

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 01/09/2026
NAME OF PROVIDER OR SUPPLIER Country Village Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions. Observed 3 of 3 Kitchen reviewed the facility stored outdated and deteriorated food. The facility failed to provide functional handwashing sinks with hot water. The facility failed to have monitor cold holding equipment temperatures due to non functional thermostats and lack of documented alternative checks. These failures had the potential to cause foodborne illness and cross contamination for residents. Observation on 01/06/2026 at 08:20 AM revealed the walk-in refrigerator had outdated and undated ready to eat foods, including containers lacking date marking. Brown, wilted lettuce was present and stored next to ready to eat foods. Cabbage was stored with no dates to show when received nor dates of expiration. Some cabbage was brown in color and bag was not sealed and exposed to cold temperatures of 32 degrees. The walk in cold storage units lacked a functioning, easily readable temperature measuring device for ambient air. Observation on 01/06/2026 at 8:45AM revealed the walk-in freezer had multiple outdated and undated food items stored in both the refrigerator and freezer. Several items in the freezer exhibited freezer burn and lacked proper labeling. In the walk in freezer unit there were brown, wilted lettuce stored with other ready to eat items, (2) bags of tomato soup with an expiration date of 06/11/2025, (2) cartons of Tropicana orange juice with best used by 01/03/2026, open box of breakfast sandwich dated with expiration date of 03/2025 and 2 bags of frozen soup stored in a zip lock bag with no date or labels. The walk in refrigerator and freezer did not have functional exterior thermostats. There were multiple bags of cabbage, lettuce that had freezer burn, missing labels, and expired dates. Observation on 01/06/2026 at 9:00AM two handwashing sinks were non functional, and an additional handwashing sink produced only cold water. Staff #1 was observed leaving food preparation areas to locate a working sink. Observation on 01/06/2026 at 9:10AM revealed the kitchen deep fryer displayed residue from previous usage, grease trap was full of grease stains, and the grease appeared to be of a dark brown color and had a foul odor. Interview with the DM on 01/06/2026 at 9:30AM. DM stated they have been having ongoing issues with the walk in cooler and freezer thermostats. She stated the Maintenance has been notified, but the replacement parts have not arrived yet. Staff were instructed to go inside the unit and use handheld thermometers, but she can see now that it's not happening consistently. They have had staffing shortages, and food rotation hasn't been done thoroughly. She was not aware that the lettuce had turned brown or that some freezer items were past their date. She said she would address this with the dietary team immediately. She said they tried to check dates, but they were short staffed. Sometimes items get pushed to the back of the freezer and they don't realize they've been there too long. The DM stated that by serving food to residents it can potentially cause food born illness; they can sick or some kind of infection. The DM stated two sinks have been out of service for several weeks. They put in a work order, but maintenance has been backed up. Staff had been using the sink near the dish area, and the bucket next to the sink, but she understood that it's not always convenient or close enough to the prep stations. The DM stated she has mentioned to the administrator about the sink and that she was just waiting for them to fix it or the plumber. Interview with [NAME] A on 01/06/2026 at 9:45AM she (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated they try to check dates, but they were short-staffed. Sometimes items get pushed to the back of the freezer and they don't realize they've been there too long. When asked about handwashing access, [NAME] A stated the sink near the prep table hasn't worked in weeks. They had to walk to the dish room to wash hands. The cook stated sometimes it was hard to leave in the middle of prepping food they use the sink outside of the stove area and it works but it takes a while for the water to get hot. Interview with [NAME] B on 01/06/2026 at 10:00AM she stated the lettuce has been coming in looking bad sometimes, but they don't always have time to sort through it. They were supposed to toss anything that looks brown, but they're rushed, so sometimes it gets checked. She said that they don't serve that to the residents. When asked what potential harm that could be to the residents [NAME] B stated they can get sick. Interview with the Administrator on 01/06/2026 at 1:00PM The Administrator stated he was not aware that expired or undated food items were still being stored in the kitchen. Administrator stated they rely on the dietary team to complete daily refrigerator and freezer checks, but it seems those checks were not being done consistently. When asked about the non-functional exterior thermostats on the walk-in cooler and freezer, the Administrator responded to maintenance reported the thermostat issue last month, but s understood that staff were supposed to use handheld thermometers in the meantime. He did not know that the readings were not documented or consistently taken. When asked regarding cold water at handwashing sinks, the Administrator stated he was informed about a plumbing issue affecting the hot water line, but he didn't realize it was impacting two sinks in the kitchen. The Administrator stated he thought only one sink was affected. He stated he agreed that staff should not have to walk away from food prep areas to find a working sink. Administrator stated he would have the plumbing company come out to look at. The Administrator acknowledged they had delays with repairs, but he can see now that they did not put effective interim measures in place to ensure food safety. Administrator stated they would address this immediately with both the dietary and maintenance departments. The Administrator stated we have been without a consistent dietitian for several weeks due to turnover and difficulty finding coverage. The consulting dietitian we normally use has only been able to come in sporadically, and we have not had regular reviews of menus, nutritional assessments, or oversight of the dietary department. When asked how this could potentially affect the residents, the Administrator stated Outdated or spoiled food absolutely puts the residents at risk as many of them have weaker immune systems, and if they were to consume something expired or contaminated, it could make them seriously ill. The Administrator said even something that looks just a little wilted could be harboring bacteria. The Administrator recognized this affects supervision over food storage, menu compliance, and ensuring staff follow proper procedures. The Dietary Manager have been trying to keep things running, but the dietitian was responsible for ensuring regulatory compliance in areas like menu accuracy, therapeutic diets, and monitoring nutritional risk They had been actively having a contract with an interim dietitian, but so far, they haven't been able to secure someone consistently. The Administrator agreed that this gap has likely contributed to issues with outdated food, improper storage, and a lack of monitoring, because the dietitian normally audits those areas during routine rounds. When asked whether the facility implemented interim measures to compensate for the absence of consistent dietitian oversight, the Administrator acknowledged the new company had a dietitian and they are switched out monthly so they have not truly had a lap, but they have one starting this month which should be permanent. Record review of the facility Food Preparation and Service policy dated November 2022 states the following: Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an infection control program designed to help prevent the development and transmission of disease and infection for 4 (wound care nurse, CNA B, ADON, and HK L) of 6 staff observed for infection control. The wound care nurse failed to perform hand hygiene after removing Resident #3's soiled dressing from her sacrum. The wound care nurse failed to perform hand hygiene before performing wound care and applying clean dressing on Resident #3. The facility failed to ensure CNA B did not pick up a wipe from the floor and continued to provide Foley care, pulled wipes from the wipe pack, and did not wash her hands before she donned clean gloves during care for Resident #13. The facility failed to ensure the ADON did not place a wedge from Resident #13 on the floor while she assessed Resident #13. The facility failed to ensure HK L did not push the cart while she wore gloves on 600 hall. These failures could place residents at risk by exposing them to care that could lead to the spread of viral infections, secondary infections, or communicable diseases. Review of Resident #3's face sheet dated 1/9/2026 showed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Alzheimer's disease unspecified (a degenerative brain disorder that primarily affects memory, thinking, and reasoning skills), chronic obstructive pulmonary disease (a progressive lung disease characterized by reduced airflow into and out of lungs), pressure ulcer (a condition that occurs when prolonged pressure on the skin causes damage to the skin and underlying tissues), gastro-esophageal reflux disease without esophagitis (a condition when stomach acid flows back in the esophagus but doesn't cause inflammation or damage to the esophagus lining), depression (a state of general unhappiness or despondency where a person may feel sad, irritable, or hopeless), muscle weakness generalized (refers to a lack of strength across the entire body). Record review of Resident #3's care plan dated for 10/15/25, read stage 3 pressure injury at sacrum, reclassified as body habitus fissure coccyx. Interventions: Body habitus fissure coccyx - Cleanse with cotton-tipped swab soaked in vashe, apply calcium alginate with silver to wound, cover with dry dressing change daily and as needed. Use my pillows when needed to assist with repositioning. Record review of Resident #3's quarterly assessment dated [DATE] revealed Resident #3 BIMS was 07 out of 15 which indicates severe cognitive impairment. Further review of Resident's #3 of MDS revealed had one stage 3 pressure ulcer. Record review of Resident# 3 physician order for January 2026 read cleanse body habitus fissure coccyx with cotton-tipped swab soaked in vashe, apply calcium alginate with silver to wound bed, skin prep to peri wound, cover with bordered dressing change daily and as needed. Observation of the wound care performed on Resident#3 by the wound care nurse on 1/8/2026 at 9:21 am showed that the wound care nurse did not perform hand hygiene after removing the soiled dressing. The wound care nurse removed the old dressing and proceeded to clean the wound and applied a new dressing. Interview with the wound care nurse on 1/8/2026 at 10:00 am revealed that the wound care nurse was aware that she didn't perform hand hygiene correctly. The wound care nurse correctly verbalized what, when, and why she should have performed hand hygiene after removing the soiled dressing from Resident #3's sacrum. The wound care nurse stated the risk to the patient of not performing hand hygiene correctly could lead to infection. The wound care nurse stated her only training for wound care was from on-site working as a nurse and from nursing school. The wound care nurse stated the facility will be sending her to receive her certification in wound care beginning in March of 2026. Interview with the DON on 1/9/2026 at 12:36 pm revealed that the wound care nurse has been the charge nurse for the past two years and performing wound care during that time. The DON stated that the facility will be sending the wound care nurse to classes to receive her certification in wound care beginning at the end of February. The DON stated the wound care nurse should have known to perform hand hygiene after removing the soiled dressing. The DON stated that the risk of not performing hand hygiene correctly could place residents at risk for infection. Record (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of the facility's undated wound care policy indicates that hand hygiene should be performed after the removal of soiled dressing and disposal of gloves. Record review of Resident #13's face sheet dated 12/04/25 revealed a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. He had diagnoses that included benign prostatic hyperplasia (enlarged prostate gland), heart failure (when the heart could not pump enough blood to meet the body's needs), and atrial fibrillation (when the upper heart chamber beat rapidly instead of pumping). Record review of Resident #13's significant change assessment MDS dated [DATE] revealed a BIMS score of 15 out of 15, which indicated intact cognition. It also showed Resident #13 had a Foley catheter. Record review of Resident #13's care plan dated 10/08/25 read in part, resident uses 18 FR/30 ML balloon Foley catheter related to urinary retention. Intervention: provide catheter care every shift. During an observation on 01/08/26 at 10:05 a.m., CNA B used the same gloves while she was providing Foley care for Resident #13 and pulled out wipes from the wipe packet. While she was wiping Resident #13's penis, one of the wipes fell on the floor, and she picked up the wipe from the floor and placed the wipe inside the trash can. She then continued to provide Foley care for the resident with the same gloves. She changed her gloves once, and she did not wash her hands before she donned a clean glove. During an interview on 01/08/26 at 10:30 a.m., CNA B said she used the same gloves while she was providing Foley care for Resident #13 and picked up a wipe from the floor, and she continued to provide care for the resident. She said she used the dirty gloves and pulled out wipes from the wipe packet, and it was an infection control issue because of cross contamination. CNA B said she forgot to wash or sanitize her hands before she donned another glove because she was going from dirty to clean. During an interview on 01/08/26 at 10:52 a.m., RN C said CNA B should not have picked up the wipe that fell on the floor with the same gloves she was using while providing Foley care for Resident #13 and continued to provide Foley care for the resident after she picked up the wipe from the floor. RN C said CNA B should not have used dirty gloves and pulled wipes from the wipe pack because of cross contamination. She said CNA B should have washed or sanitized her hands after she removed the dirty gloves before she donned a clean glove. During an interview on 01/08/26 at 11:16 a.m., the ADON said CNA B should have removed the gloves from her hands after she picked up the wipe from the floor and sanitized her hands and donned another clean glove before she continued to provide Foley care for Resident #13. She also said CNA B should not have used the same gloves she was providing Foley care for the resident and pulled out clean wipes from the packet because it was cross contamination. During an interview on 01/08/26 at 3:17 p.m., the DON said CNA B should have washed her hands and donned gloves and provided Foley care, and the aide should not have pulled wipes from the wipe packet with dirty gloves because it was cross contamination. She said CNA B should have changed her gloves after she picked up the wipe from the floor before she continued to provide Foley care for Resident #13. The DON said CNA B should have washed or sanitized her hands when she removed the dirty gloves because of cross contamination. During an observation on 01/08/26 at 10:54 a.m., the ADON took the wedge from under Resident #13 and placed the wedge on the floor. During an interview on 01/08/26 at 11:14 a.m., the ADON said she should not have placed the wedge from Resident #13's bed on the floor while assessing Resident #13. She said it was an infection control issue. During an interview on 01/08/26 at 3:22 p.m., the DON said the ADON should not have placed the wedge she took from Resident #13's bed on the floor because it was cross contamination. During an observation and interview on 01/09/26 at 10:16 a.m., HK L was pushing a cart on the 600 hall with gloves on. When she got to the 600 dining area, she stopped the cart and picked up a wet floor sign from the floor and placed the sign by the wall, then went back to pushing the cart. During an interview on 01/09/26 at 10:17 a.m., HK L said she donned the gloves when she went to the storage area and took the cart, went into a resident room, packed the resident's belongings, and moved the resident to another room. She said she was taking the cart back to the storage area when she saw the wet floor sign and picked it up. HK L said she placed the wet floor sign against the wall and continued to push the cart. She said she was not supposed to have worn (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves from room to room, in the hallway, or picked up the wet floor sign because of cross contamination. During an interview on 01/09/26 at 10:19 a.m., HKS said HK L was not supposed to wear gloves in the hallway unless she was handling chemicals. She said HK L should have removed her gloves after she left the resident room and washed or sanitized her hands. She said it was an infection control issue. Record review of the facility policy on hand washing/hand hygiene dated 2001 MED-PASS, Inc., revised October 2023, read in part: .policy statement. this facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infection. indications for hand hygiene #1f. before moving from work on a soiled body site to a clean body site on the same resident. #1g. immediately after glove removal. Record review of the facility infection prevention and control program dated 2001 MED-PASS, Inc., revised October 2018, read in part: .policy statement. an infection prevention and control program (IPCP) was established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs for 2 of 6 residents (Resident #124 and Resident #123) reviewed for call lights. The facility failed to have a call light within reach for Resident #124 while in bed and Resident #123 while she was seated in her wheelchair. This failure could have placed residents at risk of a delay in care and services, increased falls, and a decreased quality of life. Record review of Resident #124's face sheet dated 01/09/26 revealed she was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #124 had diagnoses which included: heart failure (heart not pulping blood as well as it should), hypertension (pressure in the blood vessels is always higher than normal), and cerebral infarction (the death of brain tissue). Record review of Resident #124's significant change MDS assessment dated [DATE] revealed a BIMS score of 05 of 15, which indicated severely impaired cognition. Further review revealed the resident needed partial to substantial assistance with ADLs, which required at least one staff assistance. Record review of Resident #124's care plan initiated on 10/02/25 revealed the resident had an ADL self-care deficit related to limited mobility. Intervention: the resident required substantial/maximal assistance for bed mobility. Further review revealed Resident #124 had a communication problem. Intervention: ensure a safe environment: call light within reach. During observation and interview on 01/06/26 at 10:46 a.m., Resident #124 said she was fine, but she was trying to get her clothes, and she could not get out of the bed by herself. Resident #124 said she could not reach her call light. Observation revealed the call light was pinned on the head of the mattress, and Resident #124 tried to reach the call light, but she could not reach the call light. During an observation and interview on 01/06/26 at 10:51 a.m., CNA A said the call light was not within reach for Resident #124 and she was not able to reach the call light for assistance when she needed help. CNA A said Resident #124 could get frustrated and could attempt to assist herself, and she could fall. During an interview on 01/07/26 at 3:59 p.m., the Administrator said the call light should have been within reach of Resident #124 so she could have used the call light in case of emergency or if the resident needed any care. The Administrator said a multitude of things could have happened to Resident #124, such as needing the remote or falling on the floor while trying to transfer herself. During an interview on 01/07/26 at 4:35 p.m., the DON said Resident #124's call light should always have been placed within reach of the resident. She said Resident #124 used the call light to communicate with staff when she needed assistance. She said if the call light was not within reach, Resident #124 would not have been able to call for assistance, and the resident could have fallen if she tried to assist herself, or she would not have been able to obtain assistance if the resident had an emergency, which would have delayed care for the resident. Record review of Resident #123's face sheet dated 01/09/26 revealed she was an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #123 had diagnoses which included: heart failure (heart not pulping blood as well as it should), hypertension (pressure in the blood vessels is always higher than normal), and cerebral infarction (the death of brain tissue). Record review of Resident #123's MDS assessment dated [DATE] revealed a BIMS score of 09 of 15, which indicated moderately impaired cognition. Further review revealed the resident needed partial to substantial assistance with ADLs, which required at least one staff assistance. Record review of Resident #123's care plan initiated on 12/30/25 revealed the resident had an ADL self-care deficit related to activity intolerance. Intervention: the resident required substantial/maximal assistance for bed mobility. During observation and interview on 01/06/26 at 11:47 a.m., Resident #123 was sitting on her wheelchair, and she said she could not find her call light. The surveyor looked and could not find it. During observation and interview on 01/06/26 at 11:30 a.m., LVN D said the call light was tied on the bed rail toward the head of the bed opposite from where the resident was seated at the foot of the bed, and (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the call light was dangling toward under the bed. LVN D said the resident would not have been able to reach the call light from where she was sitting. She said the call light should have been within reach of Resident #123 because the call light was a communication system for residents to call staff when the resident needed help. LVN D said Resident #123 could have fallen if she was trying to get assistance and could not get help, and then Resident #123 could have decided to ambulate by herself. LVN D said if Resident #123 could not have reached staff during emergencies, it could have resulted in a negative outcome. During an interview on 01/08/26 at 9:09 a.m., the ADON said staff should have placed the call light within reach for Resident #123 because the call light was what the resident used for communication. She said the call light should have been within reach for the safety of Resident #123. The ADON said Resident #123 could have fallen if she did not have her call light within reach, and it was resident rights. During an interview on 01/08/26 at 9:21 a.m., the PTA said he did not remember giving the call light to Resident #123 after he placed her at the foot of the bed with the bedside table in front of her. He said he had training within the therapy team and was told to place the call light within resident reach. He said the call light should have been within reach because if Resident #123 needed assistance, the resident could have called staff. He said Resident #123 could have had an emergency and could not have reached the call light; then staff would not have assisted the resident, and the resident would not have received the needed assistance. Record review of the facility undated policy on call system for long-term care, undated, read in part: .procedure #11. Be sure all call lights are placed within reach of each resident, never on the floor or bedside stand.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had a right to personal privacy for 1 of 6 residents (Resident #13) reviewed for privacy. The facility failed to ensure CNA B closed Resident #13's window blind while providing Foley catheter care for the resident. This failure could have placed residents at risk of loss of self-esteem, self-worth, and dignity. Record review of Resident #13's face sheet dated 12/04/25 revealed a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. He had diagnoses that included benign prostatic hyperplasia (enlarged prostate gland), heart failure (when the heart could not pump enough blood to meet the body's needs), and atrial fibrillation (when the upper heart chamber beat rapidly instead of pumping). Record review of Resident #13's significant change assessment MDS dated [DATE] revealed a BIMS score of 15 out of 15, which indicated intact cognition. It also showed Resident #13 had a Foley catheter. Record review of Resident #13's care plan dated 10/08/25 read in part, resident uses 18 FR/30 ML balloon Foley catheter related to urinary retention. Intervention: provide catheter care every shift. During an observation on 01/08/26 at 10:05 