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	11/26/2025

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 (Resident #1) of 3 resident reviewed for medication administration. The facility failed to ensure MA G did not administer Resident # 1's morning medication late. This deficient practice could place residents at risk for adverse effects and not receiving the therapeutic effects of the medication.Record review of Resident #1's face sheet dated 10/23/25 revealed she was a [AGE] year-old female admitted to the facility initial on 07/02/24 and readmitted on [DATE]. Resident #1 had diagnoses which included: hypertension(force of the blood pushing against the artery walls is consistently too high), epilepsy(brain disorder that causes repeated unprovoked seizures)heart failure (heart muscle cannot pulp enough blood and oxygen to meet the body's needs), and cerebral infarction (stroke where a part of the brain is damaged) Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS of 12 out of 15 indicating moderately impaired cognition. Further review revealed Resident #1needed maximal assistance with ADLs which required at least one staff assistance. Record review of Resident #1's care plan initiated on 08/19/25 revealed the following care areas: *Resident #1 had a seizure disorder. An intervention was to : administer anticonvulsant medication routinely as ordered by physician. *Resident #1 had anxiety. An intervention was to administer medication buspirone as ordered by physician. *Resident #1 had dementia and impaired thought processes. An intervention was to administer medication memantine as ordered. *Resident #1 had depression. An intervention was to administer antidepressant medications, Lexapro and trazodone as ordered by physician. Record review of Resident #1's order summary report for October 2025 read in part::*Acidophilus Probiotic Oral Tablet (Lactobacillus) 1 tablet by mouth one time a day for Supplement 500 start date 08/19/2025,* Ferrous Sulfate Tablet 325 (65 Fe) MG Give 1 table by mouth one time a day for Anemiastart date 08/27/2025, *Gabapentin Capsule 100 MG Give 1 capsule by mouth three times a day start date 01/27/2025, Levetiracetam Oral Tablet (Levetiracetam) Give 500 mg by mouth every 12 hours for Seizures start date 07/03/2024,Lexapro Oral Tablet 10 MG (Escitalopram Oxalate) Give 1 tablet by mouth one time a day for Anxiety start date 07/03/2024,Memantine HCl Oral Tablet 10 MG (Memantine HCl) Give 1 tablet by mouth two times a day for dementia start date 08/21/2025,Trazodone HCl Oral Tablet 50 MG (Trazodone HCl) Give 0.5 tablet by mouth every 12 hours for depression and insomnia r/t depression start 10/12/2025,Triamterene-HCTZ Tablet 37.5-25 MG Give 1 tablet by mouth one lime a day for HF Hold for SBP less than 100 OR DBP < 60 Start date 04/29/2025,Zinc Oral Tablet 50 MG (Zinc) Give 1 tablet by mouth one time a day for supplement start date 10/16/2024, and Buspirone HCl Oral Tablet 10 MG (buspirone HCl) Give 1 tablet by mouth one time a day for Anxiety start 02/13/2025Record review of Resident #1's MAR for October 2025 read as follows:*Acidophilus Probiotic 500 million CFU was scheduled for 8:00a.m once a day*Ferrous Sulfate Tablet 325 (65 Fe) mg was scheduled for 8:00a.m. once a day*Lexapro Oral Tablet 10 mg (Escitalopram Oxalate) was scheduled for 8:00a.m. once a day*Zinc Oral Tablet 50 MG(Zinc) was scheduled for 8:00 a.m. once a day*Trazodone HCl Oral Tablet50 MG (Trazodone HCl) Give 0.5 tablet every 12 hours was scheduled for 8:00 a.m. and 8:00 p.m.*Memantine HCl Oral Tablet 10MG (Memantine HCl) Give 1 tablet by mouth two times a day was scheduled for 8:00 a.m., and 7:00 p.m. *Gabapentin Capsule 100MG was scheduled for 8:00a.m.,1:00 p.m., and 6:00p.m., three times at *Triamterene-HCTZ Tablet 37.5-25 MG scheduled for 7:00a.m for once a day*Levetiracetam Oral Tablet (Levetiracetam) Give 500 mg by mouth every 12 hours for Seizures scheduled for 7:00 a.m. and 7:00p.m. *Buspirone HCL 10mg was scheduled for 9:00a.m., for once a day.During observation and interview on 10:23/25 at 10:49 a.m., it was revealed that MA G's computer screen showed that all morning medication for Resident #1 was marked red. MA G said the computer screen was red because she did not administer the medication as scheduled. The surveyor observed MA G administered the following medications at 10:49 a.m. : *Acidophilus Probiotic Oral Tablet (Lactobacillus), *Ferrous Sulfate Tablet 325 (65 Fe), *Gabapentin 100 mg, *Levetiracetam 500 mg, *Lexapro 10 mg, Memantine HCl 10 mg, *Trazodone HCl 50 mg, *Triamterene-HCTZ Tablet 37.5-25 mg, *Zinc 50 mg, and Buspirone HCl 10 mg. During an interview on 10/23/25 at 3:10 p.m., MA G said she did not give Resident #1's morning medication on time today, because she was late passing medication. MA G said she did not follow the physician's order because she did not administer all of Resident #1's morning medication on time. MA G said she did not give Resident #1's seizure

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, record review, and interview, the facility failed to ensure that drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles for 1(station A) of 3 medication aide cart, reviewed for medications storage.- The facility failed to ensure MA G did not leave Station A's MA medication cart unattended. This failure could affect residents, placing them at risk for taking medication which could affect the resident's health, requiring medical intervention and drug diversion. The findings include: During an observation on 10/23/25 at 9:52 a.m., surveyor observed MA G parked the unlocked station A medication aide's cart close to the TV room and the dining area. There were six residents in the TV area, and several residents were propelling themselves around the area.During an observation and interview on 10/23/25 at 9:54 a.m., LVN J said she could see MA G had left station A medication aide's cart unlocked. LVN J said MA G should always lock station A medication aide cart for safety. She said MA G should have locked the medication to prevent residents from accessing the medication cart and taking any medication. LVN J said when station A medication aide's cart was left unlocked, it would cause medication errors because anybody could get into the cart and take any medication. She said if the resident had taken any medication from the cart and administered the medication to himself, it could be harmful for the resident because the resident took the medication he was not supposed to take.During an interview on 10/23/25 at 3:29 p.m., MA G said she should have locked the station A medication aide cart when not in use or out of sight. She said she forgot to lock the cart when she went to the restroom, because she was moving very fast. MA G said it was a safety hazard issue because a resident could get into the cart and take medicine, which could harm the resident.During an interview on 10/23/25 at 3:41 p.m., the DON stated nurses and medication aides are supposed to lock their carts when not in use. The DON said the medication aides' carts are supposed to be locked to prevent residents from getting into them, and they have many residents with dementia. She said there could be a thief if staff or anyone else took medication from the unlocked cart. The DON said if a resident takes medication from Station A medication aide's cart and administers the medication to himself, the resident could overdose or be exposed to other side effects. She said Station A medication aide cart contained all the residents' medication in 200 hall.Record review of the facility undated storage of medication storage policy read in part . ensure that all medications are stored in a safe, secure. procedure #6 . compartments containing medications are locked when not in use .