

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER Country Trails Wellness & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	

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)
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>41695</p> <p>Bases on observations, interviews and record reviews, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 1 of 2 staff (LVN A) reviewed for nursing services.</p> <p>LVN A did not don a gown prior to administering Resident #18's medications, who was on enhanced barrier precautions (EBP).</p> <p>The facility did not ensure LVN A received initial EBP training upon hire.</p> <p>These failures placed could place residents at risk for cross-contamination and the spread of communicable diseases and infections.</p> <p>Findings included:</p> <p>During observation of medication administration via Resident #18's gastrostomy tube on 11/12/2024 at 11:10 AM, LVN A was observed to prepare a medication for administration, perform hand sanitation, obtain a pair of disposable gloves from her medication cart, and don the gloves. Upon entry into Resident #18's room, a sign indicating the need for EBP was noted on the door and a clear plastic 3-drawer container with PPE in it was noted just inside the door. LVN A did not don a gown prior to administering medication. LVN A disconnected Resident #18's gastrostomy tube from the feeding pump, checked the tube for patency, inserted a 30ml syringe barrel into the gastrostomy tube, and then poured the medication and prescribed water flushes into the syringe barrel. LVN A completed the procedure, removed the syringe barrel from the gastrostomy tube, and reconnected the gastrostomy tube to the feeding pump. She then removed and disposed of her gloves, performed hand sanitation, and left the room.</p> <p>(continued on next page)</p>

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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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with LVN A on 11/12/2024 at 01:15 PM, she said residents who had open wounds or indwelling devices required EBP. She said a gastrostomy tube was considered an indwelling device. LVN A said residents who required EBP had a sign on their doors to communicate the need for EBP. She said Resident #18 had an EBP sign on the door to his room. She said EBP meant Enhanced Barrier Precautions which meant gloves and gowns were to be worn when providing direct care. LVN A said she forgot to don a gown prior to administering medications via the gastrostomy route. LVN A said she should have donned a gown to reduce the risk of cross-contamination and prevent the spread of communicable diseases. LVN A said she had been worked at the facility about a month and had not been trained on EBP at this facility.</p> <p>During an interview with LVN B on 11/12/2024 at 01:20 PM, she said the focus of EBP was the use of gloves and a gown when providing direct patient care to residents with wounds and/or indwelling devices. She said administering medications through a gastrostomy tube was considered direct patient care and would require the nurse to sanitize his/her hands and put on gloves and a gown prior to starting the procedure.</p> <p>During an interview with the DCO on 11/12/2024 at 02:00 PM, she said LVN A should have donned both gloves and a gown prior to administering medications. The DCO said the facility had no evidence of LVN A being trained on EBP upon hire.</p> <p>During an interview with the DON on 11/13/2024 at 09:00 AM, she said she expected nursing staff to follow the facility's policy and EBP protocol when providing care to residents with wounds and/or indwelling devices to reduce the risk of spreading disease.</p> <p>During an interview on 11/13/2024 at 11:36 AM, RN DCO stated that there was no evidence of EBP training of employees on hire. She was able to state a potential negative outcome for failure to observe EBP on at-risk residents.</p> <p>During an interview on 11/13/2024 at 3:30 PM with the BOM, she said she was responsible for new hire employees and no new hire was trained or checked off on EBP.</p> <p>Record review of LVN A's new hire orientation and new associate training indicated reflected she had not received any training on EBP nor the facility's EBP policy.</p> <p>During an observation on 11/11/2024 at approximately 10:30 AM, revealed rooms #107, #401, and #609 had EBP signage on the doors with no PPE supplies noted at or near the entrance to the residents' rooms nor was there any PPE set up inside the residents' rooms.</p> <p>Record review on 11/13/2024 of a New Associate checklist, dated as revised February 2024, reflected EBP was not addressed upon hire.</p> <p>Record review on 11/13/2024 of New Hire Orientation Checklist, dated as revised May 2019, did not address EBP upon hire.</p> <p>A record review of the facility's EBP signage (developed by CDC) indicated reflected the following:</p> <p>Providers and staff must also wear gloves and a gown for the following High-Contact Resident Care Activities.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>.Device care or use: .feeding tube :</p> <p>A record review of the facility's, undated, policy titled Enhanced Barrier Precautions Policy reflected the following:</p> <p>Definitions</p> <p>EBP are an infection control intervention designed to reduce transmission of MDROs in nursing homes. EBP expands upon Standard Precautions by requiring the use of gowns and gloves during specific high-contact resident care activities for residents known to be colonized or infected with an MDRO as well as those at risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).</p> <p>Examples of high-contact resident care activities requiring gown and glove use for residents on EBP include, but not limited to:</p> <p>.Device care or use .feeding tubes .</p> <p>Indwelling medical device is a device that provided a direct pathway for pathogens in the environment to enter the body and cause infection.</p> <p>Staff Awareness and Training:</p> <p>1.All staff members will receive initial training on EBP upon hire and refresher training annually thereafter.