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	10/25/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45581 Based on interview and record review the facility failed to ensure the resident's right to formulate advance directives for 1 (Resident #165) of 40 residents reviewed for advance directives. Between [DATE] and [DATE] Resident #165 did not have an active physician's order for a code status with either Full Code Status, DNR or any other order to support her advanced directive. The facility failed to ensure that Resident #165 admitted on [DATE] had a code status entered in the resident's records at the facility. This deficient practice could place the residents at risk of not having their end of life wishes honored, such as receiving unwanted resuscitative measures. Findings included: Record review of Resident #165's face sheet undated reflected she was an [AGE] year-old female admitted to the facility on [DATE] with original admitted [DATE]. Her diagnoses included fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing and type 2 diabetes mellitus without complications. Record review of Resident #165's Entry MDS dated [DATE] indicated the facility had not conducted a BIMS exam and no score was recorded. Record review of Resident #165's physician order summary report dated ,d+[DATE]- [DATE], did not have an active physician's order for code status with either Full Code Status, DNR or any other order to support her advanced directive. Record review of DNR Policy dated [DATE] read in part . 1. Do not resuscitate orders must be signed by the resident's attending physician on the physician's order sheet maintained in the resident's medical record. Interview on [DATE] at 2:39 PM CNA B said if a resident was unresponsive. She would check on them to see if they could tell her anything, and she would tell her nurse if there was no response. She said that was all she would do if a resident was unresponsive. (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 2:45 PM with the MDS Nurse/LVN. The MDS nurse was working the floor at the time of interview. She said someone called out and she was working the floor. She said she worked the floor if someone called out and the facility needed a nurse on the floor. She said when a resident was unresponsive, she started measures to ensure the resident was ok like check for signs of life, start CPR, and if not responsive, get a crash cart, get coded. She said in front of the chart is where the Advance Directives could be found. She said a variety of people entered the advanced directive and it was done by the charge nurse, or medical records could also enter the Advance Directive. She said first and foremost the nurse that admitted her was responsible for entering the code status. She said the policy was the resident's code status was supposed to be in the record. Surveyor A asked her to look at Resident 165's record and she observed there was no advance directive. MDS Nurse/LVN tried to say the resident's code status was there by clicking in a search box which brought up an option for Full Code, but that was an option to select it for the resident, and not indicating what the advance directive for the resident was. This surveyor asked the MDS nurse to look in the physician's orders. The MDS nurse looked and observed there was no advance directive in Resident 165's orders. She could not say why the code status was not in there. She said the nurse that admitted the resident was responsible for entering the resident's code status into the system. She said the risk when proper protocols were not practiced was a resident could be coded and it went against their wishes. Interview on [DATE] at 3:18 PM with the DON. She said when a resident was unresponsive you assess the situation, see if they respond, look to see if the resident was a Full code or DNR. She said in PCC was where the Advance Directive would be, and on their chart. When admission was being done the nurse placed the advance directive in the orders. She said it was policy/procedure to [NAME] the advance directive information in the system for the residents. Surveyor A asked her to look at Resident 165's record and someone had entered a code status for the resident . This surveyor informed her someone had just recently entered that information as we were talking. This surveyor asked her to review the physician's orders which showed Advanced Directive but did not have a start date. She said the risk to residents if policy were not followed was it could delay care and the worst thing was delay in care, and staff did not know to either perform CPR or nothing. She said if a resident was DNR and unresponsive, then the physician was contacted and notified the resident was unresponsive of the change in condition and notified the family. She said advance directive were standing orders on their admissions. She said whenever a resident was admitted , the code status should have been put in. She said she did not know why the code status was not entered; it was probably an oversight. She said all nurse staff were responsible for ensuring advance directive were entered.

