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	08/25/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 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 observations, interview and record review, the facility failed to treat each resident with respect and dignity, and care for each resident in a manner and environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident individuality and protected and promoted the rights of the resident personal privacy for each resident's individuality for 2 of 4 residents (Resident #1 and Resident #2) reviewed for dignity in that: The facility failed to provide Resident #1 and Resident #2 with privacy covers for their urinary catheter bags.The failure could place residents with catheters at risk of emotional distress, embarrassment, lower self-esteem and decreased privacy.Findings included:Record review of Resident #1's face sheet dated 8/25/2025, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Paraplegia (loss of the ability to move in part or most of the legs and lower body) and Neuromuscular Dysfunction of Bladder (nerve damage that affects bladder control). Record review of Resident #1's quarterly MDS dated [DATE], section C revealed a BIMS score of 14 that indicated cognition was intact and section H revealed an indwelling catheter. Record review of Resident #1's Order Summary Report dated 8/25/25 revealed 18FR/30 ml [NAME] Suprapubic catheter to closed drainage every day and night shift with start date of 8/6/2025. Record review of Resident #2's face sheet dated 8/25/2025, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Cerebral Palsy (brain disorder that affects body movement and muscle coordination) and Neuromuscular Dysfunction of Bladder (nerve damage that affects bladder control). Record review of Resident #2's quarterly MDS dated [DATE], section C revealed a BIMS score of 4 that indicated severe cognitive impairment section H revealed an indwelling catheter. Record review of Resident #2's Order Summary Report dated 8/25/25 revealed Privacy bag for foley catheter in place at all times every day and night shift with start date of 8/6/25. During interview and observation on 8/25/25 at 10:05 a.m., no privacy cover was present for Resident #1's urinary catheter bag. Resident #1 said that staff would put a cover on the urinary catheter bag when they find one that fits. Observation on 8/25/25 at 10:12 a.m., revealed no privacy cover to Resident #2 urinary catheter bag while she was in a common area by the nurses' station. Observation on 8/25/25 at 11:55 a.m., revealed no privacy cover to Resident #2 urinary catheter bag while she was in dining area. During interview on 8/25/25 at 1:57 p.m., LVN A said residents should always have privacy bags on their urinary catheter bags. LVN A said the CNAs, nurses or medication aides could all put the privacy covers on the Foley catheter bags. LVN A said the privacy covers were made of a mesh material and may have gotten run over by wheelchair or got urine on them and were not reusable or washable. LVN A said the residents should be checked prior to getting them out of the room to make sure they have a privacy cover for their urinary catheter bag. LVN A said a resident not having an urinary catheter privacy bag was a dignity issue and privacy issue.During interview on 8/25/25 at 1:57 p.m., CNA A said residents should always have privacy bags on their urinary catheter bags. CNA A said they would tell the nurse if they saw a resident without a privacy cover and would put a cover on if the nurse told them to. CNA A agreed with LVN A that a resident not having a privacy cover on their urinary catheter bag would be a dignity and privacy issue for the resident. During observation and interview on 8/25/25 at 2:04 p.m., it was revealed that a privacy cover was on top of the dresser in Resident #1's room. CNA A said Resident #1 was in the gym. CNA A said Resident #1 takes off the privacy cover because he liked to empty the urinary catheter himself. LVN A said they educate Resident #1 about letting nursing staff empty his urinary catheter and he would take off the privacy cover.During observation and interview on 8/25/25 at 2:06 p.m., Resident #2 was in bed with no privacy cover noted to her urinary catheter bag. CNA A said Resident #2 had a shower today. LVN A found a privacy cover in the top drawer of the dresser in Resident #2's room and placed the privacy cover on at this time. During interview on 8/25/25 at 3:36 p.m., the DON said Resident #1 did like to take care of his own Foley (device that drains urine from bladder into a collection bag). The DON said Resident #1 was not able to get out of bed on her own and she recently returned to the facility from the hospital. The DON said that it was a dignity issue if the resident did not have a privacy bag on their Foley catheter. During interview on 8/25/25 at 5:15 p.m., the DON said she had looked but could not a find a policy with information regarding privacy covers for urinary catheters. Record review of facility's policy that was undated the purpose to prevent urinary tract infections and reduce urethral irritation but did not include any information regarding privacy covers

