STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675878	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY TRAILS WELLNESS & REHABILITATION CENTER	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)
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the right to personal privacy was provided for 1 of 24 residents reviewed for resident rights. (Resident #71) The facility did not prevent CNA H and CNA J from posting a snapchat video of Resident #71 on social media without her knowledge or consent. This failure could place residents at risk for abuse, invasion of privacy, and mental anguish. Findings included: A face sheet dated 03/04/2020 indicated Resident #71 was [AGE] years old and admitted on [DATE]. The resident had [DIAGNOSES REDACTED]. An MDS dated [DATE] indicated Resident #71 had severe cognitive impairment and required extensive assistance with most activities of daily living. A care plan revised on 04/30/19 indicated Resident #71 had impaired cognitive function and her needs would be met and dignity maintained. A provider investigation report dated 12/03/19 indicated administrator K had received a phone call from administrator L on 12/03/19 at 4:15 p.m. indicating it had been reported that someone had posted a 10 second snap chat video of a resident being aggravated. The report indicated administrator L came to the facility and showed the video to administrator K and the social worker. Administrator K and the social worker did a search and identified the resident and the CNA seen in the video (Resident #71 and CNA H). The report indicated CNA H said she meant no harm and said CNA J videoed her. The provider investigation report indicated the investigation findings were confirmed with no harm to Resident #71 as she had no knowledge of the incident. The post-investigation action taken indicated CNA H and CNA J were terminated and the facility continued to do in-services. During an observation and interview on 03/02/2020 at 09:53 a.m., Resident #71 was sitting in a wheelchair looking out her bedroom window. Resident #71 said she was good and liked living at the facility, she was noted to be very confused and self-conversing. Her responses to most questions asked were not appropriate, she did not voice any recall of the incident. During an interview on 03/02/2020 at 10:17 a.m., administrator M, said he was the interim administrator and the abuse coordinator for the facility. He said administrator K was the administrator during the time of the incident. He said administrator K was contacted by the administrator at a local nursing facility indicating he had seen a video on snapchat of two CNAs videotaping a resident at this facility. He said administrator K acted immediately upon receiving the abuse/neglect allegation, the CNAs were immediately suspended, and an investigation was started. Administrator M said the DON would know more information regarding the incident. During an interview on 03/02/2020 at 11:55 a.m., the DON said administrator K was called by administrator L, who informed him about a video that had been made of a resident and CNA. She said administrator K and the social worker watched the video and identified the resident and CNA. She said the CNAs were suspended and later terminated. She said the two CNAs were fairly new and just did not understand what they had done. The DON said there was no harm to the resident, she did not know what happened or recall the incident. During an interview on 03/02/2020 at 12:03 p.m., the social worker said administrator K was called by administrator L about a snapchat video being made of a resident and the CNAs who were identified. She said administrator L came to the facility and showed them the video and they identified the resident and CNA. She said the CNAs were suspended and later terminated. She said the two CNAs were fairly new CNAs and did not understand what they had done. She said there was no harm to the resident. She said the resident did not know the incident happened and did not recall the incident. During an interview and observation on 03/02/2020 at 04:17 p.m., administrator L said on 12/03/19, he received a phone call from the DON, at another nursing facility. He said she told him she was shown a snapchat video recording by one of her CNAs. He said she sent the video to his phone and said the video was not of a resident in her facility. He said she told him she called her mom, the DON at another local facility and it was not one of their residents, so she called him. He said he and his DON viewed the video and determined it was not one of their residents, so he called the administrator K. He said he went to the facility and showed the video to administrator K and the social worker and they determined the resident was a resident and a CNA at their facility. Administrator L showed the surveyor the video from his phone, it was a short video of a CNA tickling a sleeping resident's nose and then laughing, the name of CNA H was at the top of the video. During a telephone interview on 03/04/20 at 09:01 a.m., administrator K said he had received a phone call from an administrator across town, administrator L, that it had been reported to him that someone locally had posted a 10 second snap chat video of a resident in a nursing facility. He said administrator L said it was not at his facility, so he came to the facility and showed the video to himself and the social worker. He said a search of the facility identified the resident and CNA seen in the video (Resident #71 and CNA H). He said CNA H said CNA J was who videoed her and the resident. He said both CNAs were suspended pending outcome of the investigation and were later terminated when the allegation was confirmed. He said no harm came to Resident #71 because of her cognitive ability, she had no knowledge of the incident and could not recall anything about the incident. He said the facility did several in-services with the staff on abuse and neglect, resident rights, and HIPPA. A handwritten statement dated 12/03/19 by CNA H indicated she understood the video