</p> <p>2.Training will include identification of when EBH are needed: Which residents should be placed in EBP, MDRO (Multidrug-resistant Organisms) for which EBP are required, and high contact resident care activities for which EBP should be used.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>27140</p> <p>Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions for 1 of 1 facility kitchens.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure scoops were not left in the flour in the bulk flour bin. 2. The facility failed to ensure a box of raw cabbage was not stored on the floor in front of the reach in cooler. 3. The facility failed to ensure food items were labeled or dated. <p>These failures could place residents who ate food from the kitchen at risk of foodborne illness.</p> <p>Findings included:</p> <p>During observations and interviews on 11/11/24 of the kitchen the following was noted:</p> <p>*at 10:10 AM a scoop was left inside the flour in the bulk flour bin in the dry pantry. The DM removed the scoop and placed it in its designated storage hanger. She said new kitchen staff have not learned everything yet and indicated the scoop was labeled flour and the storage hanger indicated flour.</p> <p>*at 10:18 AM a box of raw cabbage was stored on the floor in front of the 2 door cooler.</p> <p>*at 10:19 AM in the 2 door cooler a resealable bag of breadsticks was not labeled or dated.</p> <p>*at 10:25 AM in the single door cooler the following was noted: a large plastic container containing a solid orange-brown substance was not labeled or dated, 1-46 oz. nectar thick cranberry juice had no open date, 1-46 oz. nectar thick apple juice had no open date, 1-46 oz. nectar thick sweetened tea with lemon had no open date, packaging on the nectar thickened liquids indicated After opening may be kept up to 7 days under refrigeration, and 1-2 quart pitcher of tomato juice was not labeled or dated.</p> <p>During an interview on 11/11/2024 at 10:38 AM the DM said she had no idea what substance was in the plastic container because that was normally the beverage cooler. She said the thickened liquids were to be dated when opened. She said the dates on the boxes were the truck date indicating when they were delivered to the facility. She said there had been a spill in the cooler that needed to be cleaned before she put the cabbage in the cooler.</p> <p>During an observation on 11/12/24 11:02 AM the box of raw cabbage was still stored on the floor in front of the 2 door cooler and in the single door cooler the plastic container containing the solid orange-brown substance was still unlabeled and dated and the pitcher of tomato juice was not labeled and dated.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a facility policy, dated 12/01/11, on Food Storage indicated .1. e. Scoops are used for items stored in bins, such as sugar, flour, rice, and other items. Scoops are stored covered in protected area near the food containers .i. All items are stored at least 6 inches above the floor .Food is stored on clean racks or shelves .2. e. All refrigerated foods are dated, labeled, and tightly sealed, including leftovers, using clean, nonabsorbent, covered containers that are approved for food storage. All leftovers are used within 48 hours .</p> <p>Food and Drug Administration Code, Dated, 2013, indicated: 3-305.11 Food Storage.</p> <p>(A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD:</p> <p>(1) In a clean, dry location;</p> <p>(2) Where it is not exposed to splash, dust, or other contamination; and</p> <p>(3) At least 15 cm (6 inches) above the floor.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42190</p> <p>47204</p> <p>Based on observations, interviews, and record reviews, 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 infections for 4 of 12 residents (Residents #18, #20, #58, #60) reviewed for infection control.</p> <p>1.The facility failed to ensure LVN A wore the appropriate PPE while administering medications to Resident #18 who required EBP.</p> <p>2.The facility failed to provide appropriate containers to dispose of contaminated PPE for Residents #20, #58, and #60 who required contact isolation.</p> <p>These failures could place residents at risk for cross-contamination and the spread of communicable diseases and infections.</p> <p>Findings included:</p> <p>1.A record review of Resident #18's face sheet dated 11/13/2024 indicated he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #18 had diagnoses which included gastrostomy tube placement (a flexible, hollow tube that is inserted into the stomach through the abdominal wall) and spastic quadriplegic cerebral palsy (the most severe form of cerebral palsy which is a permanent neuromuscular disorder affecting all four limbs of the body and is characterized by severe stiffness of arms and legs and other developmental disabilities such as intellectual disabilities, seizures, inability to walk, and problems with speech, vision, and hearing).</p> <p>A record review of an annual MDS dated [DATE] indicated Resident #18 was rarely or never understood, non-verbal, incontinent of bowel and bladder, had impaired vision, and was dependent on staff for all activities of daily living. The same MDS indicated Resident #18 received nutrition, water, and medications by way of a gastrostomy tube (also called a feeding tube).</p> <p>A record review of Resident #18's care plan dated 05/23/2024 indicated Resident had a concern for risk of infection and EBP were to be observed when providing care.