

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675947	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Country Care Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 2736 Farm to Market 775 LA Vernia, TX 78121	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 4 of 8 residents (Residents #12, #24, #40, and #46) reviewed for oral care.</p> <ol style="list-style-type: none"> 1. Resident #46 was not assisted with brushing her teeth on 09/17/2024. 2. Resident #40 was not assisted with brushing her teeth on 09/17/2024. 3. Resident #12 was not assisted with brushing her teeth on 09/17/2024. 4. Resident #24 was not assisted with brushing her teeth on 09/17/2024. <p>These failures could place residents at risk for a decline in health status with dental caries and oral infections.</p> <p>The findings included:</p> <p>Resident #46</p> <p>A record review of Resident #46's admission record dated 09/18/2024, revealed an admitted [DATE] with diagnoses which included polyarthritis (five or more of your joints have arthritis at the same time) and contracted left and right hands, contracted left and right knees.</p> <p>A record review of Resident #46's quarterly MDS assessment dated [DATE] revealed Resident #46 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 09 out of a possible 15 which indicated moderate impaired cognition. Further review revealed Resident #46 had no difficulty hearing, had clear speech, could understand others and could make herself understood, Resident #46 had adequate vision with the use of glasses. Further review revealed Resident #46 was totally dependent on staff and needed total assistance with oral care, personal hygiene, and transfers.</p> <p>A record review of Resident #46's care plan dated 09/18/2024 revealed, I am at risk for oral care issues: . provide and set up oral care supplies as indicated</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of Resident #46's physician's orders dated 09/18/2024 revealed Resident #40's physician on 11/22/2020, ordered for Resident #40 to receive oral care as needed.</p> <p>A record review of Resident #46's medical record for the month of September 2024, revealed CNAs had not documented oral care that was offered, preformed, and or refused.</p> <p>During an observation and interview on 09/15/24 at 10:50 AM revealed Resident #46 in her bed with the head of the bed up where she was positioned in a way so she could access her call light and her water drink with her left and right contracted hands. Further observation revealed Resident #46 had toothpaste and toothbrushes on a cubbyhole shelf by her bed. Resident #46 stated the supplies were brought to her by family member however they remained unused. Continued observations revealed LVN KT attended to Resident #46 at her bedside. Resident #46 stated she had complaints that she was not assisted with activities of daily life especially in the morning, on Fridays when church people come in, I would like my face washed and teeth brushed . I cannot do it myself I have bad arthritis. It's been weeks since I had help. LVN KT stated she worked part time on the weekends and stated Resident #46 should be assisted with her oral care due to her arthritis. LVN KT stated she was not aware if Resident #46 had her teeth brushed today and commented Resident #46 often refuses care.</p> <p>During an interview and observation on 09/17/24 at 08:30 AM revealed Resident #46's toothbrush and toothpaste in the same position and conditions as observed on 09/15/2024. Resident #46 stated no one has brushed her teeth today, yesterday and the day before. Further observation revealed Resident #46 in her bed receiving assistance eating her breakfast from CNA transport. Resident #46 stated she had not received assistance with oral care and CNA stated she had brushed her teeth this morning to which Resident #46 strongly denied and stated she had not had her teeth brushed this week.</p> <p>During an interview on 09/18/2024 at 02:44 PM Resident #46's representative and MPOA stated she believed Resident #46 had rarely received oral care. Resident #46's representative and MPOA stated she visited Resident #46 2-3 times a month and has recognized the unused toothbrushes and toothpaste. Resident #46's representative and MPOA stated Resident #46 was vulnerable and relies on staff for all care. Resident #46's representative and MPOA stated she believed the staff CNAs were caring but were short staffed and would not offer oral care like teeth brushing. Resident #46's representative and MPOA stated she had recognized a decline in Resident #46's oral health to include bad breath and dirty teeth.