should not have been videoed or posted, she did not mean any harm, and she was sorry. A handwritten statement dated 12/03/19 by CNA J indicated she understood the video posted of the resident was wrong and she was sincerely sorry. An employee signature sheet signed by CNA H dated 08/19/19 indicated that by signing below, she acknowledged she had received and read the resident's rights. An employee signature sheet signed by CNA J dated 08/19/19 indicated that by signing below, she acknowledged she had received and read the resident's rights. An undated abuse policy indicated it is the policy of the facility that all residents, including those with dementia, are not subject to abuse. An undated statement of resident rights indicated it is the policy of the facility that all residents have the right to be free from abuse; be treated with courtesy, consideration, and respect; and privacy. During an interview on 03/05/20 at 1:15 p.m., the facility was asked for any additional information at exit and no additional information was provided.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the right to be free from abuse was provided for 1 of 24 residents reviewed for abuse. (Resident #71). The facility did not prevent CNA H and CNA J from posting a snapchat video of Resident #71 on social media without her knowledge or consent. This failure could place residents at risk for abuse, invasion of privacy, and mental anguish. Findings included: A face sheet dated 03/04/2020 indicated Resident #71 was [AGE] years old and admitted on [DATE]. The resident had [DIAGNOSES REDACTED]. An MDS dated [DATE] indicated Resident #71 had severe cognitive impairment and required extensive assistance with most activities of daily living. A care plan revised on 04/30/19 indicated Resident #71 had impaired cognitive function and her needs would be met and dignity maintained. A provider investigation report dated 12/03/19 indicated administrator K had received a phone call from administrator L on 12/03/19 at 4:15 p.m. indicating it had been reported that someone had posted a 10 second snap chat video of a resident being aggravated. The report indicated administrator L came to the facility and showed the video

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) to administrator K and the social worker. Administrator K and the social worker did a search and identified the resident and the CNA seen in the video (Resident #71 and CNA H). The report indicated CNA H said she meant no harm and said CNA J videoed her. The provider investigation report indicated the investigation findings were confirmed with no harm to Resident #71 as she had no knowledge of the incident. The post-investigation action taken indicated CNA H and CNA J were terminated and the facility continued to do in-services. During an observation and interview on 03/02/2020 at 09:53 a.m., Resident #71 was sitting in a wheelchair looking out her bedroom window. Resident #71 said she was good and liked living at the facility, she was noted to be very confused and self-conversing. Her responses to most questions asked were not appropriate, she did not voice any recall of the incident. During an interview on 03/02/2020 at 10:17 a.m., administrator M, said he was the interim administrator and the abuse coordinator for the facility. He said administrator K was the administrator during the time of the incident. He said administrator K was contacted by the administrator at a local nursing facility indicating he had seen a video on snapchat of two CNAs videotaping a resident at this facility. He said administrator K acted immediately upon receiving the abuse/neglect allegation, the CNAs were immediately suspended, and an investigation was started. Administrator M said the DON would know more information regarding the incident. During an interview on 03/02/2020 at 11:55 a.m., the DON said administrator K was called by administrator L, who informed him about a video that had been made of a resident and CNA. She said administrator K and the social worker watched the video and identified the resident and CNA. She said the CNAs were suspended and later terminated. She said the two CNAs were fairly new and just did not understand what they had done. The DON said there was no harm to the resident, she did not know what happened or recall the incident. During an interview on 03/02/2020 at 12:03 p.m., the social worker said administrator K was called by administrator L about a snapchat video being made of a resident and the CNAs who were identified. She said administrator L came to the facility and showed them the video and they identified the resident and CNA. She said the CNAs were suspended and later terminated. She said the two CNAs were fairly new CNAs and did not understand what they had done. She said there was no harm to the resident. She said the resident did not know the incident happened and did not recall the incident. During an interview and observation on 03/02/2020 at 04:17 p.m., administrator L said on 12/03/19, he received a phone call from the DON, at another nursing facility. He said she told him she was shown a snapchat video recording by one of her CNAs. He said she sent the video to his phone and said the video was not of a resident in her facility. He said she told him she called her mom, the DON at another local facility and it was not one of their residents, so she called him. He said he and his DON viewed the video and determined it was not one of their residents, so he called the administrator K. He said he went to the facility and showed the video to administrator K and the social worker and they determined the resident was a resident and a CNA at their facility. Administrator L showed the surveyor the video from his phone, it was a short video of a CNA tickling a sleeping resident's nose and then laughing, the name of CNA H was at the top of the video. During a telephone interview on 03/04/20 at 09:01 a.m., administrator K said he had received a phone call from an administrator across town, administrator L, that it had been reported to him