a.m., it was revealed that CNA B did not provide complete privacy for Resident #13 while she provided Foley care. CNA B did not close the resident's window blind during care. The resident's bed was by the window. During an interview on 01/08/26 at 10:40 a.m., CNA B said she forgot to close the blind when she provided Foley care for Resident #13, and somebody could have seen the resident, and it was a privacy and dignity issue. CNA B said Resident #13 would feel embarrassed if he knew the blind was open because he was exposed. During an interview on 01/08/26 at 10:53 a.m., RN C said CNA B should have closed Resident #13's blind before she provided Foley care for the resident to prevent exposing the resident to anybody who could have passed by the resident's window because it was a dignity issue. During an interview on 01/08/26 at 11:18 a.m., the ADON said CNA B should have closed the door and the blind before providing care for Resident #13 to prevent the resident from being exposed to anybody who should not have seen the resident's exposed body. The ADON said Resident #13 would have felt bad and it was a dignity issue. During an interview on 01/08/26 at 1:44 p.m., Resident #13 said he would not have liked anybody who was not providing care for him to see his exposed body. During an interview on 01/08/26 at 3:19 p.m., the DON said CNA B should have closed Resident #13's room door, pulled the privacy curtain, and closed the blind to provide privacy while providing care for the resident. The DON said Resident #13 could have been exposed and anybody passing by the resident's window could have seen the resident's exposed body area, and the resident would have been upset. The DON said it was a dignity issue. Record review of the facility policy on resident rights dated 2001 MED-PASS, Inc., revised December 2016, read in part, .employees shall treat residents with kindness, respect, and dignity.		

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 01/09/2026
NAME OF PROVIDER OR SUPPLIER Country Village Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring and administering of all drugs to meet the needs of the residents for 1 (Resident# 2) of 3 residents observed during medication pass. MA A administered expired medication to Resident # 2. This failure could place residents at risk of receiving less therapeutic benefits from medication. Review of Resident# 2's face sheet dated 1/9/2026 showed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including heart failure (a condition where the heart cannot pump enough blood to meet the body's need for blood and oxygen), atherosclerotic heart disease of native coronary artery without angina pectoris (a condition that is characterized by the accumulation of plaque within the arterial walls leading to narrowed or blocked arteries), unspecified atrial fibrillation (a condition where the heart's upper chambers beat irregularly and chaotically causing a fast and irregular heartbeat), gastro-esophageal disease without esophagitis (a condition when stomach acid flows back in the esophagus but doesn't cause inflammation or damage to the esophagus lining), essential primary hypertension (a form of high blood pressure that has no identifiable cause), generalized muscle weakness, and cognitive communication deficit (a condition that involves impairments in cognitive processes such as attention, memory, and executive functions). Review of Resident #2's physician orders dated 11/25/2025 revealed an order for Oyster Shell Calcium/D Oral tablet 500-5 milligram (mg)- microgram (mcg) Calcium Carbonate-Vitamin D to be given once a day. Observation of medication pass on 1/7/2026 at 8:55 am revealed MA A administered Oyster Shell Calcium Carbonate 500 mg tablet to Resident #2. Observation on 1/7/2026 at 8:55 am of the bottle that Oyster Shell Calcium Carbonate tablet was contained in showed the medication had an expiration date of November 2025. Interview with MA A on 1/7/2026 at 9:48 am revealed that she knew she was not supposed to administer expired medications. MA A stated that administering expired medication would not be effective. MA A stated that she has been trained in medication administration. MA A stated that she was going to notify administration that she administered expired medication. Interview with the DON on 1/7/2026 at 10:33 am revealed that giving expired medication may not be effective. The DON stated that the expired medication could possibly be more potent or cause adverse effects. The DON stated that she has two ADON's that perform spot checks, and the pharmacy assists in reviewing for expired medications monthly. The DON stated that every time a nurse administers medication, they should check the expiration date. The DON stated that staff was trained with a preceptor in the facility and must show competence and feel comfortable before a staff member was allowed to administer medication independently. Record review of the facility's undated medication administration general policy read in part .general guidelines for medication administration/pass.#23. Return expired or outdated medications promptly to the pharmacy.		