STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675878	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Trails Wellness & Rehabilitation Center	1638 Vz Cr 1803 Grand Saline, TX 75140

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but , but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury for 2 of 6 (Resident # 4 and Resident #5) residents reviewed for abuse and neglect. The facility staff did not report to the state agency Resident #4's complaint of physical abuse by CNA J and CNA K on 2/17/25. The facility staff did not report to the state agency Resident #5's diagnosis of a subdural hematoma (a pool of blood between the brain and its outermost covering) discovered following an unwitnessed fall on 4/11/25. This failure could place residents at risk of injuries, abuse, and/or neglect. Findings Include: 1. Record review of the face sheet dated 5/8/25 indicated Resident #4 was a [AGE] year-old male, readmitted to the facility on [DATE] with diagnoses including contracture (a structural change in the body's soft tissues, like muscles, tendons, ligaments, or skin that causes them to stiffen or shorten), unspecified joint; contracture of muscle, multiple sites; abnormal posture; muscle weakness; and dementia. Record review of the MDS dated [DATE] indicated Resident #4 understood others and was understood by others. The MDS indicated Resident #4 had a BIMS of 12 and was moderately cognitively impaired. The MDS indicated Resident #4 was dependent on staff for toileting, showering, personal hygiene, and transfers. The MDS indicated Resident #4 required substantial/maximum assist with rolling left and right, sitting to lying, and lying to sitting on the side of the bed. Record review of the care plan last revised 4/1/25 indicated Resident #4 had verbal behavior symptoms directed towards others. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a grievance dated 2/17/25 indicated Resident #4 reported to the DON that when CNA J and CNA K were changing him, they were rough with him. The grievance indicated Resident #4 said they pulled his leg when repositioning him. The grievance indicated Resident #4 said the CNAs had been rough with him the morning of 2/17/25. The grievance indicated the DON explained to Resident #4 that CNA J and CNA were not at the facility the morning of 2/17/25. The grievance indicated Resident #4 said CNA K rolled up a rag and slapped him in the testicles with it and knocked a scab off his foot. The grievance indicated the DON explained to Resident #4 that the wound care physician had just seen him and removed a scabbed area to his foot due to it being healed. The grievance indicated the DON notified the Social Worker at this time to assist in interviewing the resident. The grievance indicated the Administrator was notified of the allegation. Record review in TULIP (online system for intakes regarding facility reported incidents and complaints in nursing facilities) for 2/17/25 through 5/8/25 indicated the facility had not reported to the state agency the allegation of abuse made on 2/17/25 by Resident #4. During an interview on 5/8/25 at 9:13 am Resident #4 said he did not remember the incident from January or February 2025 with 2 CNAs being rough during care and one of them hitting him in the testicles. Resident #4 said staff had been rough with him, but he could not remember any details. Resident #4 said he was not scared of anyone in the facility. During an interview on 5/8/25 at 9:36 a.m. the Administrator said she did a full investigation regarding the allegation of abuse made by Resident #4 in February 2025. The Administrator said she did not report the allegation of abuse to the state agency due to the fact the CNAs that were accused of physical abuse by Resident #4 had not worked the day and time he said the incident occurred. The Administrator said she did not think a self-report needed to be done for CNAs who were not in the building for the time of the allegation. 2. Record review of the face sheet dated 5/9/25 indicated Resident #5 was a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses including dementia, dizziness, hallucinations, and hypertension (elevated blood pressure). Record review of the MDS dated [DATE] indicated Resident #5 usually understood others and was usually understood by others. The MDS indicated Resident #5 had a BIMS of 08 and was moderately cognitively impaired. The MDS indicated Resident #5 did not use a wheelchair and was independent with ambulation. Record review of the care plan last revised on 4/15/25 indicated Resident #5 was at risk for falls related to change in environment and admission to the facility. Record review of an incident report dated 4/11/25 indicated Resident #5 had an unwitnessed fall. The incident report indicated Resident #5 was found in the floor in front of his bedroom door on his right side with his head lying on the bed handles. The incident report indicated Resident #5 was noted to be bleeding on the top of the head with a hematoma (localized collection of blood often due to injury or trauma). The incident report indicated Resident #5 said he had tripped getting out of bed and hit his head. The incident report indicated Resident #5 was transported to the hospital for evaluation. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the hospital discharge paperwork dated 4/12/25 indicated Resident #5's primary diagnosis was subdural hematoma. Record review of TULIP (online system for intakes regarding facility reported incidents and complaints in nursing facilities) for dated 4/11/25 through 5/8/25 indicated the facility had not reported to the state agency Resident #5's fall with major injury on 4/11/25. During an interview on 5/9/25 at 12:19 p.m. the DON said she had been working as a charge nurse on 4/11/25 when Resident #5 had a fall. The DON said the fall was unwitnessed. The DON said the CNA (name not provided) came to get her regarding Resident #5's fall. The DON said he was lying in the floor by his door. The DON said he had got himself up out of bed and tripped causing the fall. The DON said he was sent to the ER for evaluation. The DON said she had logged on to the hospital records between 11:00 and 11:30 am and saw Resident #5 had a diagnosis of subdural hematoma. The DON said the Administrator was responsible for reporting incidents to the state agency. During an interview on 5/9/25 at 12:47 p.m. the Administrator said she was responsible for reporting incidents to the state agency. The Administrator said abuse, neglect, misappropriation, injury of unknown source, and death of unusual circumstances should be reported to the state agency. The Administrator said the importance of reporting incidents to the state agency was to enable complete investigations to be performed and prevention of future incidents. Record review of the facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy revised 9/2022 indicated, All reports of resident abuse (including injuries of unknown origin), neglect exploitation, or theft/misappropriation of the resident property are reported to local, state, and federal agencies (as requires by current regulations) and thoroughly investigated by facility management. Findings of all investigation are documented and reported. Reporting Allegations to the Administrator and Authorities: 1. If resident abuse, neglect, exploitation, misappropriation of resident property, or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law and HHSC reporting guidelines .3. Immediately is defined as: a, within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury .6. Upon receiving any allegation of abuse, neglect, exploitation, misappropriation of resident property, or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for protection of the resident .

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review, the facility failed to ensure the necessary treatment and services, in accordance with comprehensive assessment and professional standards of practice, to prevent development of pressure injuries was provided for 1 of 4 (Resident #1) residents reviewed for pressure injuries. The facility failed to ensure Resident #1 did not develop a DTI to her right heel. These failures could place residents at risk for development of pressure ulcers, worsening of existing pressure injuries, infection, pain, and decreased quality of life. Findings included: 1. Record review of the face sheet dated 5/9/25 indicated Resident #1 was a [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses including dementia, diabetes, hypertension (elevated blood pressure), difficulty walking, and muscle weakness. Record review of the comprehensive MDS dated [DATE] indicated Resident #1 usually understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS score of 03 and was severely cognitively impaired. The MDS indicated Resident #1 was at risk for developing pressure ulcers/injuries and did not have any skin and ulcer/injury treatments in place. Record review of the care plan revised on 2/22/25 indicated Resident #1 was at risk for skin breakdown related to incontinence of bowel and bladder, use of wheelchair, disease process, and food and beverage intake with interventions including skin assessment and inspection every shift with close attention to heels. Record review of the physician's orders dated 5/9/25 indicated Resident #1 had an order to cleanse the DTI to the right heel every day shift and to offload heels while in bed every day and night shift starting 5/4/25. Record review of a skin assessment dated [DATE] indicated Resident #1had no alterations in skin integrity. Record review of a skin assessment dated [DATE] written by RN B