that someone locally had posted a 10 second snap chat video of a resident in a nursing facility. He said administrator L said it was not at his facility, so he came to the facility and showed the video to himself and the social worker. He said a search of the facility identified the resident and CNA seen in the video (Resident #71 and CNA H). He said CNA H said CNA J was who videoed her and the resident. He said both CNAs were suspended pending outcome of the investigation and were later terminated when the allegation was confirmed. He said no harm came to Resident #71 because of her cognitive ability, she had no knowledge of the incident and could not recall anything about the incident. He said the facility did several in-services with the staff on abuse and neglect, resident rights, and HIPPA. A handwritten statement dated 12/03/19 by CNA H indicated she understood the video should not have been videoed or posted, she did not mean any harm, and she was sorry. A handwritten statement dated 12/03/19 by CNA J indicated she understood the video posted of the resident was wrong and she was sincerely sorry. An employee signature sheet signed by CNA H dated 08/19/19 indicated that by signing below, she acknowledged she had received and read the resident's rights. An employee signature sheet signed by CNA J dated 08/19/19 indicated that by signing below, she acknowledged she had received and read the resident's rights. An undated abuse policy indicated it is the policy of the facility that all residents, including those with dementia, are not subject to abuse. An undated statement of resident rights indicated it is the policy of the facility that all residents have the right to be free from abuse; be treated with courtesy, consideration, and respect; and privacy. During an interview on 03/05/20 at 1:15 p.m., the facility was asked for any additional information at exit and no additional information was provided.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission and provide the resident and or the resident representative with a summary of the baseline care plan for 5 of 12 residents reviewed for the base line care plans. (Resident #s 16, 61, 38, 79 and 332) The facility did not complete a baseline care plan within 48 hours of admission for Resident #s 16, 61, 38, 79 and 332. The facility did not provide a written summary of the baseline care plan to the resident or responsible party for Resident #s 16, 61, 38, 79 and 332. This failure could place newly admitted residents at risk of not receiving continuity of care and communication among nursing home staff, increase resident safety and safeguard against adverse events that are most likely to occur right after admission. Findings included: 1.) Physician orders [REDACTED].#16 was a [AGE] year old female who admitted [DATE]. She had [DIAGNOSES REDACTED]. The electronic chart and paper chart from 11/19/19 to 3/5/20 did not have a completed baseline care plan for Resident #16. 2.) Physician orders [REDACTED].#61 was a [AGE] year old male, admitted on [DATE] and re-admitted on [DATE] receiving hospice services. He had [DIAGNOSES REDACTED].), chronic [MEDICAL CONDITION] (inflammation (swelling) and irritation of the [MEDICATION NAME] tubes), [MEDICAL CONDITION] (A circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and a disease that destroys the spinal cord and [DIAGNOSES REDACTED] ([DIAGNOSES REDACTED] and [DIAGNOSES REDACTED]). A baseline care plan initiated 06/06/19 was incomplete. The baseline care plan summary form had no initial goals based on admission orders [REDACTED]. During an interview on 03/04/20 at 03:50 p.m., the DON said she had signed the baseline care plan dated 06/06/19 for Resident # 61. She said the care plan was incomplete, she said she was the only person at the facility that did the baseline care plans. 3.) Physician orders [REDACTED].#38 was a [AGE] year old female who admitted [DATE]. She had [DIAGNOSES REDACTED]. The electronic chart and hard chart from 1/18/19 to 3/5/20 indicated there was no completed baseline care plan for Resident #38. 4.) Physician orders [REDACTED].#79 was an [AGE] year old male who admitted on [DATE]. He had [DIAGNOSES REDACTED]. A baseline care plan initiated and dated 10/2[DATE]9 was incomplete. The baseline care plan summary form sections: therapy and personal care were left blank and did not address all diagnoses. 5.) Physician orders [REDACTED].#332 was an [AGE] year old male who admitted on [DATE]. He had [DIAGNOSES REDACTED]. A baseline care plan initiated and dated 2/11/20 was incomplete. The baseline care plan summary form sections: therapy, initial goals, special instructions, special eating equipment, and personal care were left blank. During an interview on 3/4/20 at 1:35 p.m., the DON said she was responsible for completing baseline care plans. She said she did not complete the Goal, therapy or personal care sections, she said she mainly goes over the medication with a family member and have the family to sign the paperwork. The DON said she gets the family member to sign bottom section labeled acknowledgment of receipt, but she did not provide copies of the baseline care plans to the family or resident but would if they asked. During an interview on 3/4/20 at 1:41 p.m., the ADON and DON said they reviewed Resident #s 16 and 38 clinical records and contacted medical records and could not find their baseline care plans. The ADON said it should have been done and did not know why one was not completed. A revised baseline care plan policy dated December 2016 indicated a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. 4) The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to: a) the initial goals of the resident; b) a summary of the resident's medications and dietary instructions; any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d) any updated information based on the details of the comprehensive care plan, as necessary. During an interview on 03/05/19 at 01:15 p.m., the facility was asked for additional information at exit, no additional information was provided.