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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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45581 Based on observation, interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #59) of 40 residents reviewed for quality of care. The facility failed to conduct skin assessments /assess skin on Resident #59's contracted right arm and forearm resulting in redness at site of contracture and forearm with brown exudate (moisture associated skin damage) and pungent odor. This failure could place the residents at risk of not receiving the care and services to maintain their highest practicable physical, mental, and psychosocial well-being. Findings included: Record Review of Resident #59's Face Sheet reflected an [AGE] year-old-female resident with Initial admitted [DATE] and re-admitted [DATE] and history of vascular Parkinson, Cerebral Infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), contracture right elbow, and contracture right hand. Record review of the Annual MDS assessment dated [DATE] revealed a BIMS summary score of a 10 indicating moderate cognitive impairment. The MDS assessment revealed Section M - Skin Conditions: M0100. Determination of Pressure Ulcer/Injury Risk B. Formal assessment instrument/tool, C. Clinical assessment. M0150. Risk of Pressure Ulcers/Injuries, resident was at risk for developing pressure ulcers/injuries. M0210. Unhealed Pressure Ulcers/Injuries: resident did not have any unhealed pressure ulcers/injuries. Section M - Skin Conditions: M1200. Skin and Ulcer/Injury Treatments: resident should have A. Pressure reducing device for chair, B. Pressure reducing device for bed, and C. Turning/repositioning program. Record review of Resident #59's Care Plan undated read in part . Focus: The resident has an alteration in musculoskeletal status r/t contracture right arm elbow. Goal: The resident will exhibit adequate coping skills dealing with loss of use of limb and rehabilitation through the review date. Interventions: Keep skin dry at right arm and hand at all times Date Initiated: 04/09/2024 . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #59's care plan with revision date of 10/15/24 reflected a focus on the resident who has impaired skin integrity of the right arm and breast area; right anterior arm fold r/t Immobility and contracture and I often refuse treatment. Goal. o The resident will have no complications resulting from the cellulitis (a bacterial infection that affects the deeper layers of the skin and surrounding tissue) or fungus through the review date 10/23/24. Interventions: o Educate the resident that prevention of cellulitis and fungus starts with good hygiene. Any breaks in the skin should be reported to staff/MD immediately. Give antibiotics for infection and mild analgesics to relieve discomfort as prescribed by Physician. Monitor/document side effects and effectiveness. o Monitor/document and report to MD the following symptoms of Cellulitis: Red, Swollen, Tender Skin, May be accompanied by a fever, Reddened area begins to spread, Small red spots that appear on the reddened skin, small blisters which may form and burst, Swollen lymph glands. o Provide wound care/treatment as ordered. o Teach the resident not to scratch skin. Provide mittens on hands as necessary to prevent scratching, and provide medications as ordered by Physician to decrease itching. Record review of the facility's Wound Care policy dated 10/2020 read in part . Preparation: 2. Review the resident's care plan to assess for any special needs of the resident. Documentation: 2. The date and time the wound care was given. 5. Any change in the resident's condition. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why. Reporting: 1. Notify the supervisor if the resident refuses the wound care. 2. Report other information in accordance with facility policy and professional standards of practice . Record review of Resident #59's Orders Administration Note dated 10/14/2024 at 8PM read in part . apply interdry (Moisture-wicking fabric with antimicrobial silver) to inner right elbow after application of Nystatin. Refused cleaning under inner right elbow from CNA and this nurse. Record review of Resident #59's TAR dated October 2024 noted she received showers on 10/02, 10/04, 10/07, 10/09, 10/11, 10/14, 10/16, 10/18, 10/21, 10/23, and 10/25/2024. Record review of Resident #59's TAR dated October 2024 noted she had an order for Interdry to inner right elbow after application of Nystatin two times a day for wound. Start date 04/09/2024 discontinued 10/19/2024. The TAR indicated the resident was getting the treatment . The TAR noted she was monitored for pain and indicated she had a pain level of zero . The TAR noted an order for Nystatin external powder 100000 unit/gm. Apply to right arm antecubital (the front of the elbow or the area in front of the elbow) region topically two times a day for wound care. Start date 10/15/2024 at 8PM and indicated it was being done . The TAR included an order to Perform Head to Toe assessment- assess all areas of skin to be completed 2-10pm shift on Saturday evening shift every Saturday. Start date 03/05/2022 at 2PM. The TAR indicated this was done on 10/05, 10/12, and 10/19/2024. Staff updated the TAR and noted Perform Head to Toe assessment- assess all areas of skin to be completed 2-10pm shift on Thursday evening shift every Thursday. Start date 10/17/2024 at 2PM. The TAR indicated this was performed on 10/17/2024. The TAR did not indicate any refusals of wound care or showers. Record review of Resident #59's Treatment Administration Record dated [DATE] Nystatin use to right arm, antecubital. No antibiotic use [DATE] TAR pain assessment BID 0 pain level Showers documented 1-3 times a week. Physician Progress Notes DOS 9/16/2024 -Chronic problem with candida under right arm and breast. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation and interview on 10/15/2024 at 12:10 PM of Resident #59, who was in bed. Right elbow and contracture noted. Redness noted at site of contracture and forearm with brown exudate (moisture associated skin damage) and pungent odor. Resident said her arm hurts with movement due to the contracture . Interview on 10/15/2024 at 12:12 PM LVN B said she had been off the last 4 days, and she said she was not aware that the resident's arm looked the way it did. LVN B said she did an assessment this morning and Resident #59 was on the list to see the wound care doctor tomorrow. Interview on 10/15/2024 at 12:14 PM with Resident #59's Family Member A who said that the blanket was usually pulled over her arms, therefore she was not aware of the drainage until yesterday when she informed the night nurse. Attempted telephone interview on 10/15/24 at 1:05 PM two times with RN D but no answer. Interview on 10/15/2024 at 1:15 PM CNA C said her job duties included showers, hygiene, feeding, and peri-care. She denied having any residents that she was assigned to today with a skin condition/issue or change in condition. She said she always did an assessment when she dressed the residents in the morning before going to breakfast. She said she would immediately notify the nurse if there were any changes with the resident's skin or behaviors. She said she had been in-serviced on reporting change of condition and skin assessments. CNA C could not provide a month but said it was done recently. CNA C said it was also done during annual competencies conducted by the DON. Attempted telephone interview on 10/15/2024 at 2:06 PM two times with LVN C but was unable to leave a voicemail message. Interview