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure residents are offered a therapeutic diet when there is a nutritional problem, and the healthcare provider orders a therapeutic diet for 1 of 1 resident (Resident #3) reviewed for food and nutrition. The facility failed to ensure a diet order for Resident #3 was ordered and implemented timely. This failure could lead to electrolyte imbalances and other imbalances related to fluid in the body. Findings included: Record review of Resident #3's face sheet dated 8/25/2025, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Heart Failure (disorder when the heart does not pump blood as well as it should), End Stage Renal Disease (final stage of chronic kidney disease characterized by a permanent loss of kidney function) and Dependence on Renal Dialysis (medical procedure that removes excess water, solutes, and toxins from the blood when the kidneys can no longer perform these functions).Record review of Resident #3's admission MDS dated [DATE], section C revealed a BIMS score of 11 that indicated moderate cognitive impairment. Record review of Resident #3's Hemodialysis Communication with date of service 1/13/25 revealed follow-up included fluid restriction. Record review of Resident #3's Progress Notes revealed a progress note dated 1/13/25 at 8:47 p.m. that LVN B documented Resident #3 had returned from dialysis with new orders of fluid restriction. Record review of Resident #3's Order Summary Report dated 8/25/25 revealed physician's order for 1500 cc's fluid restriction every shift for fluid intake with order and start date of 1/16/2025. Record review of Resident #3's January 2025 TAR revealed 1500 cc fluid restriction every shift for fluid intake with start date of 1/16/25 at 0600. Record review of Resident #3's Care Plan Report with last review date 1/31/25 revealed focus of fluid overload or potential fluid volume overload related to kidney failure with intervention of diet as ordered.During interview on 7/8/25 at 8:14 a.m., MD A said they monitor residents' electrolytes frequently and based their diet orders and fluid restrictions on those results. During interview on 8/25/25 at 11:45 a.m., the employee from where Resident #3 received dialysis said Resident #3 was not showing up in their records anymore. The dialysis employee said that the last dietician retired, and no one was covering for the dietician that could give me further information. During interview on 8/25/25 at 12:41 p.m., the Consultant Dietician said that the facility's protocol was to liberalize residents' diet as much as possible to promote quality of life. During interview on 8/25/25 at 3:36 p.m., the DON said new orders from dialysis for diet change and fluid restrictions was referred to dietary and then they followed whatever the dietician decided to order. The DON said the nurse would not put in the order regarding diet changes or fluid restriction that night. The DON said regarding the fluid restriction MD A would be notified and the dietician and should have been followed up by at least the next day. The DON said they could call the dietician during business hours when needed regarding new orders. The DON said information regarding the diet change and fluid restriction should have been passed along to follow up with the next day. The DON said an effect that a resident could experience if they were not getting a renal diet or fluid restriction was that they could go into fluid overload which could include symptoms of anxiety, shortness of breath or heart failure (disorder when the heart does not pump blood as well as it should). The DON said she had been the DON since the end of December 2024. The DON said she did not do any direct care with Resident #3 and remembered Resident #3's name but could not remember any other details. During interview on 8/25/25 at 4:35 p.m., MD A said had she went back and reviewed Resident #3's information after she spoke to the state surveyor in July 2025. MD A said Resident #3's family would give her water and food and were not compliant. MD A said she was not sure why the order regarding fluid restriction was not put in until 1/16/25 and could not say why but guessed it was related to the resident not being compliant. MD A said she did not feel that any delay in the fluid restriction order contributed to fluid overload for Resident #3 as she was already on diuretics. MD A said she did not feel that because fluid restriction was not followed strictly that it would have caused Resident #3 to become hospitalized . Attempt to contact LVN B by phone on 8/25/25 at 1:42 p.m. by state surveyor with message left with request to call state surveyor and no return call back received. Attempt to contact LVN C who had written progress notes for Resident #3 on 1/14/25 by phone on 8/25/25 at 4:53 p.m. by state surveyor with message left with request to call state surveyor and no return call back received. Record review of facility's policy Quality of Care that was undated revealed the purpose was to ensure identification an provision of needed care and services that are resident-centered, in accordance with the resident's preferences, goals for care and professional standard of practice that will meet each resident's physical, mental and psychosocial