. She said CR #1 was admitted with an order for PRN Norco, then scheduled Norco and morphine was added. She said for this patient it would be okay to give her scheduled morphine and Norco. She said Narcan was used to reverse narcotic overdose. She said some effects of giving the two medications at the same time could be constipation, drowsiness, dizziness, nausea, and pinpoint pupils. During a telephone interview on 02/05/25 at 10:30 a.m., MA B said CR #1's name sounded familiar, but she could not put a face to her. She said she did not remember what she gave the resident on 01/01/25. She said to be honest it would help it she could see a picture of the resident. She said she did not remember what time she gave the medication, but she works with the nurse, and they were the ones who usually monitor the pain of the resident. She said she administers PRN narcotics. She said administration times were determined by what the nurse enters in the system. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675696	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Village Care	721 W Mulberry Angleton, TX 77515

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the facility's Administering Medications policy, revised April 2019, read in part .8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss concerns . Professional Reference accessed 02/24/25 - Hydrocodone and morphine Interactions - Drugs.com Using narcotic pain or cough medications together with other medications that also cause central nervous system depression can lead to serious side effects including profound sedation, respiratory distress, coma, and even death. Talk to your doctor if you have any questions or concerns. Your doctor may be able to prescribe alternatives that do not interact, or you may need a dose adjustment or more frequent monitoring to safely use both medications. Do not drink alcohol or self-medicate with these medications without your doctor's approval, and do not exceed the doses or frequency and duration of use prescribed by your doctor. Also, because these medications may cause dizziness, drowsiness, difficulty concentrating, and impairment in judgment, reaction speed and motor coordination, you should avoid driving or operating hazardous machinery until you know how they affect you. It is important to tell your doctor about all other medications you use, including vitamins and herbs. Do not stop using any medications without first talking to your doctor. Professional Reference - Toxic Encephalopathy - https://pharos.nih.gov/diseases/Toxic%20encephalopathy#diseaseSummary A group of neurologic disorders caused by damage to the nervous system following exposure to pharmacologic, biologic, and chemical agents. Examples of neurotoxins include chemotherapy agents, radiation treatment, heavy metals, pesticides, and food additives. The Administrator was notified on 02/05/25 at 9:26 a.m. that an IJ was identified due to the above failures and the IJ template was provided. The following Plan of Removal (POR) was accepted on 02/06/25 at 1:20 p.m.: Plan of Removal Immediate Jeopardy Citation called on 2/5/25 @ 9:26 AM F- 755 Pharmacy Services [] Immediate Action: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675696	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Village Care	721 W Mulberry Angleton, TX 77515

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Upon notification of the deficient practice, a 100% audit of all residents with orders for scheduled narcotic pain medications, hospice pain medications and any breakthrough pain medications including all opioid medication is being completed to ensure that no other resident had scheduled pain medications with the parameters that were closer than 2 hours apart on the medication administration record. None were found to have any parameters that were closer than 2 hours apart as of 2/5/25. Audit was completed on 2/5/25 by DON [] RN, ADON [], LVN [], LVN. In addition, In-servicing and education will be provided to all licensed or registered nursing staff and prescribing medical doctors regarding opioid use and parameters to do with any other scheduled narcotic pain medications that could cause accidental overdosing. This education and in-service will be initiated on 2/5/25 and will become a part of [] onboarding and ongoing education. All medication aides, charge nurses, nursing administration and medical doctors will be in-service and educated effective immediately beginning 2/5/25 and ongoing. Initial in-services and education was provided and completed on 2/5/25 conducted by ADON [], LVN and [] LVN. Policies were reviewed and there was no changes to the policy. Education regarding Opioid use and signs and symptoms of opioid use was initiated on 2/5/25 and is being conducted by [], LVN ADON, [], RN DON and [], LVN. Nurses and Medication Aides have been educated in all areas including Opioid use and signs of overdose and it was completed on 2/6/25. Facilities Plan to Ensure compliance quickly: An Ad Hoc QAPI meeting will be conducted on 2/5/25 at 2PM to review audit results and to ensure that the education given is covering the pertinent topics pertaining to this particular alleged deficient practice. DON and administrative nurses will have a collaborative effort with respect to monitoring medications upon admission, and weekly during standard of care meetings on going indefinitely and will be reviewed by QAPI committee monthly for 6 months to ensure compliance. Ongoing daily monitoring by DON or designee, to review medications for compliance. [] will also be adding Opioid abuse education to our onboarding and our annual in-servicing. On 02/06/25-02/07/25, surveyor confirmed the facility implemented their plan or removal (POR) to sufficiently remove the IJ by: Record review revealed on 02/06/25, the facility completed an audit of all residents in the facility with orders for scheduled narcotic pain medications, hospice pain medications and any breakthrough pain medications including all opioid medication. Review revealed 38 residents had an order(s) for narcotic(s). 12 of these residents had one or more of their narcotic medication(s) discontinued. Record review revealed on 02/05/25, in-service was initiated with nursing staff and MAs on Pharmacy Services and Opioid Use, Administering Medications, Checking 7 Rights, and Medication Labeling; 28 staff were in-serviced. Interviews were conducted from 02/06/25 to 02/07/25 with staff from all shifts (6:00 a.m.to 2:00 p.m., 6:00 a. m. to 6:00 p.m., 7:00 a.m. to 7:00 p.m., 6:00 p.m. to 6:00 p.m., and 10:00 p.m. to 6:00 a.m.): DON, Nurse A, B, C, D, E, F, G, and H, and MAs A, B, C, and D. All licensed Nursing staff and MAs interviewed, verbalized an understanding of the information presented during the in-service trainings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675696	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Village Care	721 W Mulberry Angleton, TX 77515