indicated Resident #1 had blanchable redness (skin that appear red due to increased blood flow, but becomes paler or white when pressure is applied, returning to its normal color when pressure is release) to her sacrum (the area at the bottom of the spine). Record review of the progress note dated 5/3/25 written by RN A indicated Resident #1 had a dark tissue area with surrounding redness to her right heel measuring 2.5cm x 1.5cm. The progress note indicated RN A cleansed the area with normal saline and applied skin prep (skin protectant or barrier film used to protect skin from various irritants and damage) to Resident #1's heel. The progress note indicated RN A notified the NP and Resident #1's responsible party regarding Resident #1's change in skin condition. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/25 at 11:57 a.m. RN A said she was familiar with Resident #1. RN A said when she came to work on 5/3/25 and she noted Resident #1 was not doing well (no specifics were given) and saw the dark colored area to her heel. RN A said she had not noticed the area to Resident #1's heel prior, but the nurses did not perform skin assessments, the treatment nurse had been responsible for skin assessments. RN A said she contacted the physician regarding the area to Resident #1's heel and obtained an order for skin prep daily. During an interview on 5/8/25 at 2:07 p.m. the Hospital Nurse said Resident #1 had redness to her bottom with no open area and a DTI to her right heel. During an observation at the hospital on 5/8/25 at 2:10 p.m. Resident #1's right heel indicated there was no open areas or eschar (necrotic, dead tissue that is often black or brown in the wound bed). Resident #1's right heel had a dark purple area with surrounding redness consistent with a DTI. During an interview attempt on 5/9/25 at 9:50 a.m. RN B's voicemail was full, and the surveyor was unable to leave a message. During an interview on 5/9/25 at 9:56 a.m. LVN C said the week of 5/5/25 was the facility's first week without a treatment nurse in a month. LVN C said she did not remember the last time she had seen Resident #1's feet. LVN C said nurses had not been responsible for skin assessments. LVN C said it had been the treatment nurse's responsibility to complete skin assessments. During an interview on 5/9/25 at 10:00 a.m. CNA D said residents received showers 3 times a week on Monday, Wednesday, and Friday or on Tuesday, Thursday, and Saturday. CNA D said Resident #1's scheduled showers were on the 6:00 a.m.-2:00 p.m. shift on Monday, Wednesday, and Friday. CNA D said she was off on 5/2/25 but had worked and given Resident #1 her shower on 4/30/25. CNA D said she did not notice any discoloration or skin issues to Resident #1's heel on 4/30/25 when giving her a shower. During an interview on 5/9/25 at 12:19 p.m. the DON said skin assessments should be performed on admission and weekly. The DON said when the facility had a treatment nurse the treatment nurse was responsible for completing skin assessments. The DON said if a resident's care plan said they should have a skin assessment every shift she would expect the resident to have a skin assessment every shift. The DON said she was not aware of any resident with a care plan indicating they should have a skin assessment every shift. The DON said the importance of skin assessments was to monitor the skin and prevent pressure ulcers and major skin issues. During an interview on 5/9/25 at 12:47 pm the Administrator said she would have to look at the policy to answer when skin assessments should be performed. The Administrator said the importance of skin assessments was to prevent further skin breakdown, identify areas of concerns, and for infection prevention. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Prevention of Pressure Injuries policy revised 4/2021 indicated, The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and intervention for specific risk factors. Preparation: Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Risk Assessment: 1. Assess the resident on admission (within four hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. 2. Use the standard pressure injury screening tool to determine and document risk factors. 3. Supplement the use of a risk assessment tool with assessment of additional risk factors. Skin Assessment .3. Inspect the skin on a daily basis when performing or assisting with personal care od ADLs. a. Identify any signs of developing pressure injuries. For darkly pigmented skin, inspect for changes to skin tone, temperature, or consistency. b. Inspect pressure points (sacrum, heels, buttocks, coccyx (the last bone at the bottom of the spine), elbows, ischium (a paired bone forming the lower and back parts of the hip), trochanter (a bony prominence found on the femur (though bone) near the hip), etc.) .

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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. 44637 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 5 staff (CNA F and CNA G) viewed for infection control. The facility failed to ensure the CNA F performed hand hygiene between glove changes while performing incontinent care on Resident #2. The facility failed to ensure CNA G changed gloves and performed hand hygiene after taking a dirty wipe from CNA H and handing her a clean wipe during incontinent care for Resident #3. These failures could place residents and staff at risk for cross-contamination, spread of infection and could potentially affect all others in the building. Findings Include : 1. During an observation on 5/8/25 at 9:57 a.m. CNA E and CNA F performed incontinent care on Resident #2. CNA E and CNA F knocked on the door prior to entering the room, explained the procedure, provided privacy, and performed hand hygiene prior to putting on gloves and beginning incontinent care. CNA F opened Resident #2's wet brief then changed her gloves without performing hand hygiene. CNA F wiped Resident #2's vaginal area with disposable wipes, removed the wet brief, changed gloves, and did not perform hand hygiene. CNA E assisted Resident #2 in turning over. CNA F wiped Resident #2's bottom using disposable wipes, changed gloves, and did not perform hand hygiene. CNA F put a clean brief on Resident #2, changed gloves, and did not perform hand hygiene. CNA F retrieved lotion from the bedside table, applied lotion to Resident #2's feet, changed gloves, and did not perform hand hygiene. CNA F put the lotion back on bedside table, covered Resident #2 up, removed her gloves, and washed her hands. Record review of the Clinical Competency: Handwashing dated 9/10/24 indicated CNA F had been checked off on proper handwashing techniques. During an interview on 5/9/25 at 10:27 a.m. CNA F said hand hygiene should be performed when providing resident care (did not specify what care) . CNA F said hand hygiene should not be performed between glove changes . CNA F said the importance of proper hand hygiene was to prevent the spread of infections. 2. During an observation on 5/8/25 at 10:07 a.m. CNA G and CNA H performed incontinent care on Resident #3. CNA G and CNA H knocked on the door prior to entering the room, explained the procedure, provided privacy, and performed hand hygiene prior to donning gloves and beginning incontinent care. CNA H opened the wet brief, took a clean wipe from CNA G, and wiped Resident #3's vaginal area. CNA H handed the dirty wipe to CNA G. CNA G threw away the dirty wipe, did not change her gloves or perform hand hygiene, and handed CNA H a clean wipe. Resident #3 rolled to her side and CNA H wiped Resident #3 bottom. CNA G handed CNA H a clean brief. CNA G and CNA H both removed their gloves, performed hand hygiene, and donned clean gloves. CNA H placed clean brief on Resident #3. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/25 10:07 a.m. CNA G said she should have changed her gloves and performed hand hygiene after she took the dirty wipe from CNA H and before handing her clean wipes or a clean brief. CNA G said she did not change her gloves and perform hand hygiene when she should have because she was nervous. CNA G said the importance of changing gloves and performing hand hygiene was to prevent cross contamination. During an interview on 5/9/25 at 12:19 p.m. the DON said she expected staff to perform hand hygiene before providing care, when going from dirty to clean, after providing care, and between glove changes. The DON said the importance of proper hand hygiene was to prevent the spread of infections. During an interview on 5/9/25 at 12:47 p.m. the Administrator said she expected staff to perform hand hygiene before putting on gloves, after taking offgloves, and when hands were visibly soiled. The Administrator said the importance of proper hand hygiene was prevention of the spread of infections. Record review of the facility's Handwashing/Hand Hygiene policy last revised 1/2025 indicated, The facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Administrative practices to Promote Hand Hygiene: 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to prevent the spread of infections to other personnel, residents, and visitors .Indications for Hand Hygiene: 1. Hand hygiene is indicated: a. Immediately before touching a resident .c. After contact with blood, body floods, or contaminated surfaces .f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal .