STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675696	A. Building B. Wing	09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Village Care	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** 38644 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident, for 1 of 3 (Courtyard station's Nursing Cart) medication carts reviewed for pharmacy services. The facility failed to ensure the Courtyard station's Nursing cart did not contain two expired insulin vials. This deficient practice could place residents at risk for adverse effects and not receiving the therapeutic effects of the medication or treatment. Findings include: Record review of Resident #44's face sheet dated [DATE] revealed a [AGE] year-old male who readmitted to the facility on [DATE]. His diagnosis included type 2 diabetes mellitus without complications. Record review of Resident #44's significant change in status MDS assessment dated [DATE] revealed he required extensive assistance with ADL care. His cognitive status was not assessed. Record review of Resident #44's care plan dated [DATE] revealed he had diabetes and required insulin daily. His interventions were to administer the insulin routinely as ordered. Record review of Resident #44's Order Summary Report for [DATE] revealed an order for Novolin R insulin inject as per sliding scale before meals and at bedtime, order date [DATE]. Record review of Resident #4's face sheet dated [DATE] revealed an [AGE] year-old male who admitted to the facility on [DATE]. His diagnosis included type 2 diabetes mellitus without complications. Record review of Resident #4's admission MDS assessment dated [DATE] revealed a BIMS score of 9 out of 15 which indicated moderate cognitive impairment. He required extensive assistance with ADL care. Record review of Resident #4's care plan revised on [DATE] revealed he had diabetes mellitus type 2. His interventions were to administer diabetes medication as ordered by the doctor. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's Order Summary Report for [DATE] revealed no orders for Humulin R insulin pen as of [DATE]. Observation and interview on [DATE] at 12:42 p.m. of the Courtyard Station nursing cart with LVN S revealed: - Resident #44's Novolin R insulin vial with an open date of ,d+[DATE]/ (23). The label on the vial read, discard 42 days after opening - Resident #4's Humulin R insulin vial with an open date of [DATE]. The label on the vial read, store opened vial at room temperature discard 31 days after opening. Date opened: [DATE]. LVN S said he did not check his nursing cart often enough and said the night shift nurse normally did it. He said he mostly checked for expiration dates as he administered the medication to residents. He said the Novolin R was good for 42 days and it would need to be tossed and reordered due to the efficacy. He said Resident #4 was no longer on the Humulin R and he would destroy the medication. Interview on [DATE] at 2:16 p.m. the DON said insulin should be labeled with open and discard date. She said the charge nurse who opened the insulin should put the date in order to know when to discard the insulin in the sharps container. She said the insulin would probably not be effective after the specified timeframe. Interview on [DATE] at 2:26 p.m. the Administrator said staff should follow proper storage protocols regarding insulin pens because that is what is stated on the pen. Record review of Medications with shortened expiration dates dated 2021 provided by the facility read in part, . Novolin R vial: 42 days. Humulin R vial: less than or equal to 31 days . Record review of the facility's policy Storage of Medications dated [DATE] read in part, .the facility stores all drugs and biologicals in a safe, secure, and orderly manner . Policy interpretation and implementation: 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed .

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644 Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 12%, based on 4 errors out of 32 opportunities, which involved 2 (Residents #89 and #49) of 5 residents and 2 (LVN B and MA G) of 4 staff reviewed for medication errors in that: -LVN B failed to administer Resident #89's medications individually via gastrostomy tube (a surgically placed device used to give direct access to the stomach for supplemental feeding, hydration, or medicine) and failed to administer a water flush between each medication according to the physician orders. -MA G administered Sodium Bicarbonate 325 mg to Resident #49 instead of Sodium Bicarbonate 650 mg as ordered by the Physician. (Sodium Bicarbonate is a base substance that can help keep kidney disease from getting worse by buffering retained acids in the body). These failures could place residents at risk of inadequate therapeutic outcomes. Findings included: Resident #89 Record review of Resident #89's face sheet dated 9/6/23 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included cerebral infarction (a type of stroke caused by impaired blood flow to the brain), hypertension (high blood pressure), gastrostomy status, and epilepsy (a neurological disorder that causes seizures or unusual sensations and behaviors). Record review of Resident #89's 5-day MDS assessment dated [DATE] revealed a BIMS score of 8 out of 15, indicating moderately impaired cognitive skills for daily decision making. He needed limited assistance of 1 staff for ADL care. He had a feeding tube. Record review of Resident #89's Order Summary Report for September 2023 revealed active orders for: Enteral feed order every shift flush with 5 mL water in between each medication, order date 8/30/23, Amlodipine 5 mg give 1 tablet via PEG-tube one time a day, order date 8/29/23. Aspirin chewable 81 mg give 1 tablet via PEG -tube one time a day, order date 8/29/23, and Losartan 25 mg give 1 tablet via PEG-tube one time a day, order date 8/29/23. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 9/6/23 at 8:31 a.m. LVN B prepared Resident #89's medication for g-tube administration. She prepared chewable Aspirin 81 mg - 1 tablet, Amlodipine 5 mg - 1 tablet, Losartan 25 mg - 1 tablet, 15 mL of Valproic acid, 15 mL of Levetiracetam, and 8 mL of Phenytoin. She crushed the 3 tablets together and placed them in the same medication cup and prepared the liquids in 3 separate cups. LVN B entered Resident #89's room to begin medication administration via g-tube. She checked Resident #89's g-tube for placement, flushed with water, administered liquid medication, flushed with water, administered phenytoin liquid, flushed with water, administered liquid medication, flushed with water, administered the tablet mixture, flushed with water, and completed the medication pass. In an interview on 9/6/23 at 9:08 a.m. LVN B said she crushed the three pills together. She said she was taught elsewhere to crush and administer the tablets together. She said there was no physician's order to administer the pills separate or mixed. She said this was her first resident with a PEG tube at the facility and the facility did not normally have residents with g-tubes. In an interview on 9/6/23 at 2:06 p.m. the DON said pills should be crushed and administered separately via peg-tube because if one medication did not go down the tube, staff would know which pills were given. She said the PEG tube could also clog if the right amount of fluid was not used in between medications. She said nurses were trained on g-tube administration when hired and received focused training on g-tube administration. Record review of LVN B's Competency Assessment: G-Tube Medication Administration dated 7/28/23 revealed the following procedures: 4. Dissolve crushed medication order in lukewarm water (use separate plastic sleeves and medication cups) . 15. Administer dissolved medications separately and flush with water in between medications. The evaluator/supervisor was the DON and LVN B was competent in all areas assessed. Resident #49 Record review of Resident #49's face sheet dated 9/6/23 revealed an [AGE] year-old female who readmitted to the facility on [DATE]. Her diagnoses included chronic kidney disease (a condition where the kidneys are damaged and cannot filter blood properly), gastro-esophageal reflux disease (a chronic digestive disease where the liquid content of the stomach refluxes into the esophagus), cerebral artery disease (a group of disorders that affect the blood vessels and blood supply to the brain), and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Record review of Resident #49's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 which indicated intact cognition. She required supervision of one staff for ADL care. Record review of Resident #49's Order Summary Report for September 2023 revealed an order for Sodium Bicarbonate 650 mg give 1 tablet by mouth one time a day, order date 6/15/23. Record review of Resident #49's MAR for September 2023 revealed Sodium Bicarbonate oral tablet 650 mg Give 1 tablet by mouth one time a day related to chronic kidney disease, start date 6/17/23. In an observation on 9/6/23 at 9:22 a.m. MA G prepared Resident #49's medication for administration. She prepared Sodium bicarbonate 325 mg - 1 tablet, Diphenhydramine, Acetaminophen, Furosemide, Spironolactone, Amiodarone, Januvia, Losartan, Vitamin D, Zinc, Vitamin C, and Olopatadine eye drops. She entered the room and administered the medication to Resident #49. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 9/6/23 at 9:37 a.m. MA G said she prepared 1 Sodium Bicarbonate tablet for Resident #49, but it was supposed to be 2. She said the strength on the Sodium Bicarbonate bottle was 325 mg and 1 tablet was only 325 mg. She said the information on the MAR said Sodium Bicarbonate 650 mg, but the directions said to give 1 tablet. She said the MAR said to give 1 tablet, so she gave 1 tablet. She said whoever put the order into the system made the order contradict itself. She said medication aides could not calculate dosing. She said if she noticed an error with the order, she would ask the nurse. In an interview on 9/6/23 at 2:10 p.m. the DON said if a medication aide noticed a discrepancy in the order, they should report it to the nurse to change the order to match. She said it was best to notify the nurse before giving the medication so the resident would receive the right dose. She said medication aides were trained to check the dose to the MAR. In an interview on 9/6/23 at 2:26 p.m. the Administrator said he expected staff to follow the physician orders because the physician made the order specifically for that manner. Record review of the facility's policy Administering Medications through an Enteral Tube dated November 2018 read in part, . the purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube .General Guidelines: . 3. Administer each medication separately and flush between medications . Steps in the Procedure: . 3. Prepare the medication: a. check the label and confirm the medication name and dose with the MAR .10. Administer each medication separately .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644 Based on observation, interview, and record review the facility failed to ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 of 3 medication carts (Parkside station Nurse cart and Courtyard station Nurse cart) reviewed for medication storage. - The facility failed to ensure the Parkside station's Nursing cart did not contain two opened and undated insulin pens. -The facility failed to ensure the Courtyard station's Nursing cart did not contain one undated insulin pen. These failures could place residents at risk of adverse medication reactions. Findings include: Parkside Station nursing cart Record review of Resident #63's face sheet dated 9/6/23 revealed an [AGE] year-old female who admitted to the facility on [DATE]. Her diagnosis included type 2 diabetes mellitus without complications (a condition results from insufficient production of insulin, causing high blood sugar). Record review of Resident #63's quarterly MDS assessment dated [DATE] revealed a BIMS score of 9 out of 15 which indicated moderate cognitive impairment. She required supervision to extensive assistance with ADL care. Record review of Resident #63's Order Summary Report for September 2023 revealed an order for Lantus solostar inject 10 unit at bedtime, order date 4/11/23. Record review of Resident #25's face sheet dated 9/6/23 revealed a [AGE] year-old male who readmitted to the facility on [DATE]. His diagnosis included type 2 diabetes mellitus with hyperglycemia (high blood sugar). Record review of Resident #25's quarterly MDS assessment dated [DATE] revealed a BIMS score of 11 out of 14 which indicated moderate cognitive impairment. He required limited to extensive assistance with ADL care. Record review of Resident #25's care plan dated 6/2/23 revealed he had diabetes and required daily insulin injections. His interventions were to administer Lantus insulin routinely as ordered. Record review of Resident #25's Order Summary Report for September 2023 revealed an order for Lantus solostar inject 30 units at bedtime for diabetes, order 8/14/23. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and Interview on 9/6/23 at 12:05 p.m. of the Parkside Station Nursing cart with LVN G revealed: - Resident #63's opened Lantus insulin pen with no open date. The label on the pen read, store opened pen at room temperature. Expires 28 days after opening date. - Resident #25's opened Lantus insulin pen with no open date. The label on the pen read, store opened pen at room temperature. Expires 28 days after opening date. LVN G said the insulin pens for Resident #63 and Resident #25 were open and in use. She said there was no open date marked on either pen. She said the nurse who opened the pen should write the open date on the pen. She said the insulin was not effective after 28 days. She said she checked her cart regularly for expiration dates and the insulin pens may have been overlooked. Courtyard Station nursing cart Record review of Resident #49's face sheet dated 9/6/23 revealed an [AGE] year-old female who readmitted to the facility on [DATE]. Her diagnoses included type 2 diabetes without complications. Record review of Resident #49's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 which indicated intact cognition. She required supervision of one staff for ADL care. Record review of Resident #49's Order Summary Report for September 2023 revealed an order for Lantus (insulin glargine) inject 15 units at bedtime, order date 7/24/23. Observation and interview on 9/6/23 at 12:42 p.m. of the Courtyard Station nursing cart with LVN S revealed: - Resident #49's Basaglar (insulin glargine) insulin pen with no open date. The label on the pen read, store opened pen at room temperature pen expires 28 days after opening. LVN S said he did not check his nursing cart often enough and said the night shift nurse normally did it. He said there was no open date on Resident #49's Basaglar insulin pen and said the pen was good for 28 days after opening. Interview on 9/6/23 at 2:16 p.m. the DON said insulin should be labeled with open and discard date. She said the charge nurse who opened the insulin should put the date in order to know when to discard the insulin in the sharps container. She said the insulin would probably not be effective after the specified timeframe. Interview on 9/6/23 at 2:26 p.m. the Administrator said staff should follow proper storage protocols regarding insulin pens because that is what is stated on the pen. Record review of the facility's policy Storage of Medications dated November 2020 read in part, .the facility stores all drugs and biologicals in a safe, secure, and orderly manner . Policy interpretation and implementation: 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed .

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. 47572 Based on observation, interview, and record review the facility failed to ensure each room was designed or equipped to assure full visual privacy for each resident. The facility failed to ensure 7 of 56 resident rooms (rooms 409, 410, 411, 412, 413, 414, and 418) were provided with ceiling suspended curtains, which extended around the bed, to provide total visual privacy. This failure could lead to a lack of privacy for residents, allow residents' private medical treatment to be observed by roommates or others, and lead to a decline in psychosocial well-being. Findings included: Observation on 9/5/2023 at 12:28 PM of rooms 409, 410, 411, 412, 413, 414, and 418 revealed the rooms had two beds. The rooms did not have full-length, floor to ceiling, privacy curtain separating the two beds. The rooms had a free-standing privacy screen made of three panels. The free-standing privacy screens were approximately six feet long by five feet, ten-inches-high. The screens did not block the view of the bed completely from either inside the room or the exterior hallway if the door was open. Observation on 9/6/2023 at 2:32 PM revealed rooms 409, 410, 411, 412, 413, 414, and 418 did not have full-length, floor to ceiling, privacy curtains, but instead utilized approximately six feet long by five feet, ten-inch-high free-standing privacy screens. Observation on 9/7/2023 at 8:05 AM revealed rooms 409, 410, 411, 412, 413, 414, and 418 did not have full-length, floor to ceiling, privacy curtains, but instead utilized approximately six feet long by five feet, ten-inch-high free-standing privacy screens. Interview on 9/6/2023 at 1:28 PM with the DON and Admin, the DON said the facility's rooms on the 400 hall had always had free-standing room dividers and not utilized full-length, floor to ceiling, privacy curtains. The DON said she had worked at the facility for eight years, and as DON for five, and the rooms had always had the privacy screens used to provide privacy to the residents. The Admin said the facility had no waivers from HHS-LTCR or CMS to utilize the free-standing room dividers in place of full length, floor to ceiling, privacy curtains. The Admin said he would place an order to add privacy curtains to all rooms without them in the facility. Interview on 9/7/2023 at 8:23 AM with the DON, he said he had contacted a local company to order the supplies to install curtains in rooms 409, 410, 411, 412, 413, 414, and 418. The DON provided a copy of an invoice for privacy curtain supplies. Interview on 9/7/2023 at 1:55 PM with MA N, said the rooms on the 400-Hall of the facility had always had a privacy screen, not full-length, floor to ceiling, privacy curtains. MA N said she did not believe the screens were effective for privacy for residents as if a roommate was in the room, he/she could still see into the resident's bed. MA N said she believed a full-length, floor to ceiling, privacy curtain would be best to provide privacy to the residents. (continued on next page)

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 9/8/2023 at 9:01 AM with the Admin and DON revealed the DON had been employed by the facility for eight years. The DON said the facility had used the free-standing privacy screens for resident privacy on the 400 hall for the entirety of her employment. The Administrator said the rooms without ceiling to floor privacy curtains were in the oldest part of the building. The DON said the free-standing privacy screens provided the residents with the privacy needed. The Admin said the free-standing privacy screens provide the same amount of privacy to the residents as ceiling to floor privacy curtains. Record review of the facility's Resident Rights policy revealed a policy statement which read Employees shall treat all residents with kindness, respect, and dignity. The policy documented resident rights including: dignified experience; communication with and access to people and services; exercise his or her rights as a resident of the facility and as a resident or citizen of the United States; privacy and confidentiality; and retain and use personal possessions to the maximum extent that space. Record review of the facility's Confidentiality of Information and Personal Privacy policy dated October 2017 revealed a policy statement which read Our facility will protect and safeguard resident confidentiality and personal privacy. The policy documented the facility would safeguard residents' personal privacy and the confidentiality of resident personal information. Per the policy, the facility would protect the residents' privacy related to: accommodations; medical treatment; personal care; visits; and family and/or group meetings. Record review of the facility's invoice dated 9/6/2023 from a local retailer revealed the Admin had ordered 112 Cubicle Curtain Track Packages with Spool Carrier at $9.49 for a total of $1,062.88. The invoice documented a purchase of 14 Bezel Privacy Curtains at $102.99 for a total of $1441.86