</p> <p>Resident #40</p> <p>A record review of Resident #40's admission record dated 09/18/2024, revealed an admitted [DATE] with diagnoses which included aphasia (impairment of language, speech, comprehension, and the ability to read and write), multiple sclerosis (a disease where a person's own immune system deteriorates muscle nerves), and myasthenia gravis (results from a problem in signaling between nerves and muscles.)</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of Resident #40's quarterly MDS assessment dated [DATE] revealed Resident #40 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 06 out of a possible 15 which indicated severe impaired cognition. Further review revealed Resident #40 had minimal difficulty hearing, clear speech, could usually understand and could usually make herself understood, Resident #40 had impaired vision, did not use glasses, and could see large print. Further review revealed Resident #40 needed assistance with oral care, personal hygiene, and transfers. Resident #40 was totally dependent on staff for activities of daily life to include personal hygiene and transfers (bed to chair) and Resident needed, substantial maximal assistance helper does more than half the effort with oral care.</p> <p>A record review of Resident #40's care plan dated 09/18/2024 revealed, I am at risk for oral care issues: own teeth, some loss or carious teeth. provide and set up oral care supplies as indicated</p> <p>A record review of Resident #40's physician's orders dated 09/18/2024 revealed Resident #40's physician on 05/30/2023, ordered for Resident #40 to receive oral care as needed.</p> <p>A record review of Resident #40's medical record revealed CNAs had nowhere to document oral care that was offered, preformed, and or refused.</p> <p>During an interview on 09/15/2024 at 10:48 AM Resident #40 stated she could not recall when staff had offered assistance with brushing her teeth. Resident #40 stated she had not had her teeth brushed today.</p> <p>During an interview on 09/17/2024 at 08:48 AM Resident #40 stated she could not recall when staff had offered assistance with brushing her teeth. Resident #40 stated she had not had her teeth brushed today.</p> <p>Resident #12</p> <p>A record review of Resident #12's admission record dated 09/18/2024, revealed an admitted [DATE] with diagnoses which included dementia (a group of symptoms affecting memory, thinking and social abilities. In people who have dementia, the symptoms interfere with their daily lives), and end stage COPD (chronic obstructive pulmonary disease).</p> <p>A record review of Resident #12's annual MDS assessment dated [DATE] revealed Resident #12 was an [AGE] year-old female admitted for long term care and diagnosed with a life expectancy of less than 6 months. Resident #12 was assessed with a BIMS score of 05 out of a possible 15 which indicated severe cognitive impairment. Resident #12 was assessed and needed substantial maximal assistance helper does more than half the effort with transfers to and from a bed to a chair or wheelchair.</p> <p>A record review of Resident #12's physician's orders dated 09/18/2024 revealed Resident #12's physician on 11/07/2022, ordered for Resident #12 to receive oral care as needed.</p> <p>A record review of Resident #12's medical record revealed CNAs had nowhere to document oral care that was offered, preformed, and or refused.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 09/15/2024 at 12:20 PM Resident #12 and her family member were observed in Resident #12's bedroom. Resident #12 was seated in her wheelchair and appeared sleepy. Resident #12's family member was concerned Resident #12 was not receiving assistance from staff to eat and daily hygiene, specifically teeth brushing. Resident #12's family member stated they had been visiting 1-2 times a month for the last 6-7 months and had never seen any evidence Resident #12 was receiving dental care as evidenced by the same toothpaste tube and new toothbrushes stored in Resident #12's dresser. Observation of Resident #12's dresser drawer revealed new toothbrushes and a tube of tooth paste in good condition.</p> <p>During an observation and interview on 09/16/2024 at 8:30 AM revealed Resident #12 and her family member #2 were in Resident #12's bedroom while Resident #12 ate her breakfast. Resident #12's family member #2 stated she visited 3 times a week and had never seen Resident #12 receive assistance with brushing her teeth as evidenced by unused toothpaste and brushes. Resident #12's family member #2 stated their expectation would be that Resident #12 would receive oral care daily prior to breakfast.</p> <p>Resident #24</p> <p>A record review of Resident #24's admission record dated 09/18/2024 revealed an admitted [DATE] with diagnoses which included Alzheimer's disease (a disabling degenerative disease of the nervous system occurring in middle-aged or older persons and characterized by dementia and failure of memory for recent events, followed by total incapacitation and death), muscle wasting, and heart failure.