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F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2)
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure CNAs demonstrated competency in techniques necessary to care for residents' needs as identified through assessments and as described in the written plan of care for 2 of 4 residents reviewed for incontinent care. (Resident #s 32 and 45). *CNA B did not separate Resident #32's labia or sanitize her hands between glove changes while performing incontinent care. *CNA G touched clean items with soiled gloves during Resident #45's incontinent care. This failure could place residents who required incontinent care at risk for cross contamination and infections. Findings included: 1. During an observation on 03/05/20 at 3:15 PM, CNA B provided Resident #32 with incontinent care. CNA B put on gloves and cleaned Resident #32's peri area twice, she did not separate the labia or clean the groin area. Resident #32 had a large amount of bowel in the brief, back of her legs, the sheet and cover. CNA B turned Resident #32 over and wiped the bowel from her buttocks with the same visibly soiled gloves. CNA B changed gloves, she did sanitize her hands between glove changes. Physician orders [REDACTED].#32 was a [AGE] year-old female, admitted on [DATE] with [DIAGNOSES REDACTED]. A significant change MDS dated [DATE] indicated Resident #32 was always incontinent of bowel and bladder and needed extensive assistance. A care plan revised on 02/05/20 indicated Resident #32 was total care for incontinence management. During an interview on 03/05/20 at 3:23 PM, CNA B said she would have changed her gloves more often if she had more in the room. 2. During an observation on 03/02/20 at 09:42 AM, CNA G provided incontinent care for Resident #45. She did not change her gloves after cleaning Resident #45's buttocks. CNA G placed the clean brief on Resident #45 while wearing the same soiled gloves. Physician orders [REDACTED].#45 was a [AGE] year-old female, admitted [DATE] with [DIAGNOSES REDACTED]. An MDS dated [DATE], indicated Resident #45 was always incontinent of bowel and bladder and needed extensive assistance. A care plan revised 01/21/20 indicated Resident #45 wore a brief, required assistance with ADLs, and was to have peri-care provided after each incontinent episode. During an interview on [DATE] at 12:17 PM, CNA G said she forgot to change her gloves after cleaning Resident #45. She said she should have changed her gloves before she picked up the clean brief. A Perineal Care policy dated 2001 and revised February 2018 indicated 8 .b. (1) separate labia and wash area downward from front to back . (2) continue to wash the perineum moving from inside outward to the thighs . During an interview on 03/05/20 at 1:15 PM, the facility was asked for any additional information at exit and no additional information was provided.
F 0790 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide routine and 24-hour emergency dental care for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide routine/emergency dental services to meet the needs of 1 of 4 residents on the secured locked unit reviewed for dental services. (Resident #16) The facility did not arrange dental services for Resident #16 after she admitted with discharge orders for facility to follow up with dental evaluation. This failure could place the residents at risk for not receiving the care and services to maintain the highest practicable well-being. Findings included: Physician orders [REDACTED].#16 was a [AGE] year old female who admitted [DATE]. She had [DIAGNOSES REDACTED]. The order indicated effective 11/19/19 [MEDICATION NAME] regular strength 10% gel apply 4 times daily PRN (as needed) for tooth pain. Effective 11/26/29 [MED] 325mg, 2 tablets Q (every) 6 hours PRN for pain. An initial admission nursing evaluation dated 11/19/19 indicated Resident #16 did not have mouth pain. An initial pain assessment dated [DATE] indicated Resident #16 did not have pain and currently was not taking any pain meds. The initial MDS assessment dated [DATE] indicated in section L, Resident #16 had dental pain, discomfort and had difficulty chewing. An undated care plan indicated Resident #16 had acute chronic pain due to [DIAGNOSES REDACTED].