on 10/15/2024 at 2:12 PM. CNA B who worked from 6 AM- 2 PM. She said she worked the 600 hall today . She said her job duties included ADLs, feeding assistance, peri-care, and showers. She said that she did an assessment when she gave showers or bed baths. She said if there were any changes in the resident's skin, she immediately notified the nurse. She said if the resident refused a shower, she made three attempts and also notified the nurse. She said if the resident was adamant about not taking a shower, the residents signed refusal forms. Interview on 10/15/2024 at 2:50 PM MDS Nurse said she had worked here for about a year and worked the floor whenever a nurse called out and they needed help. She said residents showered usually on either Mon, Wed, Fri, or Tues, Thurs, Sat unless there were special orders to have their hair shampooed daily. She said Resident #59 had a shower three times a week. She said the resident had contractures in her arm and wrist She noted by looking at Progress notes and could not find when the resident last had a recent skin assessment. She said when Resident #59 last had a skin assessment on her arm it appeared slightly red and was treated with nystatin and she was given a roll to put in her hand. She said she only was involved with the resident's arm in January 2024. She said whoever the charge nurse was did weekly skin assessments and the assessments were reported to the wound care doctor each Wednesday. She said she did not know how the resident's arm looked today. After being told how Resident #59's arm looked, she said she did not know why the resident's arm looked the way it did today. She said the wound care doctor had not seen the resident within the last 3 months. She said the resident refused her showers a lot and refused repositioning. She said CNAs should have observed/assessed the resident's arm and reported it to nursing staff. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 10/15/2024 at 3:01 PM ADON said residents got showers Mon, Wed, Fri, or Tues, Thurs, Sat. She said did not know how often Resident #59 got a shower. She said she thought the resident was afraid of getting into the shower chair. She said when the resident refused, nursing staff notified family and asked them to help get the resident to take a shower. She said the resident had a contracted arm and wrist. She said she had not seen the resident's arm. She said Resident #59 had an order for nystatin to put on the arm. She said when there was a change of condition staff notified the family, doctors and if the family did not want the resident to be hospitalized , then hospice was notified. If the resident declined enough, then they were sent to the hospital. She said she only knew status of the resident's arm when the DON told her this morning. She said the resident was frequently being treated for fungal infection and it had turned into cellulitis more than a couple of times. After telling her of this surveyor and a state nurse's observations of the wound being wet, discolored, and smelled, the ADON said it sounded like fungus. She said without looking at the wound herself, it sounded like a fungal infection. She said she did not know how staff had not noticed the status of the wound and the nurse on the floor should have been aware. She said the nurse did weekly skin assessments. She did not know why there were no weekly skin assessments . The ADON said in the past Resident #59 has had different treatments like Nystatin and the wound care doctor saw her for her arm. She said she had worked at the facility a total of [AGE] years She said she routinely watched for infection control on the residents, so if a new fungal infection arose, she was in charge of that. She said the policy/procedure was residents were and the MD or wound care doctor was notified. She said the wound was something chronic that came and went with her. She said the risk to the residents when skin assessment policy/procedure was not followed, and they were not assessed was they could have a decline in care and get sepsis or end up in the hospital. She said the worst thing that can happen to the resident when proper protocols are not practiced was sepsis (infection of the blood) and hospitalization . Interview on 10/15/2024 at 3:31 PM DON said she had been DON for 2 years this time and total worked at the facility for 9 years. As the DON she ensured the wellbeing of residents and ensured they were taken care of, ensured appropriate staff, and ensured staff were taken care She said routinely she was there for what the nurses needed and supported them with family issues and staffing concerns. She said residents got showers Mon, Wed, Fri, or Tues, Thurs, Sat, some get once a week, and it was care planned. She said they tried to encourage them to get showers three times per week. She said the resident agreed to once week. The DON said Resident #59 had an order for Nystatin and a wicking towel (a towel that draws away moisture). She said she added a prn order for the Nystatin. She could not say where the failure occurred and why the resident's arm looked like it did. She did not know how the wound got to the level it was. She would have to get with the charge nurse and the charge nurse was supposed to assess residents when notified. She said when a resident refused care they would let the family know and continue to try to care for the resident. She said she did not know how long Resident #59's arm looked like it did in its current status. She said she became aware of the resident's wound this morning. She said she bathed the resident's whole arm, put nystatin on it, and put a towel in place. She said she was looking into why the shower aide did not notice the wound. She said if there was special wound, then care/treatment was referred to the wound care doctor. She said Resident #59 had some yeast infection/rash underneath and to the side of her right breast as well. She said the policy for wounds/skin assessments/change of condition was to notify the MD and get orders from them and then follow those orders. The DON said if policy were not followed there could be a possible decline in health and the worst thing that could happen when policy was not followed was a resident could get an infection or worse. She said nursing staff were responsible for ensuring skin assessment policy was followed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #59's Wound Care Physician Note dated 10/23/2024 read in part . Focused wound exam (site 2) non-pressure wound of the right flank (the side of a person's or animal's body between the ribs and the hip) partial thickness. Etiology: Moisture associated skin damage. Wound size (L x W x D): 1. 