</p> <p>During observation of medication administration via Resident #18's gastrostomy tube on 11/12/2024 at 11:10 AM, LVN A was observed to prepare a medication for administration, perform hand sanitation, obtain a pair of disposable gloves from her medication cart, and don the gloves. LVN A did not put on any additional PPE. Upon entry into Resident #18's room, a sign indicating the need for EBP was noted on the door and a clear plastic 3-drawer container with PPE in it was noted just inside the door. LVN A disconnected Resident #18's gastrostomy tube from the feeding pump, checked the tube for patency, inserted a 30ml syringe barrel into the gastrostomy tube, and then poured the medication and prescribed water flushes into the syringe barrel. LVN A completed the procedure, removed the syringe barrel from the gastrostomy tube, and reconnected the gastrostomy tube to the feeding pump. She then removed and disposed of her gloves, performed hand sanitation, and left the room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with LVN A on 11/12/2024 at 01:15 PM, she said residents who had open wounds or indwelling devices required EBP. She said a gastrostomy tube was considered an indwelling device. LVN A said residents who required EBP had a sign on their doors to communicate the need for EBP. She said Resident #18 had an EBP sign on the door to his room. She said EBP meant Enhanced Barrier Precautions which meant gloves and gowns were to be worn when providing direct care. LVN A said she forgot to don a gown prior to administering medications via the gastrostomy route. LVN A said she should have donned a gown to reduce the risk of cross-contamination and prevent the spread of communicable diseases. LVN A said she worked at the facility about a month and had not been trained on EBP at this facility.</p> <p>During an interview with LVN B on 11/12/2024 at 01:15 PM, she said the focus of EBP was the use of gloves and a gown when providing direct patient care to residents with wounds and/or indwelling devices. She said administering medications through a gastrostomy tube was considered direct patient care and would require the nurse to sanitize his/her hands and put on gloves and a gown prior to starting the procedure.</p> <p>During an interview with the DCO on 11/12/2024 at 02:00 PM, she said LVN A should have donned both gloves and a gown prior to administering medications to Resident #18. The DCO said the facility had no evidence of LVN A being trained on EBP upon hire. The DCO said the facility's policy was for all staff to be trained on EBP upon hire.</p> <p>During an interview with the DON on 11/13/2024 at 09:00 AM, she said she expected nursing staff to follow the facility's policy and EBP protocol when providing care to residents with wounds and/or indwelling devices to reduce the risk of spreading disease. The DON said the facility's policy required staff to wear both gloves and a gown when providing direct patient care to residents with a gastrostomy tube.</p> <p>2. During an observation on 11/11/2024 at 10:20AM, posted signage on resident #58's door indicated contact isolation. Resident #58 was observed in bed asleep. Resident #58's room did not have a lined bio-hazard container in the room to place doffed PPE into.</p> <p>During observation on 11/11/2024 at 10:46AM, posted signage on resident #20's door indicated contact isolation. Resident #20 was observed, sitting in a chair, in her room. Resident #20's room did not have a lined bio-hazard container to place doffed PPE into.</p> <p>During observation on 11/11/2024 at 11:11AM, posted signage on resident #60's door indicated contact isolation. Resident #60 was standing in the doorway of his room. Resident #60's room did not have a lined bio-hazard container to place doffed PPE into.</p> <p>During an interview on 11/23/2024 at 2:36PM, HK-G said Resident #58 did not have anything in her room to put doffed PPE into. She said when she went out of the room, she put her PPE in the trash on her housekeeping cart.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/13/2024 at 3:06PM, CNA-F said bio-hazard boxes were not in the rooms of residents who were identified as requiring contact isolation on 11/11/2024. She said she last worked on 11/08/2024 and there was no bio-hazard boxes in either of the 3 rooms with contact isolation signage on the door. She said 11/11/2024 was her first day back to work and there were no bio-hazard boxes in any room with contact isolation signage on the door. She said she was in-serviced that she had to put on a gown and wear gloves when she entered to provide care or service. She said once, when she doffed, she put her PPE in a plastic bag and removed it from the room and the other times she exited, she said she put the PPE in the trash can in the room.</p> <p>During an interview on 11/13/2024 at 3:31PM, the DON said contact isolation meant staff should put on a gown and wear gloves, before entering a room with contact isolation signage on the door. She said staff should doff before exiting and doffed PPE should go in a bio-hazard box, in the room. She said all staff were in-serviced and bio-hazard boxes were in the rooms identified as contact isolation. The DON said medical services notified housekeeping, who provided the bio-hazard box for the rooms identified as contact isolation. She said it was medical services responsibility to place the bio-hazard box in the room for doffed gloves and gowns.</p> <p>A record review of the facility's EBP signage (developed by CDC) indicated the following:</p> <p>Providers and staff must also wear gloves and a gown for the following High-Contact Resident Care Activities.</p> <p>.Device care or use: .feeding tube .</p> <p>A record review of the facility's undated policy titled Enhanced Barrier Precautions Policy indicated the following:</p> <p>Examples of high-contact resident care activities requiring gown and glove use for residents on EBP include, but not limited to: .Device care or use .feeding tubes .</p> <p>Record review of a revised policy, dated 03/2020, titled: Isolation - Categories of Transmission-Based Precautions indicated the following:</p> <p>c. Gloves and Handwashing (3) Remove gloves before leaving the room and perform hand hygiene. d. Gown (1) Wear a disposal gown entering the Contact Precautions room or cubicle. (2) After removing the gown, do not allow clothing to contact potentially contaminated environmental surfaces.</p> <p>A record review of CDC guidelines indicated the following:</p> <p>Transmission-Based Precautions (April 3, 2024)</p> <p>Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission. Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens.</p> <p>How do you safely remove and dispose of PPE?</p> <p>(continued on next page)</p>		

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