

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/17/2025
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)		
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents' clinical record was complete and accurate for 2 (Resident #3, Resident #50) in that: 1. Resident #3's facesheet, care plan, and physician orders did not match. 2. Resident #50's diet order was missing from the clinical record for one month. This deficient practice could result in delayed or improper care due to inaccurate clinical records. The findings were: 1. Record review of Resident #3's facesheet, dated 12/14/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including Cerebral infarction, Type 2 diabetes mellitus without complications, and Chronic obstructive pulmonary disease. Record review of Resident #3's Quarterly MDS, dated [DATE], revealed a BIMS score of 11 which indicated moderate cognitive impairment. Record review of Resident #3's care plan, dated 09/11/2025, revealed, [Resident #3] require[s] anti-depressant medication [related to diagnosis:] Depression. Record review of Resident #3's physician order, dated 07/28/2025, revealed, Medication: Mirtazapine Tablet 7.5 MG, Medication Class: Antidepressants, Order Summary: Mirtazapine Tablet 7.5 MG Give 1 tablet by mouth at bedtime for Appetite Stimulant. Record review of Resident #3's clinical record, as of 12/17/2025, revealed Depression was not among the listed diagnoses. During an interview with the DON on 12/17/2025 at 10:55 a.m., the DON confirmed that Resident #3 had not been diagnosed with depression, was prescribed an antidepressant class medication for appetite stimulation, and stated that the care plan erroneously noted a diagnoses of depression. The DON stated the error was likely due to the medication classification. The DON confirmed that the resident's diagnoses list, care plan, and physician orders should be uniform, and stated it was important for providers and clinicians to have an accurate understanding of the residents' health status. 2. Record review of Resident #50's facesheet, dated 12/14/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Aftercare following explantation of hip joint prosthesis, Unspecified fall subsequent encounter, and Acute kidney failure. Record review of Resident #50's Quarterly MDS, dated [DATE], revealed a BIMS score of 3 which indicated severe cognitive impairment. Record review of Resident #50's care plan, revised 09/12/2025, revealed, I [Resident #50] am at risk for nutritional deficits and/or dehydration risks [related to] Chronic comorbidity medical diagnosis, therapeutically restricted diet (No animal meat). Record review of Resident #50's order summary, dated 12/14/2025, revealed no diet order was present. Record review of Resident #50's diet order history as of 12/14/2025, revealed the resident's most recent diet order had a start date 10/16/2025 and an end date 11/15/2025. During an interview with [NAME] A on 12/16/2025 at 4:40 p.m., [NAME] A stated the Dietary Manager was unavailable for interview and stated that the kitchen staff was informed of the residents' diet order via the electronic medical record. [NAME] A further stated that kitchen staff would utilize the last recorded order if there was not a current diet order in the residents' record. [NAME] A also confirmed that Resident #50 had been receiving the diet approved by his physician and the Registered Dietician. During an interview with the Registered Dietician on 12/16/2025 at 4:45 p.m., the Registered Dietician stated the facility nursing communicates order changes to dietary department and that she has never encountered a communication error regarding a (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's diet order. The Registered Dietician also confirmed that Resident #50 has been receiving the correct diet. Observation on 12/16/2025 at 12:36 p.m. revealed Resident #50 received a meal in accordance with the physician and Registered Dietician orders. During an attempted interview with Resident #50 12/16/2025 at 12:36 p.m., Resident #50 was unable to participate in the interview but nodded and smiled when asked if he enjoyed his meal. Additional record review of Resident #50's order summary, dated 12/15/2025, revealed a diet order dated 12/14/2025 was present. During an interview with the DON on 12/16/2025 at 4:55 p.m., the DON confirmed that Resident #50's diet order had been missing for one month, stated the order should have been present, and stated the oversight was an error. Record review of the facility policy, Medical Records, revised January 2023, revealed, A medical record is maintained for every person admitted to a community in accordance with accepted professional standards and practices.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public on 5 of 12 resident rooms (rooms 101, 105, 107, 108, and 110) and 3 of 3 areas (hallway 100 shower room A, laundry room, and the maintenance office) reviewed for environmental concerns: The facility failed to repair bathroom ceiling vents in rooms #'s 101, 105, 107, 108 and 110, a non-functioning light in room # 110, a ceiling vent in the # 100 resident hallway shower room, a ceiling light in the laundry room, and a ceiling vent in the Maintenance office. These failures could place residents and staff at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe. The findings included: Observation on 12/16/25 from 1210-1230pm with the Administrator and Maintenance Director revealed the following:a-There was a bathroom ceiling vent that had rust on the vents in room # 101.b-There was a bathroom ceiling vent that had rust on the vents in room # 105.c-There was a bathroom ceiling vent that had rust on the vents in room # 107.d-There was a bathroom ceiling vent that had rust on the vents in room # 108.e-There was a bathroom ceiling vent that had rust on the vents in room # 110 and 1 of 2 bathrooms lights did not come on when engaged.f-There was a shower room in the Resident hallway #100 that had a bathroom ceiling vent with rust on the vents.g-There was a overhead light fixture with two 4 ft florescent lights that did not have a cover and 10 cracked 1x1 ft floor tiles in the laundry room.h-There was a 6x12 inch ceiling vent in the Maintenance office that had dirt and rust on the ceiling vents During an interview on 12/16/25 at 12:35pm with the Administrator and Maintenance Director the Maintenance Director stated he was aware of the resident room ceiling vents which needed repaired, and the repairs had been noted on the TELS work order list. The Maintenance Director stated that a cover for the ceiling lights in the laundry room would be beneficial for employee safety. The Administrator stated that making all of the facility repairs would promote a better facility building appearance. Record review of the facility work order log from 6/16/25 through 12/16/25 revealed that bathroom air vents were repaired as needed. Record review of the facility policy titled Preventative Maintenance from the Environment of Care Policy and Procedure Manual that was undated revealed preventative maintenance will be completed routinely and according to protocol by the Maintenance Supervisor or qualified designee.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview, and record review, the facility failed to ensure that residents received appropriate treatment and services to prevent urinary tract infections for 1 of 8 residents (Resident #25) who were reviewed for indwelling urinary catheter care, in that: Resident #25's indwelling urinary catheter bag was on the floor. These failures could affect residents with indwelling urinary catheters, placing them at risk of urinary tract infections. The findings were: Record review of Resident #25's face sheet, 12.14.25, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnosis that included: retention of urine [the inability to empty your bladder], heart failure[condition where the heart is too weak to pump blood and oxygen to meet the needs of body], and diabetes type 2 [condition where body does not produce enough insulin or can't use insulin effectively]. Record review of Resident #25's Quarterly MDS, dated [DATE], revealed the resident had a BIMS of 12, which indicated moderate cognitive impairment. Record review of the quarterly MDS for Resident #25 revealed that, under the Bowel and Bladder section, option A was selected, indicating an Indwelling Foley catheter. Record review of Resident #25's care plan, dated 11/20/2025, revealed I require a catheter; check for kinks each shift. Observation on 12/14/2025 at 10:45 AM revealed Resident #25 was in bed sleeping. Further observation revealed that Resident # 25's indwelling urinary catheter bag was on the floor. Interview with Resident #25 on 12/14/2025 at 10:50 AM; stated his Foley catheter bag should not be on the floor, as this could cause urine to travel back up his urinary system and cause an infection. He was unaware that the bag was on the floor and did not know how long it had been there. During an interview with CNA (A) on 12/14/2025 at 10:55 AM, CNA (A) , stated she was the assigned to Resident #25's and his indwelling urinary catheter bag was on the floor not attached to movable part of bed, she stated that she forgot to attach catheter bag to the movable part of the bed this morning as she provided perineal care. During an interview with LVN (B) on 12/14/2025 at 11:05 AM, LVN (B) stated she was the assigned nurse for Resident #25 and that his catheter bag was on the floor. She noted that catheter bags should not be on the floor, as this was not good nursing practice and could lead to urinary infections. During an interview with the DON on 12/17/2023 at 9:35 AM, the DON stated that Resident #25's indwelling urinary catheter bag should not have been on the floor. She noted that all staff had been in-service on not allowing catheter tubing/bags to touch the floor to prevent urinary infections. The DON stated she did not know this deficient practice occurred, but would in-service all staff again. The DON noted that the risk to the resident of the catheter bag being on the floor was that urine bacteria could travel through the tubing and reach the kidneys, causing a urinary infection. She also stated that her ADON currently monitors whether the catheter bags are on or off the floor during rounds, and she oversees this task. Record review of facility policy Incontinence and Catheterization, dated 2017, revised January 2023, revealed, The community employs standard infection control practices in managing catheters and associated with the drainage system.		