6cm x 7 x .1cm. Duration: > 20 days. Surface area: 11.2cm squared . Objective: Healing/Maintain healing. Exudate (fluid that leaks out of blood vessels into nearby tissues): light serous (Having to do with serum, the clear liquid part of blood). Dermis: Open areas with exposed dermis. Dressing Treatment plan: Nystatin powder apply once daily for 30 days. Summarized Wound Care Assessment and Individualized Treatment Plan Debridement (a medical procedure that removes dead, damaged, or infected tissue from a wound to help the healthy tissue heal) history: This wound has previously undergone autolytic (relating to self-digestion or the breakdown of cells or tissues by the action of their own enzymes) debridement. Coordination of Care: During today's visit, 21 minutes were spent in providing patient care specific to Moisture Associated Skin Damage wound on the right flank . These minutes do not include time spent in activities related to procedures or application of therapeutic treatments. Spoke mostly about moisture associated dermatitis within skin folds. Interview and observation on 10/25/24 at 9:54AMwith Resident #59. EBP sign at door. Two staff assisted to pull resident up in bed and placed roll in right hand . Observation revealed right arm contracted at the elbow, white powder to her right elbow and right forearm area. No drainage, no odor, no redness at right elbow and forearm area. Resident denied having any pain at site. She stated she was showered last Wednesday. Interview on 10/25/24 at 10:30 AM attempted telephone interview with Family Member B left voicemail message. Interview on 10/25/24 at 10:45 AM. Family Member A returned called for Family Member B who said that Family Member B was taking someone to dialysis, and she was unable to talk about her Resident #59. Family Member A said she was the family member who spoke with the surveyor last week. She said since she reported the wound to the nurse, facility staff have been doing everything to address the wound to include cleaning it several times a day and applying medication. She denied that Resident #59's complaint of pain was associated with the wound to her right arm. Interview on 10/25/2024 at 12:52 PM with the ADON and DON who said the skin assessment was done weekly by the charge nurse. There also may be assessments documented on the progress notes if there was a change outside of the weekly skin assessment. Interview on 10/25/2024 at 1:06 PM with RN D who worked at the facility from 6AM- 6PM. She had been working at the facility for 5 months. She said any nurse can perform a skin assessment. She said she assessed the Resident 59's skin daily, but the order was for weekly skin assessments . If there was a change in condition, you should contact the MD and document your findings. She said the risk of not having a skin assessment routinely was if the resident needed further treatment, there was a risk of harm, and could have a delay in care. The nurse denied receiving skin assessment training during onboarding because she said she knew what to do as a nurse. She said doing a skin assessment was automatic. She said when there was a change in condition, she knew to notify the MD. She said Resident #59 refused care on 10/14/24 , she notified the MD by writing in the communication book for the MD to assess the resident on the next visit to the facility. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Phone Interview on 10/25/24 at 1:08PM with RN D said she had been on the Express Hall on night shift for 5 months. Her job duties included skin assessment of residents which was done daily and weekly and with changes. She said skin assessment were done routinely. She said if there were any changes, she would notify the physician. She said the risk of not following policy/procedure of assessing residents was there could be a potential need for further treatment, or delay of care, or harm. She said there was no on-boarding training for doing skin assessments, as a nurse it's done automatically. She said she knew what to do as a nurse. She said if there were any issues or changes in condition, she would notify the physician. Interview on 10/25/24 at 1:36PM with CNA C said she did skin assessments every day when she got residents up out of bed, during showers and checked their body for any changes. She said she would notify the nurse and doctors and made changes in the POC if it was something that looked really bad like discoloration, and if there were open areas, she would get the nurse immediately to look at it and explain what she had found. She said the risk to residents if they did not follow procedure/policy regarding assessing residents was the resident may have skin breakdown. She said she had been in-serviced on assessing residents. Interview on 10/25/24 at 1:39 PM with CNA E said she had worked here for 6 months, and she said she checked the resident's skin every time she changed them and when they got their showers. She said if there were any changes, she reported it to the nurse. She said the risk of no skin assessment and not following policy/procedure was she could not report any changes if they occurred. . Interview on 10/25/24 about 2:00pm with LVN D said he had worked here since 2015. He said he was a charge nurse, and his job duties were to monitor the CNAs and ensure they got their work done. He said he did skin checks and wound care on residents. He said he believed skin checks were done weekly but he did not believe the skin assessments were done weekly on everyone. He said a skin assessment was done if anyone had something that came up. He said the risk to residents if staff did not follow procedure/policy and were not assessed was the residents could have a wound being untreated. He said he was not in-serviced here on skin assessment. He said a change in condition for skin was reported to the wound care nurse so they could notify the wound care doctor. He said staff either called or documented on the physician log depending on the severity of the change. He said when there was something less severe, a skin tear document was noted in the physician book, and when it was more severe, he called the doctor. He said for residents that refused care, staff tried to reapproach the resident later and charted if the resident refused. He said staff also asked another nurse who may be more effective and if refusals continued, staff called the physician. Interview on 10/25/2024 at 2:05 PM with CNA D who worked Part-time at the facility and works from 3PM-10PM. She said on 10/14/24 she came to the facility and did assessments on all her residents. She went into Resident #59's room and noticed there was stuff on her sheets when she went in to change her linen. She said she noticed an odor in the room and the resident's arm had brown, wet, mucus like substance on her arm which she initially thought was food. CNA D said she notified LVN B of the discoloration and the evening nurse when she arrived for the 6PM shift. She said that night she tried to provide care, but the resident refused to let her, or the nurse touch her arm. She said the risk of not doing a skin assessment was possible infection or pressure injury. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 10/25/24 at 2:53PM with ADON. She said she expected the skin assessment to be done routinely weekly. If the CNA saw something they notified the nurse. She said the nurse was expected to assess the skin and if something new was seen they did an incident report, and called the doctor if there were signs or symptoms of infection then antibiotic needed to be started. She said it was charted by exception. Interview on 10/25/24 at 3:04 PM with NP who said staff documented any refusals and notified the physician. The staff did notify the nurse practitioner or the medical director if a resident refused. Interview on 10/25/24 at 3:07 PM with MD. She said the staff notified the Nurse practitioner and I of the resident's wound on her forearm and breasts and we treated it. She said she was notified if a resident refused care and we went to the family for help. She said Resident #34 interfered with the resident's care . She said the family was very involved, and we let the family know. She said the pain Resident #59 felt was from contractures when the resident attempted to move, it can cause pain, but the pain was not by the fungal infection. She said to check the communication binder we are also available 24/7 by phone. She said a change in skin condition was based on severity and staff contacted us if needed.