#16 will remain free of complaints or signs/symptoms of pain. Approaches: Observe for complaints or signs of pain and document findings, administer meds per md (doctor) orders and pain meds and notify doctor if medications are ineffective. A patient discharge orders/instruction form dated 11/19/19 indicated Resident #16 discharged to facility and skilled nursing facility to assist with referral for needed dental evaluation. A behavioral health note dated 11/19/19 indicated Resident #16 was discharging to facility and was complaining of tooth pain that was relieved with [MEDICATION NAME] and [MED] ([MEDICATION NAME]). The note indicated at admission nursing home physician is to follow up and dental evaluation was advised. A nursing note dated 11/19/19 indicated the charge nurse did a call-in report with referring facility indicating Resident #16 had complained of tooth pain, was assessed by their doctor who felt it was TMJ and was given [MED]. The note indicated Resident #16 had upper partial with missing teeth. A nursing note dated 12/18/19 indicated Resident #16 had a diet change to mechanical soft due to mouth/jaw pain. Resident #16's spouse requested dental appointment. Staff N notified to schedule an appointment. A nursing note dated 12/18/19 indicated Resident #16's diet was changed to puree. The note indicated staff on the unit reported Resident #16 was having jaw pain (TMJ) (temporomandibular disorder) and was making it painful for the resident to eat. The note indicated the charge nurse was going to talk to physician about jaw pain. A nursing note dated 1/7/20 indicated Resident #16 was agitated and refused going to dental appointment. A nursing note dated 1/14/20 indicated Resident #16 returned back from dental appointment, tooth was extracted, and post-operative instructions was received. During an interview on 3/3/20 at 12:41 p.m., Resident #16's spouse said she had TMJ, and she also had a problem with a tooth which was causing her a lot of mouth pain. He said he had to ask for a dental appointment and he paid out of pocket for appointment. He said Resident #16 mouth pain had decreased a lot since tooth extraction. During an interview on 3/4/20 at 12:30 p.m., the SW said she does not see the discharge orders or paperwork from the discharging facility. She said admissions are the one who reviews discharge orders, and if it was something she needed to assist with then admissions would notify her by communication note. She said she was not aware Resident # 16 had an order for [REDACTED].#16 got a tooth extracted in January. During an interview on 3/4/20 at 1:00 p.m., the DON said for new admissions the charge nurse assigned to the hall the resident will be admitting to will be the admitting nurse. The charge nurse initiates assessments and gives the discharge paperwork to either herself or MDS coordinator. The DON said she enters the orders, completes the face sheet, and [DIAGNOSES REDACTED]. The DON said she did not see the discharge order for dental evaluation, she said she just missed it. She said she would have been the one to see it and enter order into computer. The DON said she should had given a communication note to Staff N who was responsible for scheduling residents' appointments. She said there was not a dental referral made from 11/19/19 to 12/18/19 until Resident #16's spouse requested an appointment. The DON said her expectations were for residents to receive dental services when needed and they should have followed the order for the dental evaluation at admission. She said if it had not been for Resident #16's spouse requesting the appointment then she did not know if Resident #16 would have seen a dentist as soon as she had. During an interview on 3/4/20 at 1:32 p.m., Staff N said she had not been notified to make a dental appointment until the spouse requested it on 12/18/19. She said she was not aware of a dental referral at admission. She said after she spoke with the spouse on 12/18/19 the first available appointment with local dentist was on 1/7/20, she said the resident declined, and she rescheduled the appointment for 1/14/20. Staff N said Resident #16's spouse picked her up and took her to the dental appointment. A revised dental service policy dated December 2016 indicated routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. 1. Routine and 24-hour emergency dental services are provided to our residents through: a) a contract agreement with a licensed dentist that comes to the facility monthly; b) referral to the resident's personal dentist; c) referral to community dentists; or d) referral to other health care organizations that provide dental services.,,,6) social services representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible. During an interview on 03/05/19 at 01:15 p.m., the facility was asked for additional information at exit, no additional information was provided.

F 0803 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation and record review, the facility failed to ensure the menu was followed for 1 of 2 meals reviewed for

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F 0803 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) menus and nutritional adequacy. (Lunch meal 03/02/20) (Resident #s 5, 20, 24, 32, 58, and 79) Dietary staff did not serve pureed bread during the noon meal on 03/02/20 to Resident #s 5, 20, 24, 32, 58, and 79 who received pureed diets. This failure could place residents who eat pureed foods at risk of not having their nutritional needs met. Findings included: The planned menu dated 03/02/20 for the noon meal was meatloaf, baked potato, green peas, roll, and banana pudding for dessert. The diet spreadsheet for the noon meal indicated residents on pureed diets received a #16 scoop (cup) of puree bread. During an observation on 03/02/20 at 12:10 PM, Resident #20's meal tray did not have any pureed bread. During an observation on 03/02/20 at 12:22 PM, Resident #58's meal tray did not have any pureed bread. During an observation on 03/02/20 at 12:34 PM, Resident #79's meal tray did not have any pureed bread. During an observation on 03/02/20 at 12:21 PM, Resident #32's meal tray did not have any pureed bread. During an observation on 03/02/20 at 12:23 PM, Resident #5's meal tray did not have any pureed bread During an observation on 03/02/20 at 12:30 PM, Resident #24's meal tray did not have any pureed bread. During an observation and interview on [DATE] at 11:10 AM, DA E was preparing pureed lemon cake and she said they had 9 residents receiving pureed meals and one resident receiving only pureed meats. A covered stainless-steel pan on the steam table was labeled puree cornbread. During an interview on [DATE] at 12:45 PM, Cook D said they forgot to prepare the pureed bread for the noon meal on 03/02/20 so no residents on pureed diets received bread. During an interview on 03/05/19 at 01:15 PM, the facility was asked for additional information at exit, no additional information was provided.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have an effective infection control program to prevent the development and transmission of disease and infection for 2 of 4 residents reviewed for incontinent care (Resident #32 and #45), 2 of 2 residents reviewed for blood sugar monitoring (Resident #51 and 75), 2 of 2 residents reviewed for insulin injections (Resident #51 and 75), and to conduct an annual review of its Infection Prevention and Control Program (IPCP). *CNA B did not separate Resident #32's labia or sanitize her hands between glove changes while performing incontinent care. *CNA G touched clean items with soiled gloves during Resident #45's incontinent care. *LVN F did not disinfect the glucometer (glucose meter or blood glucose monitoring device, is a home measurement system you can use to test the amount of glucose (sugar) in your blood) after checking Resident #s 51 and 75's fasting blood sugar. *LVN F did not clean the site of injection for insulin for Resident #s 51 and 75. * The facility did not review and update the Infection Prevention and Control Program (IPCP) annually. This failure could place residents at risk for cross contamination and infections. Findings included: 1. During an observation on 03/05/20 at 3:15 PM, CNA B provided Resident #32 with incontinent care. CNA B put on gloves and cleaned Resident #32's peri area twice, she did not separate the labia or clean the groin area. Resident #32 had a large amount of bowel in the brief, back of her legs, the sheet and cover. CNA B turned Resident #32 over and wiped the bowel from her buttocks with the same visibly soiled gloves. CNA B changed gloves, she did sanitize her hands between glove changes. During an interview on 03/05/20 at 3:23 PM, CNA B said she would have changed her gloves more often if she had more in the room. 2. During an observation on 03/02/20 at 09:42 AM, CNA G provided incontinent care for Resident #45. She did not change her gloves after cleaning Resident #45's buttocks. CNA G placed the clean brief on Resident #45 while wearing the same soiled gloves. During an interview on [DATE] at 12:17 PM, CNA G said she forgot to change her gloves after cleaning Resident #45, she said she should have changed her gloves before she picked up the clean brief. An infection control guideline for all nursing procedures dated 2001 revised August 2012 indicated . General guidelines: 1. Standard precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, non-intact skin, and /or mucous membranes . 3. Employees must wash their hands for 10 to fifteen seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: a. Before and after direct contact with residents . c. After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin. D. after removing gloves . 3. During an observation on 03/02/20 at 11:40 AM, LVN F put on gloves, gathered the glucometer, one 2x2 gauze pad, a test strip, and a lancet and entered Resident #75's room. LVN F pricked Resident #75's finger to obtain blood for test, she did not clean her finger with alcohol before or after. LVN F then drew up insulin for Resident #75, she administered the insulin in her right upper arm, without cleaning the injection site. LVN F did not clean the glucometer after use. 4. During an observation on 03/02/20 at 11:53 AM, LVN F put on gloves, gathered the glucometer, one 2x2 gauze pad, a test strip, and a lancet and entered Resident #51's room. LVN F pricked Resident #51's finger to obtain blood for test, she did not clean her finger with alcohol before or after. LVN F did not clean the glucometer after use. 5. During an observation on 03/02/20 at 11:58 AM, LVN F was at the nurse cart, she sanitized her hands, put on gloves, reached into her pocket for the keys, she unlocked the cart and pulled out the [MEDICATION NAME]pen for Resident #51. LVN F locked the cart, put the keys back into her pocket, and coughed into her right hand. She removed the glove from her right hand using her gloved left hand, she put a clean glove on her right hand only and she did not sanitize. LVN F entered Resident #51's room and administered her insulin, she did not clean the injection site. During an interview on 03/02/20 at 12:00 PM, LVN F said she had completed all of the blood sugar checks, she put all trash and the uncleaned glucometer into the drawer of the nurse medication cart. An obtaining a fingerstick glucose level policy dated 2001, revised October 2011 indicated .steps in the procedure .3. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. Single-resident use fingerstick devices should never be used by more than one resident 7. Wash the selected fingertip, especially the side of the finger, with warm water and soap. (Note: if alcohol is used to clean the fingertip, allow it to dry completely because the alcohol may alter the reading. Repeated use of alcohol may toughen the skin) . 12 Wipe the fingertip with a cotton ball to seal the puncture site .18. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standard of practice . An Insulin administration policy dated 2001 revised September 2014 indicated .17. Clean the injection site with an alcohol wipe and allow to air dry An undated glucometer manufacturing manual indicated . To minimize the risk of transmission of blood-borne pathogens, the cleaning and disinfection procedure should be performed as recommended in the instruction below . the meter should be cleaned and disinfected after use on each patient. This blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed . According to the Centers for Disease Control website, http:///www.cdc.gov/mmwr/PDF/wk/mm5409.pdf, viewed on 03/06/20 .the recommended practice for preventing patient-to-patient transmission of [MEDICAL CONDITION] viruses from diabetes-care procedures in long term care settings was to clean and disinfect the device between resident uses . 5. During a record review on 03/04/20 at 11:30 AM, there was no documentation to indicate the facility conducted an annual review of its IPCP and updated their program as necessary. During an interview on 03/04/20 at 11:35 AM, the DON said the facility did not review the IPCP annually and did not have any documentation of an annual review. During an interview on 03/05/20 at 1:15 PM, the facility was asked for any additional information at exit and no additional information was provided. Based on observation, interview, and record review, the facility failed to have an effective infection control program to prevent the development and transmission of disease and infection for 2 of 4 residents reviewed for incontinent care (Resident #32 and #45), 2 of 2 residents reviewed for blood sugar monitoring (Resident #51 and 75), 2 of 2 residents reviewed for insulin injections (Resident #51 and 75), and to conduct an annual review of its Infection Prevention and Control Program (IPCP). *CNA B did not separate Resident #32's labia or sanitize her hands between glove changes while performing incontinent care. *CNA G touched clean items with soiled gloves during Resident #45's incontinent care. *LVN F did not disinfect the glucometer (glucose meter or blood glucose monitoring device, is a home measurement system you can use to test the amount of glucose (sugar) in your blood) after checking Resident #s 51 and 75's fasting blood sugar. *LVN F did not clean the site of injection for insulin for Resident #s 51 and 75. * The facility did not review and update the Infection Prevention and Control Program (IPCP) annually. This failure could place residents at risk for cross contamination and infections. Findings included: 1. During an observation on 03/05/20 at 3:15 PM, CNA B provided Resident #32 with incontinent care. CNA B put on gloves and cleaned Resident #32's peri area twice, she did not separate the labia or clean the groin area. Resident #32 had a large amount of bowel in the brief, back of her legs, the sheet and cover. CNA B turned Resident #32 over and wiped the bowel from her buttocks with the same visibly soiled gloves. CNA B changed gloves, she did sanitize her hands between glove changes. During an interview on 03/05/20 at 3:23 PM, CNA B said she would have changed her gloves more often if she had more in the room. 2. During an observation on 03/02/20 at 09:42 AM, CNA G provided incontinent care for Resident #45. She did not change her gloves after cleaning Resident #45's buttocks. CNA G placed the clean brief on Resident #45 while wearing the same soiled gloves. During an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675878	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY TRAILS WELLNESS & REHABILITATION CENTER	1638 VZ CR 1803 GRAND SALINE, TX 75140

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) interview on [DATE] at 12:17 PM, CNA G said she forgot to change her gloves after cleaning Resident #45, she said she should have changed her gloves before she picked up the clean brief. An infection control guideline for all nursing procedures dated 2001 revised August 2012 indicated . General guidelines: 1. Standard precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, non-intact skin, and /or mucous membranes . 3. Employees must wash their hands for 10 to fifteen seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: a. Before and after direct contact with residents . c. After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin. D. after removing gloves . 