</p> <p>A record review of Resident #24's quarterly MDS assessment dated [DATE] revealed Resident #24 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 08 out of a possible 15 which indicated moderately impaired cognition. Further review revealed Resident #24 needed assistance with personal hygiene and transfers, substantial maximal assistance helper does more than half the effort with transfers to and from a bed to a chair or wheelchair and partial / moderate - helper does less than half the effort.</p> <p>A record review of Resident #24's physician's orders dated 09/18/2024 revealed Resident #24's physician on 04/07/2024, ordered for Resident #24 to receive oral care as needed.</p> <p>A record review of Resident #24's medical record revealed CNAs had nowhere to document oral care that was offered, preformed, and or refused.</p> <p>During an observation and interview on 09/15/2024 at 10:44 AM revealed Resident #24 in her bedroom lying in bed. Resident #24 stated she had lived in the facility since spring and has not been offered to brush her teeth since. Resident #24 stated she would like to be offered a mouthwash if she could be assisted to the bathroom. Resident #24 stated she may not brush her teeth daily but would like to be offered assistance daily.</p> <p>During an observation and interview on 09/16/2024 at 1:44 PM revealed Resident #24 in her bedroom lying in bed while her representative visited. Resident #24's representative and Resident #24 stated the facility had treated her fine, but the facility had not offered to assist with brushing her teeth over the weeks she had been admitted .</p> <p>During an interview on 09/17/2024 at 8:50 AM Resident #24 stated she was not offered assistance with brushing her teeth.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/17/2024 at 8:28 AM CNA D stated she was the CNA for Residents #12, #24, #40, and #46 as well as other residents on 100-hall. CNA D stated she had not had time to provide residents on 100-hall oral care.</p> <p>During a joint interview on 09/17/2024 at 09:40 AM with ADON E and ADON F stated residents should be assisted and or offered assistance with oral care, teeth brushing, denture cleaning, and mouth washing at a minimum once a day in the mornings and preferably 2x a day morning and evening. The ADONs stated lack of oral care could lead to a health status decline with poor oral health.</p> <p>During a joint interview on 09/18/2024 at 03:00 PM with the Administrator and the DON, the administrator stated residents should receive oral care daily and staff should document the care. The DON stated the expectation was for residents to receive assistance with oral care daily and for staff to document the care. The DON and the administrator stated lack of oral care could lead to dental caries.</p> <p>A record review of the facility's Activities of Daily Living policy dated February 2017, revealed, . Activities of daily living include: personal hygiene . Residents who refuse care and treatment will be offered alternative treatment options and be advised of the negative impact of continued refusal to accept treatment and care.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937</p> <p>Based on interviews and record reviews the facility failed to record in residents' medical records sufficient information to identify the Resident and services provided, for 4 of 8 residents (Residents #12, #24, #40 and #46) reviewed for services provided with activities of everyday life hygiene.</p> <ol style="list-style-type: none"> CNA B had no log in ID number to document care services provided to residents for 2 weeks. CNAs had not documented oral care that was offered, preformed, and or refused for Resident #46 during the review period of September 2024. CNAs had nowhere to document oral care that was offered, preformed, and or refused for Resident #40. CNAs had nowhere to document oral care that was offered, preformed, and or refused for Resident #12. CNAs had nowhere to document oral care that was offered, preformed, and or refused for Resident #24. <p>These failures could place residents at risk for of having incomplete or inaccurate records and inadequate care.</p> <p>The findings included:</p> <p>Resident #46</p> <p>A record review of Resident #46's admission record dated 09/18/2024, revealed an admitted [DATE] with diagnoses which included polyarthritis (five or more of your joints have arthritis at the same time) and contracted left and right hands, contracted left and right knees.