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	675696	A. Building B. Wing	10/25/2024

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

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45581 Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice, physicians orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 40 (Resident #93) residents reviewed for quality of care. The facility failed to ensure Resident #93's oxygen tubing was labeled and dated. This failure places the resident at an increased risk of infection leading to a decline in health. The findings included: Record review of Resident #93's face sheet undated reflected an [AGE] year-old female with admitted [DATE] and re-admitted [DATE]. Pertinent diagnosis included acute respiratory failure with hypoxia (low levels of oxygen in body tissues). Record review of Resident #93's MDS assessment, dated 09/27/2024 reflected the resident's BIMS score was 14 indicating very little cognitive impairment. Record review of Resident #93's Care Plan last updated 10/01/2024 read in part . Focus: I require oxygen therapy, I have CHF Date Initiated: 0/01/2024 Revision on: 10/01/2024, Goal: I will exhibit no anxiety related to shortness of breath over the next 90 days Date Initiated: 10/01/2024, Interventions: Change my tubing weekly per protocol Date Initiated: 10/01/2024. Record review of Resident #93's Treatment Administrative Record (TAR) dated 10/01- 10/17/2024 read in part . Order: Change O2 humidifier Q Monday on 10p-6a shift and PRN every night shift every Mon -Start Date- 10/07/2024 2200. Change oxygen tubing/nasal canula / mask Q Monday on 10p-6a shift and PRN every night shift, every Mon -Start Date- 10/07/2024 2200. Change oxygen tubing/nasal canula/mask Q Monday on 10p-6a shift and PRN as needed -Start Date- 10/01/2024 1339 The TAR indicated the humidifier bottle and oxygen tubing had been changed on 10/07 and 10/14/2024. Record review of the TAR dated October 2024 reflected the humidifier bottle and oxygen tubing had been changed on 10/07 and 10/14/2024. Interview and observation on 10/16/2024 at 9:16 AM with Resident #93 revealed she had an O2 concentrator, and there was no date on the tubing. Resident #93 said she did not know how often the tubing was changed. Interview and observation on 10/16/2024 at 1:05 PM Resident #93 said staff had not come and labeled/dated the oxygen tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/17/2024 at 1:51 PM CNA B said nurses set up the oxygen for the resident. She said she thought nurses set the oxygen levels and she would check the tubing to ensure it was not kinked or caught up, and that it was working properly. If it was not working properly, she notified the nurse if something was wrong. She said the oxygen tubing usually had dates and if she saw the date was past due then she would notify a nurse. She said she did not know if the resident's tubing was changed. She said she did not know if it was dated. Interview on 10/17/2024 at 1:55PM with the MDS Nurse said the Admissions nurse worked the floor earlier today. Interview on 10/17/2024 at 2:06 PM Admissions Nurse/LVN said normally if a resident required oxygen, we informed the physician, and an order was put in and then got a concentrator, tubing, and hydration bottle. She said there were orders to change the tubing, and the hydration bottle, and filter. She said the tubing was changed on Mondays on the night shift. She said the tubing was usually labeled. She did not know if the tubing was labeled for Resident #93. She said she did not know why the tubing was not labeled. Admissions Nurse/LVN said all nurses were responsible for labeling the tubing, but the night nurse should have labeled the tubing. She said the risk to residents when policy wasn't followed was at risk of respiratory infections and the worst thing to occur of policy was not followed was a serious infection could develop into a sinus infection or the tubing could get clogged, and the resident didn't get the oxygen they needed, and the resident might go into respiratory distress. Interview on 10/17/2024 at 2:19PM DON said the procedure for setting a resident up for oxygen was when on concentrator the canula was placed on the resident and ensured the concentrator was on right setting. She said Mondays was when the tubing and humidifier were changed. She said the night shift nurse was responsible for changing the tubing. DON said there was a label on the canula to tell when it had been changed. DON said she did not know when the resident's tubing was last changed or why it was not labeled. She said the nurse probably forgot to label the tubing. DON said she was last trained on Relias (online modules) but labeling the oxygen tubing was something you learned in nursing. DON said everyone was responsible for ensuring procedure and policy were followed and especially the nurse on those Monday nights. She said the risk to residents if policy were not followed was the canula could not be good, or the tubing might be kinked, and the worst thing was the resident did not get the appropriate O2 and saturation. Record review of the facility Oxygen Administration policy dated October 2010 read in part . Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27846 Based on observations, interviews and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 23 residents (Resident #100) reviewed for significant medication errors. The facility failed to ensure Midodrine (a blood pressure (BP) medication given to elevate hypotension (low blood pressure) was administered on 10/05/2024 and 10/11/2024 to Resident #100 as ordered on 08/05/2024 by the physician. This failure could place residents at risk of not receiving desired therapeutic outcomes, increased side effects, or a decline in health. Findings included: Record review of Resident #100's admission face sheet, undated, reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included: hypotension (low blood pressure), heart failure (a chronic condition in which the heart not pumping blood as well as it should), respiratory failure, atrial fibrillation (an irregular rapid heart rate that causes poor blood flow). Record review of Resident #100's care plan initiated 05/29/2024 revision updated 06/13/2024 reflected: Focus: The resident had hypotension. Goal: The resident would remain free of complications related to hypotension. Interventions: Give medications as ordered Record review of Resident #100's Admission Minimum Data Set (MDS) dated [DATE] reflected the resident's Brief Interview for Mental Status (BIMS) was scored at 11 which indicated moderate cognitive impairment. The resident required moderate assistance from staff for her toileting, dressing and personal hygiene. The MDS identified Resident #100's active diagnosis was debility, cardiorespiratory (chronic respiratory conditions and heart failure) condition. Record review of Resident #100's order listing report, undated, revealed, Midodrine 5 mg. Give one tablet by mouth three times a day for low B/P. HOLD if SBP (the top blood pressure number which measures the pressure in the arteries when the heart beats) was 120 or more. Order dated 08/05/2024. Record review of Resident #100's November 2024 Medication Administration Record (MAR) dated 10/01/2024 -10/31/2024 reflected, the resident was administered Midodrine 5 mg outside of physician set parameter of SBP over 120 on: 10/05/2024 at 7:00 AM with BP 122/57 by MA A (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/11/2024 at 1:00 PM with BP 122/66 by MA B In an observation and interview on 10/16/2024 at 9:22 AM revealed Resident #100 in bed with Oxygen at 3 liters on by nasal cannula (tube to deliver oxygen to the nose). Resident #100 stated she had no problems or concerns with her medications. She stated she looked them over before she took them. In a phone interview on 10/16/2024 at 10:35 AM with the pharmacist who stated Midodrine was given for low blood pressure. The medication was intended to elevate blood pressure. She stated the doctor ordered the parameter, so the medication would not be given if not needed. The pharmacist stated the risk of giving this medication if the blood pressure was over the ordered parameter was it could cause the resident's blood pressure to go too high. In an interview and record review on 10/16/2024 at 1:36 PM MA B stated Midodrine was given for low blood pressure. MA B reviewed Resident #100's MAR dated 10/11/2024. MA B stated she did administer the medication on that date. MA B stated she checked the resident's BP then she checked the MAR. The MA stated the Midodrine was to be held if the BP was 120 or higher. The MA stated the parameter was to hold the medication to keep the resident's BP from going too high. MA B stated the SBP was 122. The medication should not have been given the risk was it could have cause BP too be too high. MA B stated she did not know how this happened perhaps she documented incorrectly but she did not know. MA B stated the policy was to give medications as ordered by the physician. She stated she had been in-serviced on medication administration. MA B stated she would double check before she gave it again to prevent this in the future. In a phone interview on 10/16/2024 at 2:11 PM MA A stated the Midodrine was too be given to keep the resident BP stable so it would not go too high. MA A stated the parameter was to be followed as ordered because the doctor did not want the resident's BP to go too high. MA A stated the medication should not have been given since the resident's BP was over 120. MA A stated she was not sure how this happened except she may have read the order incorrectly. MA A stated the risk was the medication could cause the medication to go too high. MA A stated she had been in-serviced on medication administration. MA A stated she would double and triple check the order next time. In an interview and record review on 10/17/2024 at 1:23 PM DON reviewed Resident #100's physician's order. The DON stated the Midodrine was not to be given if the SBP was higher than 120. The DON reviewed Resident #100's MAR. The DON stated Resident # 100's SBP was documented as 122. The DON stated the medication should not have been given. She stated the medication was to elevate blood pressure. The risk was the BP could be too elevated. The DON stated she did not know why this happened. The DON stated she would reeducate on the medication administration and side effect to prevent this again. She stated the policy was to administer medications as ordered. In an interview on 10/17/2024 at 2:25 PM Administrator stated he did not have clinical background. He did understand the medication was given and it should not have been given based on the physician's order. The Administrator stated the expectation was the policy would be followed which was to follow the physician's order. The Administrator stated the staff would be reeducated to prevent this again. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled Administering Medication revised dated April 2019 read in part . Policy Statement: Medications are administered in a safe and timely manner, and as prescribed . Policy Interpretation and Implementation 4. Medications are administered in accordance with prescriber orders, including any required time frames .