3. During an observation on 03/02/20 at 11:40 AM, LVN F put on gloves, gathered the glucometer, one 2x2 gauze pad, a test strip, and a lancet and entered Resident #75's room. LVN F pricked Resident #75's finger to obtain blood for test, she did not clean her finger with alcohol before or after. LVN F then drew up insulin for Resident #75, she administered the insulin in her right upper arm, without cleaning the injection site. LVN F did not clean the glucometer after use. 4. During an observation on 03/02/20 at 11:53 AM, LVN F put on gloves, gathered the glucometer, one 2x2 gauze pad, a test strip, and a lancet and entered Resident #51's room. LVN F pricked Resident #51's finger to obtain blood for test, she did not clean her finger with alcohol before or after. LVN F did not clean the glucometer after use. 5. During an observation on 03/02/20 at 11:58 AM, LVN F was at the nurse cart, she sanitized her hands, put on gloves, reached into her pocket for the keys, she unlocked the cart and pulled out the [MEDICATION NAME]pen for Resident #51. LVN F locked the cart, put the keys back into her pocket, and coughed into her right hand. She removed the glove from her right hand using her gloved left hand, she put a clean glove on her right hand only and she did not sanitize. LVN F entered Resident #51's room and administered her insulin, she did not clean the injection site. During an interview on 03/02/20 at 12:00 PM, LVN F said she had completed all of the blood sugar checks, she put all trash and the uncleaned glucometer into the drawer of the nurse medication cart. An obtaining a fingerstick glucose level policy dated 2001, revised October 2011 indicated .steps in the procedure .3. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. Single-resident use fingerstick devices should never be used by more than one resident 7. Wash the selected fingertip, especially the side of the finger, with warm water and soap. (Note: if alcohol is used to clean the fingertip, allow it to dry completely because the alcohol may alter the reading. Repeated use of alcohol may toughen the skin) . 12 Wipe the fingertip with a cotton ball to seal the puncture site .18. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standard of practice . An Insulin administration policy dated 2001 revised September 2014 indicated .17. Clean the injection site with an alcohol wipe and allow to air dry An undated glucometer manufacturing manual indicated . To minimize the risk of transmission of blood-borne pathogens, the cleaning and disinfection procedure should be performed as recommended in the instruction below . the meter should be cleaned and disinfected after use on each patient. This blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed . According to the Centers for Disease Control website, http:///www.cdc.gov/mmwr/PDF/wk/mm5409.pdf, viewed on 03/06/20 .the recommended practice for preventing patient-to-patient transmission of [MEDICAL CONDITION] viruses from diabetes-care procedures in long term care settings was to clean and disinfect the device between resident uses . 5. During a record review on 03/04/20 at 11:30 AM, there was no documentation to indicate the facility conducted an annual review of its IPCP and updated their program as necessary. During an interview on 03/04/20 at 11:35 AM, the DON said the facility did not review the IPCP annually and did not have any documentation of an annual review. During an interview on 03/05/20 at 1:15 PM, the facility was asked for any additional information at exit and no additional information was provided.
F 0920 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture.** Based on observation, interview and record review the facility failed to ensure sufficient space to accommodate all activities for 1 of 1 dining room on secured unit observed. The facility did not provide a main dining room on the secured locked unit that accommodated all residents without causing resident crowding. This failure could place the residents at risk for injury, discomfort, and decreased quality of life. Findings included: During an observation of the lunch meal on 3/2/20 at 12:34 p.m., there was 2 tables with 4 residents at each table and two staff assisting residents with lunch meals. There was 4 additional residents who sat in the sitting area located next to the dining room tables, one resident sat in a recliner, a second resident sat in a loveseat, and two residents sat in sofa chairs using overbed tables as a table for the lunch meal. A resident roster printed on 3/2/20 indicated there was 14 residents who reside on the secured locked unit. During an interview on 3/4/20 at 12:42 p.m., CNA C said there was not enough space for all the residents on the unit to sit at the tables in the dining room during meal services and some of the residents had to sit in the sitting area and use the overbed tables. She said the max they normally sat at each table was four residents and the rest either ate in their rooms or had to sit in the sitting area on the couch with overbed tables. During an interview on 3/4/20 at 12:47 p.m., CNA B said there was not enough space at the two dining room tables for all 14 residents to eat at. She said normally they just put four residents to a table for comfortable seating, but if they had to seat everyone at the table they could move one of the tables away from the wall and attempt to seat 6 residents at each table totaling 12 residents. She said it still would not work because two residents would have to eat at the couch, nor would it be room at the tables for staff to assist residents who required assistance with meals. She said there was 2 or 3 residents who staff assist with meals. During an interview on 3/4/20 at 3:41 p.m., the administrator said the two dining room tables were about 6 feet long each and if he needed to he could try and squeeze 8 residents in one table and 6 at the second table although it would be tight. The administrator did not answer when asked by surveyor where would the staff sit who assisted residents with meals and required assistance. During an interview on 03/05/19 at 01:15 p.m., the facility was asked for additional information at exit, no additional information was provided.