</p> <p>A record review of Resident #46's quarterly MDS assessment dated [DATE] revealed Resident #46 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 09 out of a possible 15 which indicated moderate impaired cognition. Further review revealed Resident #46 had no difficulty hearing, had clear speech, could understand others and could make herself understood, Resident #46 had adequate vision with the use of glasses. Further review revealed Resident #46 was totally dependent on staff and needed total assistance with oral care, personal hygiene, and transfers.</p> <p>A record review of Resident #46's care plan dated 09/18/2024 revealed, I am at risk for oral care issues: . provide and set up oral care supplies as indicated</p> <p>A record review of Resident #46's physician's orders dated 09/18/2024 revealed Resident #40's physician on 11/22/2020, ordered for Resident #40 to receive oral care as needed.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of Resident #46's medical record for the month of September 2024, revealed CNAs had not documented oral care that was offered, preformed, and or refused.</p> <p>Resident #40</p> <p>A record review of Resident #40's admission record dated 09/18/2024, revealed an admitted [DATE] with diagnoses which included aphasia (impairment of language, speech, comprehension, and the ability to read and write), multiple sclerosis (a disease where a person's own immune system deteriorates muscle nerves), and myasthenia gravis (results from a problem in signaling between nerves and muscles.)</p> <p>A record review of Resident #40's quarterly MDS assessment dated [DATE] revealed Resident #40 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 06 out of a possible 15 which indicated severe impaired cognition. Further review revealed Resident #40 had minimal difficulty hearing, clear speech, could usually understand and could usually make herself understood, Resident #40 had impaired vision, did not use glasses, and could see large print. Further review revealed Resident #40 needed assistance with oral care, personal hygiene, and transfers. Resident #40 was totally dependent on staff for activities of daily life to include personal hygiene and transfers (bed to chair) and Resident needed, substantial maximal assistance helper does more than half the effort with oral care.</p> <p>A record review of Resident #40's care plan dated 09/18/2024 revealed, I am at risk for oral care issues: own teeth, some loss or carious teeth. provide and set up oral care supplies as indicated</p> <p>A record review of Resident #40's physician's orders dated 09/18/2024 revealed Resident #40's physician on 05/30/2023, ordered for Resident #40 to receive oral care as needed.</p> <p>A record review of Resident #40's medical record revealed CNAs had nowhere to document oral care that was offered, preformed, and or refused.</p> <p>Resident #12</p> <p>A record review of Resident #12's admission record dated 09/18/2024, revealed an admitted [DATE] with diagnoses which included dementia (a group of symptoms affecting memory, thinking and social abilities. In people who have dementia, the symptoms interfere with their daily lives), and end stage COPD (chronic obstructive pulmonary disease).</p> <p>A record review of Resident #12's annual MDS assessment dated [DATE] revealed Resident #12 was an [AGE] year-old female admitted for long term care and diagnosed with a life expectancy of less than 6 months. Resident #12 was assessed with a BIMS score of 05 out of a possible 15 which indicated severe cognitive impairment. Resident #12 was assessed and needed substantial maximal assistance helper does more than half the effort with transfers to and from a bed to a chair or wheelchair.</p> <p>A record review of Resident #12's physician's orders dated 09/18/2024 revealed Resident #12's physician on 11/07/2022, ordered for Resident #12 to receive oral care as needed.</p> <p>A record review of Resident #12's medical record revealed CNAs had nowhere to document oral care that was offered, preformed, and or refused.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #24</p> <p>A record review of Resident #24's admission record dated 09/18/2024 revealed an admitted [DATE] with diagnoses which included Alzheimer's disease (a disabling degenerative disease of the nervous system occurring in middle-aged or older persons and characterized by dementia and failure of memory for recent events, followed by total incapacitation and death), muscle wasting, and heart failure.</p> <p>A record review of Resident #24's quarterly MDS assessment dated [DATE] revealed Resident #24 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 08 out of a possible 15 which indicated moderately impaired cognition. Further review revealed Resident #24 needed assistance with personal hygiene and transfers, substantial maximal assistance helper does more than half the effort with transfers to and from a bed to a chair or wheelchair and partial / moderate - helper does less than half the effort.</p> <p>A record review of Resident #24's physician's orders dated 09/18/2024 revealed Resident #24's physician on 04/07/2024, ordered for Resident #24 to receive oral care as needed.</p> <p>A record review of Resident #24's medical record revealed CNAs had nowhere to document oral care that was offered, preformed, and or refused.</p> <p>During an interview on 09/18/2024 at 01:30 PM CNA B stated she was the CNA usually assigned to the facility's 100-hall and usually worked from 02:00-10:00 PM and has also worked some 06:00 AM to 02:00 PM shift on 100-hall. CNA B stated she had provided care, oral, personal hygiene, and incontinence care for Residents #12, #24, #40, #46. CNA B stated she had no log-in ID number to access the electronic medical record to document care provided to residents. CNA B stated she had access prior to September 2024 and as of September 2024 she had lost access. CNA B stated she had not been able to document any care offered and or refused. CNA B stated she had reported the loss of access to the ADON E.</p> <p>During an interview on 09/17/2024 at 09:40 AM ADON E stated she had just today learned CNA B had no access to document in residents' electronic medical record. ADON E stated CNA B should have access to document in the electronic medical record. ADON E stated the risk for harm to residents would be neglect and CNA B had the responsibility to report loss of access to document immediately.</p> <p>During a joint interview on 09/18/2024 at 03:00 PM with the Administrator and the DON, the administrator and the DON stated the expectation was for all CNA's to document the care provide immediately and to immediately report the inability to access the electronic record.</p> <p>A record review of the facilities Medical records policy dated February 2017, revealed, . Compliance Guidelines: A medical record is maintained for every person admitted to a community in accordance with accepted professional standards and practices. The administrator has ultimate responsibility for the maintenance of medical records but may delegate this responsibility to another team member.</p> <p>The medical record consists of but not limited to the following:</p> <p>? information to identify the Resident . ? the plan of care and services provided</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27923</p> <p>47611</p> <p>Based on observations, interviews, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for Residents for two (Hall 100 and 200) of six shower rooms observed for environment and 1 laundry room reviewed for a safe, functional, sanitary, and comfortable environment.</p> <ol style="list-style-type: none"> The facility failed to ensure Residents' shower rooms on Halls 100 and 200 were clean, safe, and in good repair. The facility failed to ensure the laundry washroom was clean, safe, and in good repair. The ceiling vent in the bathroom of Resident room [ROOM NUMBER] had dirt and rust on the vent slats and parameter surface. The bathroom door of Resident room [ROOM NUMBER] had a large indentation on the bottom of wood surface of the door. <p>This failure could place residents at risk for diminished quality of life due to the lack of a well-kept environment.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Observation on 9/17/2024 at 10:57 am of the resident shower room on the 100-hall revealed black mildew and rust on the doorframe of the shower room, black mildew along the bottom of the shower room, and orange sediment on the shower chair. <p>Observation on 9/17/2024 at 11:00 am of the resident shower room on the 200-hall revealed black mildew along the bottom of the shower room and orange sediment on the shower chair and black mildew on the shower chair wheels.</p> <p>Interview with the Maintenance Director on 9/17/2024 at 11:55 am, the Maintenance Director verified the black mildew and orange sediment on the shower chairs and the black mildew and rust on the 100-hall shower room door. He did verify that the bottom of the doorframe was rusted and needed to be repaired or replaced. He stated, the black stuff could be poop. He stated, the orange stuff looks to be sediment. He also explained that deep cleaning the shower rooms were housekeeping's responsibility.</p> <p>During an interview with the Administrator on 9/17/2024 at 1:22 pm, the Administrator stated the shower rooms should be sprayed down after every resident by the CNA's. He stated that housekeeping should be performing a deep clean as needed.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Housekeeping Manager on 9/18/2024 at 11:57 am, the Housekeeping Manager stated that housekeeping performs a deep cleaning on the resident showers once a week or sooner if needed.</p> <p>2. During an observation and interview on 09/18/2024 at 12:04 PM revealed the facility's laundry washroom without drywall around 4 inches from the floor due to previous flooding and a significant gap under the exit door. The Maintenance Director stated the facility bought and installed a new commercial washer around 2 months ago (July 2024) because the old washer failed and leaked water and flooded the laundry washroom. The Maintenance Director stated the flood damaged the drywall about 3-4 above the floor, had missing pieces of drywall, and needed to be replaced. The Maintenance Director stated the threshold at the exit door had to be removed to allow the old washer and new washer to be removed and installed and thus revealed a 5/8 gap at the bottom of the door and could potentially allow insects and pest to enter the facility.</p> <p>Record review of the facility policy review titled, Physical Environment, revision date January 2023, showed under section titled Environmental Issues, The community is designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. Under the section titled, Preventative Maintenance, it showed The community has a preventive maintenance program that ensures that all essential mechanical, electrical, and patient-care equipment is in safe operating condition.</p> <p>3. Observation on 09/17/24 at 12:00 p.m. with the Maintenance Director, revealed Resident room [ROOM NUMBER] had a bathroom ceiling vent which measured approximately one foot in diameter that had dirt and rust on the vent slats and parameter surface.</p> <p>4. Observation on 09/17/24 at 12:05 p.m. with the Maintenance Director, revealed Resident room [ROOM NUMBER] had a bathroom door that had an indentation on the bottom of wood surface of the door which measured approximately 1.5 ft x 13 inches.</p> <p>During an interview with the Maintenance Director on 09/17/24 at 12:10 p.m., Maintenance Director stated he had not been made aware by staff of the noted areas to be repaired. The Maintenance Director stated that completing the repairs would promote a homelike environment for the residents.</p> <p>During a tour with the Administrator on 9/17/24 at 12:15 to 12:20p.m., he observed Resident rooms #407 and #413 and stated that completing the repairs would promote a homelike environment for the residents.</p> <p>Record review of the facility's policy on Physical Environment dated 01/2023 stated that the community environment is safe, functional, sanitary, and comfortable for residents, team members, and the public.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675947	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Country Care Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 2736 Farm to Market 775 LA Vernia, TX 78121	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>27923</p> <p>Based on interview, and record review, the facility failed to ensure Quality Assurance Performance Improvement (QAPI) Training that outlines and informs staff of the elements and goals of the facility's QAPI program for 3 of 22 staff (CNAs G &H and LVN I) reviewed for training, in that:</p> <p>The facility failed to ensure that 3 of 22 staff (CNAs G&H and LVN I) had completed their mandatory QAPI annual training.</p> <p>This failure could place residents at risk for care by C.N.A. and L.V.N staff who had been insufficiently trained while working in the facility.</p> <p>The findings included:</p> <p>Record review of the annual CNA, and LVN training information revealed that: CNA G (hired-7/7/23), CNA H (hired-7/7/23), and LVN I (hired 8/16/16) had not completed their mandatory QAPI annual training requirement.</p> <p>During an interview with the Human Resources (HR) Director on 9/17/24 at 2:30p.m., she stated that there was not a record of completed annual QAPI training for C.N.A.-G, C.N.A.-H, and L.V.N-I. The HR Director stated that she had responsibility for coordinating the employee's training program and that it was the staff member's responsibility to have completed their training assignments. The HR Director stated that the staff member's completion of the training would have assisted them with providing improved resident care services.</p> <p>During an interview with the Regional HR Director on 9/17/24 at 2:40pm she stated that staff completion of their training requirements would have helped improve their resident care services.</p> <p>During an interview with the Administrator on 9/17/24 at 3:30p.m., he stated that staff's completion of their QAPI training would have made them aware of the process for improving resident care services.</p> <p>Record review of the facility's Team Member Handbook dated 9/2022 stated that All personnel are required to attend regularly scheduled in-service training classes and may also be asked to complete certain training programs using online modules.</p>		