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27846 Based on observation, interview, and record review the facility failed to ensure that drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional principles for 1 of 4 halls (200 Hall) and 1 of 4 treatment carts (treatment cart 200 hall) reviewed for medication storage. The facility failed to ensure RN C locked the 200-hall treatment Cart before leaving it unattended on 10/17/2024. This failure could place residents at risk for possible drug diversions or accidental ingestion. Findings included: During an observation and interview of the 200-hall on 10/17/2024 at 12:37 PM revealed the 200-hall treatment cart parked in the hall between rooms [ROOM NUMBERS]. Observation at this time revealed no residents were in the hall. Observation revealed there was no nursing staff present in the hall. During the observation the Administrator and Regional VP walked down the hall toward the cart. Interview with the Administrator who stated he saw the treatment cart was not locked. Regional VP left for the dining room to get RN C to come to the treatment cart. Observation and interview on 10/17/24 at 12:38 PM RN C arrived at the treatment cart. Inventory of the 200-hall treatment cart accompanied by RN C revealed items including the following: Drawer #1: Betadine swaps (antiseptic swaps to prevent skin infection) Scissors Insulin flex pens (prefilled insulin administration device) Individual packets of triple antibiotic ointments Tylenol pills Tylenol suppositories Ceftriaxone injectable vial (antibiotic to treat bacterial infections) Lidocaine vials (injectable local numbness or loss of feeling medication for certain procedures). Drawer #2: Dry gauze dressing supplies Calcium Alginate dressing (a wound dressing that absorbs wound fluid to create a wound environment for healing) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Iodoform gauze packing (medicated gauze for packing a wound to remove dead tissue and enhance healing) Drawer #3: Nystatin cream (cream medication to treat yeast or fungal infections) Nystatin powder (powered medication to treat yeast or fungal infections) Hydrocortisone cream (steroidal anti-inflammatory) Diclofenac Gel (nonsteroidal anti-inflammatory) Bio freeze (muscle pain relief) Triamcinolone (treats skin itching, redness, dryness) Drawer #4 Lidocaine patch (pain patch applied to the skin0 Aspercream with Lidocaine (deep penetrating pain cream) Albuterol Sulfate inhalation (medication to open the airways for wheezing, difficulty breathing and chest tightness) Drawer #'s 5 and 6 miscellaneous dressing supplies Gauze dressing (wound care dressing) Tape Kling (stretch bandage) ABD dressings (thick abdominal gauze pads) Drawer #7 Hydrogen Peroxide Dressing supplies In an interview on 10/17/2024 at 12:53 RN C stated the treatment cart was to be locked when it was not in use and the nurse was not working on it. RN C stated she was not sure why this happened perhaps she was called away and forgot to lock it. RN C stated she was normally good about locking the carts when she leaves them. RN C stated it was important to lock the carts when you leave it. The risk was a resident could get into it and remove something from it. RN C stated to prevent this again she would double check the lock prior to leaving. RN C stated she was in-serviced on locking the medication and treatment cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/17/2024 at 1:46 PM the DON stated she was notified the treatment cart was not secured when the nurse was not near it. The DON stated she did not know why this occurred. The DON stated the policy was the cart was expected to be locked when the nurse leaves it. The risk was a resident, or anyone could get into the cart and get something out they should not have. The DON stated to prevent this again we will reeducate the staff to lock the medication and treatment carts. In an interview on 10/17/2024 at 2:25 PM the Administrator stated he expected the treatment carts to be locked when not in use. The Administrator stated the policy was to keep the carts locked when not in use. The Administrator stated the risk was something could be taken out of the cart when not locked. Record review of the facility policy titled Security of Medication Carts revision dated April 2007 reflected in part, Policy statement: The medication cart shall be secured during medication passes . 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry . 4. Medication carts must be securely locked at all times when out of the nurse's view . 5. When the medication cart is not being used, it must be locked ad parked at the nurse's station or inside the medication room .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46678 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. Seven dented cans were on the rack located in the dry storage room. This deficient practice could place residents who received meals from the main kitchen at risk for food borne illness. Findings included: Observation on 10/15/24 at 11:50 am of the dry storage room revealed the following: -Five 50 oz cans of tomato soup with a small dent at the top of the seam -Two 50 oz cans of tomato soup with s small dent at the top and bottom of the seam Interview with the Dietary Supervisor on 10/15/24 at 11:54 am confirmed the dented cans should have been stored away from the dry storage with the other dented cans. The Dietary Supervisor said she was out of town when the groceries were received on Friday, 10/11/24 and did not check the cans. Interview with the Dietary Supervisor on 10/16/24 at 2:43 pm, she had worked at the facility for [AGE] years. The Dietary Supervisor said groceries would come in every Wednesday and Friday. She said all the dietary staff put up groceries and was responsible for checking dented cans. The Dietary Supervisor said the dented cans were missed because they were in a case and the dents were not visible. Dietary Supervisor said the risk to the resident was they get could get sick from botulism. Interview with Dietary Aide A on 10/15/24 at 2:54 pm, she had worked at the facility for [AGE] years. She said the Dietary Supervisor checks all items in the dry storage. Dietary Aide A said there was a section for dented cans, where staff put a dented can if they find one. Dietary Aide A said the risk to the resident was they could get sick from botulism. Interview with Dietary Aide B on 10/15/24 at 3:00 pm, she had worked at the facility for one year. She said she checked cans and dated them and if she found a dented can, she would set it to the side. Dietary Aide B said the risk to the resident was they could get sick. Record review of the Food Receiving and Storage policy dated November 2022 read in part . dry food and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use .