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The Administrator was informed the Immediate Jeopardy was removed on 02/07/2025 at 2:37 p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675696	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Village Care	721 W Mulberry Angleton, TX 77515

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45328 Based on interview and record review the facility failed to ensure that its residents were free of any significant medication errors resident for 1 (CR #1) of 5 residents reviewed for pharmacy services. -The facility failed to ensure CR#1's morphine (opioid pain-relieving medication that usually provides significant pain relief for short term or chronic pain) and Norco (combination of acetaminophen and hydrocodone to relieve moderate to severe pain) medications were not administered too close together to prevent accidental overdose on 01/01/25. An Immediate Jeopardy (IJ) was identified on 02/05/25. The IJ template was provided to the facility on [DATE] at 9:26 a.m. While the IJ was removed on 02/07/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal (POR). This failure could place residents at risk for adverse side effects, overdose, hospitalization , and death. The findings included: Record review of CR #1's Admission Record, dated 01/10/25, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included age-related osteoporosis with current pathological (broken bone) fracture, left femur (thigh bone), asthma (narrowing of the airways), and muscle weakness. Record review of CR #1's MDS Assessment, dated 12/31/24, revealed a BIMS score of 3, indicating severe cognitive impairment. Further review revealed resident was dependent (the assistance of 2 or more helpers was required for the resident to complete the activity) with toileting, shower/bathe, and upper and lower body dressing. Section J - Health Conditions, Pain Management indicated CR #1 received scheduled and PRN pain medication, pain was present, experienced frequently, and resident verbalized intensity as moderate (scale 2) over the last 5 days. Record review of CR #1's baseline care plan, dated 12/27/24, revealed the resident was alert, cognitively intact, and incontinent. Further review revealed CR #1 was taking psychotropic, antibiotics, anticoagulants, opioids, and black box medications. Record review of CR #1's MAR dated, 01/01/2025-01/31/2025, revealed an order for morphine sulfate oral tablet 15 mg, 1 tablet by mouth every 12 hours for pain (8:00 a.m. and 2000 (8:00 p.m.)), start date 12/30/24, end date 01/03/25. Further review revealed an order for Norco oral tablet, 7.5-325 mg, 1 tablet by mouth three times a day (8:00 a.m. 1300 (1:00 p.m.), and 1800 p.m. (6:00 p.m.)) for pain, start date 12/30/24, end date 01/01/25. On 01/01/25, CR #1 was administered a morphine tablet and Norco tablet at 8:00 a.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675696	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Village Care	721 W Mulberry Angleton, TX 77515

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of physician orders, dated 12/30/24, revealed an order for morphine sulfate oral tablet 15 mg, give 1 tablet by mouth every 12 hours for pain, start date 12/30/24. Further review revealed an order for Norco oral tablet 7.5-325 mg (hydrocodone-acetaminophen), give 1 tablet by mouth three times a day for pain, do not exceed 3 GM in 24 hours, start date 12/30/24. Record review of CR #1's progress notes, dated 01/01/25 at 12:20 p.m., revealed upon entering resident room to assist CNA in brief change and repositioning, this nurse [Nurse A] noted resident to be lethargic. Pupils pinpoint and barely reactive, speech unclear, unable to follow commands, respiratory rate decreased. Doctor and 911 called and RP notified. Record review of CR #1's hospital records, report date 01/29/25, revealed resident was given 1 injection and 2 syringes of NARCAN (used to treat an opioid overdose emergency). Further review read in part .ED course as of 01/01/25 .Narcan given helps with RR and now making more noise, gives her name when asked . Narcan ordered with some improvement[,] wore off quickly, will redose .After narcan pt is now yelling call the police and they are drugging me .She was given Narcan by EMS and her symptoms improved. She was recently given morphine for pain which has probably been too strong for the patient .was admitted for acute encephalopathy in setting of accidental narcotics overdose .presented to the hospital for acute encephalopathy in the setting of accidental opiate overdose that resolved while here at the hospital .treated with IV ceftriaxone yet her encephalopathy did not improve .developed acute respiratory failure with hypoxia during hospice admission .pronounced dead at 2:57 PM . Resident was admitted to inpatient hospice care on 01/04/25 and passed away on 01/09/25 from acute toxic encephalopathy. During a telephone interview on 01/10/25 at 10:28 a.m., CR #1's family member said on two separate visits, 12/28 and 12/29, resident was overmedicated, and she asked nurses not to administer anything other than what the hospital had given her and to talk with her before any medication changes. Observation of CR #1's narcotics blister packs revealed one for HYDROcod/APAP tab 7.5/325MG, 1 tablet by mouth every twelve hours as needed for pain and one for morphine ER TAB 15MG, 1 tablet by mouth every twelve hours. During an interview on 01/10/25 at 11:06 a.m., Nurse A said she knew CR #1 had scheduled pain medication but still complained of pain. She said that was one of the main reasons she would refuse care. She said if there was ever a refusal or discrepancy in medications, she or the charge nurse at the time would be notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675696	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Village Care	721 W Mulberry Angleton, TX 77515

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a follow-up interview on 01/10/25 at 1:20 p.m., Nurse A said on the 01/01/25 CR #1 was the same as 12/31/24, refusing care all morning. She said a CNA came to her and told her the resident did not want her brief to be changed by the CNA. She said she thinks it was CNA C that notified her and so she went in the room with CNA C and noticed a change in condition. She said she noticed CR #1 had slurred speech, was lethargic, her pupils were pinpoint, altered mental status, and said that was all she could remember off the top of her head, and that it was noticeable. She said she immediately called Doctor and reported the change of condition, and she gave the order to send the resident to the hospital. She said she called 911 for transport, assessed her vitals, EMS arrived, and once she was leaving with them, she notified the family member and explained her change of condition and that she was going to the hospital. She said the medication aides pass the medications including narcotics. She said the CNA on 01/01/25 was CNA C. She said the resident may have gone out to the hospital sometime after breakfast or lunch. She said she had taken the residents vitals earlier that morning between 6:45 a.m. and breakfast. She said she cannot recall what her vital signs were off the top of her head but if they were not within normal limits for resident, the doctor would have been notified. She said she did not receive any notifications about a change in condition from the CNA before assisting her with the brief changing. She said that she knew with all the medications she got, she was still in pain. On 01/10/25 at 2:00 p.m., a telephone call made to CNA B but received message saying the subscribers number was not in service. On 01/10/25 at 2:18 p.m., a telephone call made to CNA C, but call went unanswered. Left a voicemail requesting a return phone call. During an interview on 01/01/25 at 3:22 p.m., the DON said she knew CR #1 went out to the hospital and was admitted with acute encephalopathy related to UTI, dehydration, acute kidney injury, and they suspected a possible stroke and CT showed some stenosis to the carotid artery but could not completely rule that out. She said Nurse A described the resident as failure to thrive and that she had been refusing to eat and drink and medications at times. She said the Doctor made a recent pain medication adjustment a couple days before the resident went out to the hospital. She said the resident was not seeing a pain management doctor. She said the resident came to the facility because she had a recent hip fracture and was not a surgical candidate. She said she was on hydrocodone, but it was not managing her pain so the Doctor prescribed morphine twice a day and CR #1 could have hydrocodone 3 times a day if she needed it. She said If the pain was not being managed, they notify the doctor and go from there and always try to do things like repositioning and non-medication interventions such as therapy and a hot pack. On 02/04/25 at 10:18 a.m. and 11:24 a.m., called CNA B but at two different numbers provided by the facility but received the following messages: the subscriber you have called is not in service, please check the number and try your call again; your call cannot be completed as dialed please check the number and try again. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675696	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Village Care	721 W Mulberry Angleton, TX 77515

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a telephone interview on 02/04/25 At 12:32 pm, the Doctor said morphine was used for pain management. She said CR #1 had excruciating left hip pain. She said she had started her on Morphine because CR #1 complained of pain score of 10/10. She said Norco was for pain management as well. She said she was on Norco but said Norco was not helping. She said she ordered Morphine Sulfate 15 mg, 1 tablet to be administered by mouth to be schedule for every 12 hours. She said she told them she can also have Norco as needed. Norco was the breakthrough pain medication. She said despite the two medications, CR #1 was still in pain. She said she had a femur fracture and was in a lot of pain. She said Norco was to be administered every 6 hours as needed for pain. She said CR #1 refused food, and care due to pain. She wanted Morphine. She said when a medication was ordered for three times a day, it should be administered at, 8 a.m., 2 p.m., and 9 p.m. bedtime. She said she never writes orders in the Electronic Medication Administration Record (eMAR) the nurses do. She said she sees the orders because she signs any order under her name. She said after you give Morphine, you wait, if the resident was still in pain, then you give the Norco. She said wait for at least 2 hours to administer a second pain medication. She said the consequences of administering two opioids were: constipation, drossiness, altered mental status, pupils' constriction, dizziness, vomiting, nausea, confusion, and changes in pupils. She said the elderly population were frail. Surveyor mentioned that the hospital mentioned accidental opioid overdose, the Dr., said the hospital don't know what they are doing. During an interview on 02/04/25 at 1:38 p.m., the DON said she was not at the facility when CR #1 was transported to the hospital. She said Nurse A told her the resident had a decrease in responsiveness. She said she was not aware of what pain medication CR #1 was taking until after she went out to the hospital. She said Nurse A said she was also concerned that it could be her pain medication. She said she looked at the hospital site and they had encephalopathy, UTI, and dehydration. She said she was not aware of the hospital notes about opiate overdose, but she did call the Doctor to let her know she was transferred to the hospital and what the hospital's notes were at that time. She said Nurse A was concerned it was about the medications because of how she found the resident before she sent her out. She said she did not know CR #1's order for Norco and morphine were together at 8:00 a.m. She said when starting to manage breakthrough pain you start with one and space out the other at least a couple of hours. She said the Doctor ordered the morphine in addition to the Norco because Norco was not helping with pain. During follow-up interview on 02/05/25 at 9:46 a.m., Doctor/Medical Director/Physician said when the EMS comes, to be on the safe side, they will give Narcan even with the slight suspicion of overdose. She said hospital gave Narcan because probably EMS told them. The Doctor said in spite of being on the schedule morphine 2 times a day CR #1 was still needing the Norco because she was still in pain. The Doctor said because CR #1 was yelling and in pain, she thinks that was why they gave it to her. She said CR #1 was admitted with an order for PRN Norco, then scheduled Norco and morphine was added. She said for this patient it would be okay to give her scheduled morphine and Norco. She said Narcan was used to reverse narcotic overdose. She said some effects of giving the two medications at the same time could be constipation, drowsiness, dizziness, nausea, and pinpoint pupils. During a telephone interview on 02/05/25 at 10:30 a.m., MA B said CR #1's name sounded familiar, but she could not put a face to her. She said she did not remember what she gave the resident on 01/01/25. She said to be honest it would help it she could see a picture of the resident. She said she does not remember what time she gave the medication, but she works with the nurse, and they were the ones who usually monitor the pain of the resident. She said she administers PRN narcotics. She said administration times were determined by what the nurse enters in the system. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675696	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Village Care	721 W Mulberry Angleton, TX 77515

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a follow-up interview on 02/05/25 at 10:50 a.m., the DON said the medication administration times were picked by the nurses. She said one unit might have a maximum of 30 residents so they may start medication pass at 7:00 a.m. and space out from there because not everyone could be done at the same time. She said someone who wants to sleep in might be given their medication at 9:00 a.m. She said their computer system would flag when there were any medications that were contraindicated which in that case they checked with the physician. She said medication start times were 7:00 a.m., 8:00 a.m., and 9:00 a.m., which was pretty routine. Record review of the facility's Administering Medications policy, revised April 2019, read in part .8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss concerns . Record review of the facility's Medication Utilization and Prescribing - Clinical Protocol policy, dated 2001, read in part .Treatment/Management .4. The staff and physician will identify and address unexpected, unintended, undesirable or excessive responses to a medication based on the severity of underlying conditions, the seriousness of any adverse drug reactions, risk of worsening of medical conditions, and other factors. a. This may include changing doses, changing times of administration, switching to another medication, or stopping one or more medications. Professional Reference accessed 02/24/25 - Hydrocodone and morphine Interactions - Drugs.com Using narcotic pain or cough medications together with other medications that also cause central nervous system depression can lead to serious side effects including profound sedation, respiratory distress, coma, and even death. Talk to your doctor if you have any questions or concerns. Your doctor may be able to prescribe alternatives that do not interact, or you may need a dose adjustment or more frequent monitoring to safely use both medications. Do not drink alcohol or self-medicate with these medications without your doctor's approval, and do not exceed the doses or frequency and duration of use prescribed by your doctor. Also, because these medications may cause dizziness, drowsiness, difficulty concentrating, and impairment in judgment, reaction speed and motor coordination, you should avoid driving or operating hazardous machinery until you know how they affect you. It is important to tell your doctor about all other medications you use, including vitamins and herbs. Do not stop using any medications without first talking to your doctor. Professional Reference - Toxic Encephalopathy - https://pharos.nih.gov/diseases/Toxic%20encephalopathy#diseaseSummary A group of neurologic disorders caused by damage to the nervous system following exposure to pharmacologic, biologic, and chemical agents. Examples of neurotoxins include chemotherapy agents, radiation treatment, heavy metals, pesticides, and food additives. The Administrator was notified on 02/05/25 at 9:26 a.m. that an IJ was identified due to the above failures and the IJ template was provided. The following Plan of Removal (POR) was accepted on 02/06/25 at 1:20 p.m.: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675696	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Village Care	721 W Mulberry Angleton, TX 77515

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Plan of Removal Immediate Jeopardy Citation called on 2/5/25 @ 9:26 AM F- 755 Pharmacy Services [] Immediate Action: Upon notification of the deficient practice, a 100% audit of all residents with orders for scheduled narcotic pain medications, hospice pain medications and any breakthrough pain medications including all opioid medication is being completed to ensure that no other resident had scheduled pain medications with the parameters that were closer than 2 hours apart on the medication administration record. None were found to have any parameters that were closer than 2 hours apart as of 2/5/25. Audit was completed on 2/5/25 by DON [] RN, ADON [], LVN [], LVN. In addition, In-servicing and education will be provided to all licensed or registered nursing staff and prescribing medical doctors regarding opioid use and parameters to do with any other scheduled narcotic pain medications that could cause accidental overdosing. This education and in-service will be initiated on 2/5/25 and will become a part of [] onboarding and ongoing education. All medication aides, charge nurses, nursing administration and medical doctors will be in-service and educated effective immediately beginning 2/5/25 and ongoing. Initial in-services and education was provided and completed on 2/5/25 conducted by ADON [], LVN and [] LVN. Policies were reviewed and there was no changes to the policy. Education regarding Opioid use and signs and symptoms of opioid use was initiated on 2/5/25 and is being conducted by [], LVN ADON, [], RN DON and [], LVN. Nurses and Medication Aides have been educated in all areas including Opioid use and signs of overdose and it was completed on 2/6/25. Facilities Plan to Ensure compliance quickly: An Ad Hoc QAPI meeting will be conducted on 2/5/25 at 2PM to review audit results and to ensure that the education given is covering the pertinent topics pertaining to this particular alleged deficient practice. DON and administrative nurses will have a collaborative effort with respect to monitoring medications upon admission, and weekly during standard of care meetings on going indefinitely and will be reviewed by QAPI committee monthly for 6 months to ensure compliance. Ongoing daily monitoring by DON or designee, to review medications for compliance. [] will also be adding Opioid abuse education to our onboarding and our annual in-servicing. On 02/06/25-02/07/25, surveyor confirmed the facility implemented their plan or removal (POR) to sufficiently remove the IJ by: Record review revealed on 02/06/25, the facility completed an audit of all residents in the facility with orders for scheduled narcotic pain medications, hospice pain medications and any breakthrough pain medications including all opioid medication. Review revealed 38 residents had an order(s) for narcotic(s). 12 of these residents had one or more of their narcotic medication(s) discontinued. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675696	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Village Care	721 W Mulberry Angleton, TX 77515

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review revealed on 02/05/25, in-service was initiated with nursing staff and MAs on Pharmacy Services and Opioid Use, Administering Medications, Checking 7 Rights, and Medication Labeling; 28 staff were in-serviced. Interviews were conducted from 02/06/25 to 02/07/25 with staff from all shifts (6:00 a.m.to 2:00 p.m., 6:00 a. m. to 6:00 p.m., 7:00 a.m. to 7:00 p.m., 6:00 p.m. to 6:00 p.m., and 10:00 p.m. to 6:00 a.m.): DON, Nurse A, B, C, D, E, F, G, and H, and MAs A, B, C, and D. All licensed Nursing staff and MAs interviewed, verbalized an understanding of the information presented during the in-service trainings. The Administrator was informed the Immediate Jeopardy was removed on 02/07/2025 at 2:37 p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.