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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** 48863 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 infection for 1 of 8 residents (Resident #31) reviewed for infection control. The facility failed to ensure LVN A followed proper infection control and handwashing during wound care for Resident #31on 10/16/2024. The facility failed to ensure CNA A followed proper infection control and hand washing procedure before incontinent care for Resident #31 on 10/16/2024. These failures could lead to cross-contamination and the development of infection. Findings included: Record review of a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Cerebral Palsy(neurological condition that can present as issues with muscle tone, posture and/or a movement disorder), Multiple sclerosis (disease in which the immune system eats away at the protective covering of the nerves), Chronic Kidney disease (long-term condition where the kidneys do not work as well as they should, and dysphagia(difficulty swallowing). Record review of Resident #31's OSA MDS Assessment on 08/26/24 which revealed a BIMS summary score of 07 indicating moderate cognitive impairment. She also required extensive support with most of her ADLs to include mobility, transfers, and toileting. Record review of Resident #31's care plan date initiated 03/16/21 reflected she used an indwelling catheter due to neurogenic bladder and urinary retention, incontinent of bowel, and required assistance from staff with dressing, showers, and personal hygiene related to generalized weakness, impaired mobility, poor balance, and risk for falls. Observation on 10/16/24 at 10:43 AM, revealed LVN A provided Resident #31 with wound care. LVN A did not wash her hands prior to entering the room, and she donned (process of putting on PPE) gloves and gown to initiate wound care. She used the same gloves to adjust the bed with a cranking lever located at the foot of the resident near the floor. LVN A proceeded to remove the old dressing with same gloves. LVN A doffed (process of removing PPE) gloves, sanitized her hands and donned new gloves. She cleaned the wound per MD orders and doffed gloves. She sanitized hands and donned new gloves to apply collagen and border dressing. LVN A then proceeded to assist the CNA with incontinent care for Resident #31. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/16/24 at 10:48 AM, revealed CNA A provided Resident #31 with incontinence care. CNA A did not perform hand hygiene prior to entering the resident's room, nor prior to donning clean gloves and her gown. CNA A unfasted the resident's brief and initiated peri care/r catheter care 3 times with wet wipes from multi-wipe packet. She retrieved wipes from the same multi-use packet without changing gloves. CNA A doffed soiled gloves sanitized her hands and donned clean gloves. CNA A continued incontinent care and turned resident to the side and cleaned resident buttocks 3 times with wet wipes from multi-wipe packet with same gloves. She doffed gloves used hand sanitizer and donned new gloves to apply the resident's brief. She completed her incontinent care, and she and LVN A both washed their hands after doffing gloves before leaving the room. Interview on 10/16/24 at 10:53 AM with LVN A who said she started working full time at the facility 9 years ago. She said that she normally served as the charge on the floor but sometimes round with the Wound Care MD. LVN A said the importance of hand hygiene prior wound care was to prevent the spread of infection. She said she should not use the same gloves to adjust the bed and to provided wound care because it can cause increased risk to compromised resident with a history of reoccurring UTIs for additional infections and cross contamination. Interview on 10/16/24 at 11:02 AM with CNA A who said she started working at the facility for 1 year. She said her job duties consist of assisting resident with their ADLs to include showers, assistance with feeding, and incontinent/peri-care. She acknowledged that she did not perform hand hygiene prior to putting on her gloves to provide incontinent care. She said the expectation is to wash her hands or use hand sanitizer before donning gloves and gowns when providing incontinent care when a resident was on EBP. She said the staff regularly gets in-serviced on infection control and hand hygiene. CNA A said not performing hand hygiene before applying gloves could cause infection and cross-contamination. Interview on 10/17/24 at 2:17 PM, ADON said she expected staff to make sure they provided proper hand hygiene prior to performing incontinent or wound care on a resident. She said these failures could result in infection, cross-contamination and/or cause the wound to deteriorate. ADON said the staff was in-serviced and check-off on infection control during the skills fair April 3rd-18th 2024. Interview on 10/17/24 at 3:32 PM, DON said she expected staff to introduce themselves to the resident, wash/sanitize their hands before, during and after providing incontinent/wound care to residents. DON said the risk of not washing/sanitizing their hands was increase infection and contaminating surface areas. DON said the skills fair was done by the ADON (Infection Preventionist) recently which included hand hygiene, EBP, and PPE (equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) Record review of facility's In-Service Program Attendance Record dated 04/18/2024 reflected Topic: Hand Hygiene, EBP, and PPE. Record review of facility's Wound care policy revised 10/2010, read in part: .Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Steps in the procedure: l. Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached. 2.Wash and dry your hands thoroughly . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675696	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Country Village Care		STREET ADDRESS, CITY, STATE, ZIP CODE 721 W Mulberry Angleton, TX 77515	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's Cather Care policy revised 09/2014, read in part: .Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Steps in the procedure: 1. Place the clean equipment on the bedside stand or overbed table. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly .