

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Paradigm at First Colony		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 Lexington Blvd Missouri City, TX 77459	
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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure 7 of 7 residents reviewed for admission to the secured unit were free from involuntary seclusion. The facility failed to ensure Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9 and Resident #10, whose assessments indicated they were low risk for elopement, had no evidence of history of elopement, had no physician's order for admission to the secure unit, had no IDT decision, were admitted to the secure unit with evidence of clinical criteria. The failures placed all residents on the secured unit at risk of not being assessed properly, not meeting the criteria to be placed on the unit., diminished quality of life and involuntary seclusion. 1. Record review of Resident #4's admission face sheet revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included arthritis (condition that cause joint pain, stiffness and swelling), Non-Alzheimer disease (brain disorder that causes a decline in thinking skills), seizure disorder (involuntary movement), and malnutrition (a serious health condition caused by a lack of excess of or imbalance in nutrient and energy intake. Record review of Resident #4's admission MDS dated [DATE] revealed a BIMS score of 10 indicating she was moderately impaired for decision making. Record review of Resident #4's physician's order dated revealed Resident #4 was to be placed on the secured unit. Further record review of Resident #4's clinical record revealed no documentation that the resident was assessed, the resident had a prior risk of elopement, or that the IDT had discussed the resident's placement in the secured unit. Record review of Resident #4's elopement risk assessment dated [DATE] revealed she was coded as low risk for elopement. Observation on 7/24/2026 at 9:18am, Resident #4 was observed in the secured unit. She was clean and groomed with no offensive odor. She was alert with some confusion. Interview with Resident #4 revealed she wanted to go home. She said her home was in north side, and she could take care of herself. She said she had seizures and sometimes she forgot to take her medication. Resident #4 said she did not care about moving to another part of the facility, said she wanted to leave and go home. She said she had a cell phone but it was not working. 2. Record review of Resident #5's admission face sheet revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included non-Alzheimer (disease brain disorder that causes a decline in thinking skills), hypertension (high blood sugar), and unspecified dementia (decline in memory and thinking). Record review of Resident #5's admission MDS dated [DATE] revealed a BIMS score of 10 indicating she was moderately impaired for decision making and had no behaviors. Record review of Resident #5's physician's order dated revealed no physician's order for Resident #5 to be placed in the locked unit. Further record review of Resident #5's clinical record revealed no documentation that the resident was assessed, the resident had no prior risk of elopement, or that the IDT discussed the resident's placement in the locked unit. Further (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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record review revealed no documentation of Resident #5 wandering and trying to exit. Observation of Resident #5 at 2:45pm revealed she was sitting in a chair, asleep in the lobby area. She was clean and groomed with no offensive odor. 3. Record review of Resident #6's admission face sheet revealed she was a 62-year - old female who was admitted to the facility on [DATE]. Her diagnoses included arthritis (swelling and tenderness in one or more joints), non-Alzheimer (disease brain disorder that causes a decline in thinking skills), and malnutrition (a serious health condition caused by a lack of excess of or imbalance in nutrient and energy intake). Record review of Resident #6's admission MDS dated [DATE] revealed a BIMS score of 10 indicating she was moderately impaired for decision making. Record review of Resident #6's physician's order dated July 2026 revealed no order for Resident #6 to be placed on the locked unit. Further record review of Resident #6's clinical record revealed no documentation that the resident was assessed, the resident had no history of elopement, or that the IDT discussed the resident's placement in the locked unit. Record review revealed the incident happened overnight and decides on 7/6/2026 based on the charge nurse documentation. Where Resident #6 pull the door alarm around 12 mid night when Resident #6 pull the alarm at the exit door and walk out. The CNA got the Resident #6 and brought him back. Resident #6 was placed on 1 to 1 and the following day he was placed in the secured unit. Record review of the Resident #6's elopement risk assessment dated [DATE] revealed he was coded as low risk for elopement. Further record review revealed no documentation that the resident was monitored or any other intervention was put in place before the resident was placed on the unit. Observation on 7/23/2026 at 2:40pm revealed Resident #6 was not alert or oriented. He was in his wheelchair. He was clean and groomed with no odor. 4. Record review of Resident #7's admission face sheet revealed she was an [AGE] year-old female who was admitted to the facility on [DATE] and was readmitted on [DATE]. Her diagnoses included hypertension (high blood pressure), metabolic encephalopathy (brain failure caused by body illness or chemical imbalance), diabetes (high blood sugar), Parkinson's (brain disorder characterized by tremors, muscle stiffness and slow movement), and unspecified dementia (decline in memory and thinking), unsteady gait and, muscle weakness. Record review of Resident #7's admission MDS dated [DATE] revealed a BIMS score of 00 indicating she was severely impaired for cognitively for decision making and had no behaviors. Record review Resident #7's physician's order dated July 2026 revealed no physician's order for Resident #7 to be placed in the locked unit. Further record review of Resident #7's clinical record revealed no documentation that the resident was assessed, the resident had no prior risk of elopement, and that the IDT team did not discussed the resident's placement in the locked unit. Record review of the Resident #7's elopement risk assessment dated [DATE] revealed the resident was coded as low risk for elopement. Observation 7/24/2026 at 9:36 am of Resident #7 revealed she was in bed, and she was unable to transfer herself from the bed to wheelchair. Resident #7 was non interview able, and she did not respond to any questions. Record review of the care plan dated 3/27/2026 for Resident #7 requires a secure unit related to dementia. Revision on 3/27/2026Resident #7 safety will be maintained through appropriate supervision and a structured/supportive environment through the review. Administer medications as ordered. Behavior Control: utilize techniques such as redirection, distraction, and calming.ELOPEMENT RISK: Resident #7 at risk for wandering and elopement related to Dementia. Resident #7 safety will be maintainedthrough a structured environment through the review date revised on 4/11/2026. Resident #7 will not wander outside the facility or elope through the review date. Conduct frequent checks on the resident, especially during high-risk times, Maintain resident safety during increased episodes of wandering. Missing Resident: initiate elopement protocols, Monitor resident's location frequently throughout shift. Offer engaging activities that interest the (continued on next page)		

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents and reduce restlessness. Offer fluids and snacks during increased episodes of wandering - encourage frequent rest breaks. Provide comfort measures such as familiar objects, music, or sensory activities that calm the resident. 5. Record review of Resident #8's admission face sheet revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included hypertension (high blood pressure), anxiety (reaction to stress), Paranoid schizophrenia (heavy distrust, false belief and sensory disturbance) depression (mood disorder catheterized by persistent sadness and loss of interest in activities), cognitive communication (way of thinking, reasoning and understanding), and unspecified dementia (decline in memory and thinking). Record review of Resident #8's quarterly MDS dated [DATE] revealed a BIMS score of 00 indicating he was severely impaired for cognitive decision making and had no behaviors. Record review Resident #8's physician's order dated July 2026 revealed no physician's order for Resident #8 to be placed in the locked unit. Further record review of Resident #8's clinical record revealed no documentation that the resident was assessed, the resident had a prior risk of elopement, or that the IDT team discussed the resident placement in the locked unit. Record review of Resident #8's elopement risk assessment dated [DATE] revealed she was coded as low risk for elopement. Observation of Resident #8 on 7/23/2026 at 2:40 pm in her wheelchair asleep in the lobby area. She was clean groomed with no odor. 6. Record review of Resident #9's admission face sheet revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included hypertension (high blood pressure), diabetes (high blood sugar), Alzheimer (progressive brain disorder) and unspecified dementia (decline in memory and thinking). Record review of Resident #9's quarterly MDS dated [DATE] revealed for cognitive decision making she was coded as moderately impaired and had no behaviors. Record review Resident #9's physician's order dated July 2026 revealed no physician's order for Resident #9 to be placed in the secure unit. Further record review of Resident #9's clinical record revealed no documentation that the resident was assessed, the resident had a prior risk of elopement, and that the IDT team discussed the resident's placement in the locked unit. Record review of Resident #9's elopement risk assessment dated [DATE] revealed was coded as low risk for elopement. Observation of Resident #9 on 7/23/2026 at 4:45pm revealed she was sitting in a chair asleep in the lobby area. 6. Record review of Resident #10's admission face sheet dated 7/24/2026 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE] and was readmitted on [DATE]. Her diagnoses included hypertension high blood pressure), bipolar disorder (a mental health condition that causes extreme shift in mood and energy level), metabolic encephalopathy (brain failure caused by body illness or chemical imbalance), diabetes (high blood sugar), Parkinson (brain disorder characterized by tremors, muscle stiffness and slow movement), and unspecified dementia(decline in memory and thinking). Record review of Resident #10's admission MDS dated [DATE] revealed a BIMS score of 00 indicating she was severely impaired for decision making and had no behaviors. Record review Resident #10's physician's order dated July 2026 revealed no physician's order for Resident #10 to be placed in the locked unit. Further record review of Resident #10's clinical record revealed no documentation that the resident was assessed, the resident had a prior risk of elopement or that the IDT discussed the resident's placement in the locked unit. Record review of Resident #10's care plan dated 7/15/2026 has a diagnosis of dementia and is at risk for increased confusion and decline in ADL's as the diseases progress. Resident #10 needs will be anticipated and met by staff over the next 90 days. Administer medication(s) as ordered by MDR. Record review of the Resident #10's elopement risk assessment dated [DATE] revealed the was coded as low risk for elopement. Observation on 7/24/2026 at 11:00 am revealed Resident #10 in activity. The resident was clean with no offensive odor. The resident was alert but confused, and the (continued on next page)		

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident did not respond when her name was called. Interview on 7/23/26 12:25pm the memory care Unit Manager said he had been working at the facility since September 2025. He said residents who were admitted to the secured unit usually have diagnosis of dementia or history of elopement and needed to be in memory care. He said the elopement risk was done at admission and follow ups and evaluations were usually done. He said the residents would be considered if they were not cognitive aware. He said they some residents were assessed by other facility or hospital and make they will make recommendation as to which unit in a facility a resident should be admitted . He said admission would be determined based on medical history and evaluation. He said the Unit Manager did not play a role in determining which resident was admitted . He said the elopement assessment was done 30 days from the time of admission. He said the IDT group determined who was admitted to the unit. He said the main reasons for admission to the memory care unit was elopement (the main reason), being severely confused and dementia. Interview on 07/24/26 at 10:08AM with the Social Worker revealed she had been working at the facility for 4 years. She said she was not a part of the admission process regarding admission to the MCU but provided input as needed when the facility has their morning meetings if she felt the resident was not properly placed on the MCU. The SW said it was the nurses who did the elopement assessment/risk. The SW said she thought the criteria to place a resident on the MCU would be memory issues with a diagnosis of dementia, low BIMS under 12, and elopement risk. She said if a resident's elopement risk was not high in her opinion, the resident should not be on the MCU but a resident's BIMS could also change. The SW said sometimes she disagrees with the placement of residents on the MCU when discussed in the morning meetings. The SW said regarding Resident #4 the speech therapist assessed Resident#4 and her BIMS score was 6 and that she went later and Resident #1's BIMS score was 10. The SW said was admitted to the NF on 07/02/26. The SW said a care plan meeting was done with Resident #4's family members because the resident was very confused and that family member was very involved with the resident care. The SW said when a resident was admitted to the facility, she noticed the resident did not have a RP and they added the family member to the face sheet as the RP who signed the admission paperwork. The SW said the family had shared that Resident #4 was independent and until recently. The SW said the family or Resident #4 never shared that there were any problems with their relationship. The SW said the facility had not done an IDT meeting regarding Resident #4 but had done the Comprehensive Care Plan. The SW said Resident #4 was on skilled care at the present time because she was not safe to go home and the family members could not drive. The SW said a POA had not been signed for Resident #4 due to resident's decreased cognition, and the resident's plan of care was still being discussed. The SW said no guardianship had been initiated for Resident #4 but she would start today on initiating the process. The SW said ongoing assessments needed to be done for resident's residing on the MCU. The SW said if a resident was improperly placed on the MCU, it would place the resident at risk of their freedom, depression, and decline in health. In an interview on 7/24/26 at 10:50am with the Regional Nurse revealed that residents on the memory care unit are reassessed when there was a change in condition or quarterly. She said they receive clinical risk assessment and risk of elopement. She said residents are placed in secure unit when they have a history of elopement but still will evaluate them. She said resident history was important and past behaviors can be triggered. She said they did not confine residents to the unit and they can go outside. She said she did not feel residents' rights were not violated, she said their safety was important. She was asked about Resident #6 being placed on the unit because he pulled the exit door alarm and went through the door. She said they had him on 1:1 monitoring and lab work was done to see if he had a UTI before he was placed on the unit. She said he needed constant redirecting and attempted to leave one night, and he was placed on the (continued on next page)		

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unit. The Regional Nurse reported the nurses did not document Resident #6's exact behaviors, but she knew he tried to get out the exit door. She said they were aware that staff had issues with documentation. She said the nursing team reassessed residents on the secure unit on the night of 7/23/2026 and Resident #7 and Resident #10 would be moved off the secure unit to the general population and Resident #6 would be discharged home. In an interview on 7/24/2026 at 11:00am with the DON, she said before admission of a resident they reviewed their clinical records to ensure the proper criteria for the secured was met. She said moving forward they will also gather information from family and previous facility and monitor residents to ensure they are properly placed. In an interview with the DON on 7/24/2026 at 1:23 PM she said they had QAPI meeting monthly, but it did not specifically address the secured unit. She said QAPA usually addresses changes in condition and behaviors of residents. She said the IDT also discussed who should be on the secured unit. She said they usually involved the MDS nurse, the SW, and in the care plan meetings. She said moving forward they will ensure that residents were properly assessed ensuring the criterias for the secured unit were met. Record review of the facility's policy and procedures for the Secured Unit dated 1/2026 read in part. PolicyThe facility may provide a secure unit environment for residents requiring additional supervision related to cognitive impairment, wandering risk, behaviors, or safety concerns. The facility will provide care and supervision in a safe manner while maintaining resident rights and dignity. Procedureadmission to Secure UnitResidents may be admitted or transferred to the secure unit based on:Physician recommendation, Cognitive impairment, Wandering or exit-seeking behaviors and Interdisciplinary Team recommendation Resident CareResidents will: Receive supervision based on assessed needsHave individualized care plans and interventionsBe monitored for changes in condition or behaviorsReceive activities and services appropriate to their needs Safety The facility will:Use the least restrictive interventions possible		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview and record review the facility failed to ensure residents who were incontinent of bowel and bladder received appropriate treatment and services to prevent urinary tract infections for 2 of (Resident #2, Resident #3) of 3 residents reviewed for incontinent care. -CNA A failed to provide incontinent care in a timely manner for Resident #3. During incontinent care on 07/22/26, Resident #3's brief and draw sheet was heavily soiled with urine. -CNA C failed to clean Resident #2's perineal area one wipe at a time during incontinent care. These failures could place residents at risk for unwanted skin breakdown and infections. Resident #3 Record review of Resident #3's face sheet dated 07/22/26 revealed a [AGE] year-old female admitted to the facility on [DATE] and again on 07/12/26. Resident #3's diagnoses included: altered mental status, depression, and anxiety. Record review of Resident #3's admission MDS dated [DATE] revealed a BIMS score of 9 indicating the resident's cognition was moderately impaired. Section H-Bladder and Bowel revealed that Resident #3 was always incontinent of bladder and bowel. Record review of Resident #3's Comprehensive Care Plan dated 06/15/26 reflected the resident was care planned for urinary incontinence that include the following intervention: perform routine rounding to include incontinence care and brief changes. Observation on 07/22/26 at 9:48AM of incontinent care for Resident #3 by CNA A and CNA B revealed Resident #3's brief was heavily soiled in urine. When Resident #3 was positioned to her left side, it was observed the resident had a towel on top of the draw sheet, and both linens were heavily soiled in urine. Resident #3 had a wound to her sacral region (the bone that is situated at the base of the spine, above the tailbone, and between the hip bones). The dressing to the sacral wound was no longer intact. When done providing care for Resident #3, the CNAs informed the Wound Care Nurse to redress the resident's wound to the sacral region. Interview on 07/22/26 at 10:34 AM Resident #3 said the last time her brief had been changed was on the night shift around 3:00AM. Resident #3 said the morning CNA had not changed her brief until the surveyor observed incontinent care on 07/22/26 at 9:48AM. Interview on 07/22/26 via phone at 4:30PM CNA A said she worked at the facility full time on the morning shift from 6AM-2PM. CNA A said she was Resident #3's CNA. CNA A said she provided incontinent care for the residents every 2 hours. CNA A said the reason she did not provide incontinent care for Resident #3 when she came on shift was because she could not find any disposable wipes or towels. CNA A said she attempted to provide incontinent care for Resident #3 around 7:00AM after she took wipes from the hospice storage room to provide care for Resident #3. She said she did not provide care to Resident #3 because she had to start passing breakfast tray. CNA A said it was important to provide the residents with timely incontinent care to avoid skin breakdown and infections. Interview on 07/22/26 at 5:06PM the Laundry Supervisor said the facility did not have any issues with linen and that the laundry aide made rounds on each nursing unit every 2 hours and as needed stocking the units with linen. The laundry supervisor said the staff in the laundry department went home at 7:00PM. The laundry supervisor said every unit charge nurse had a key to the laundry room if they needed more linen. Observation on 07/22/26 at 5:15PM revealed the laundry room having linen with the staff organizing clean linen to be delivered to the units. Further observation of the laundry department having a storage room with overflow of linen that consisted of towels, sheets, blankets, and bedspreads. Observation on 07/23/26 at 6:10AM of the units stocked with resident care supplies on carts on the halls that consisted of clean linen, disposable wipes, and briefs. Interview on 07/23/26 at 7:00AM the DON said she took the role of the DON about 2 weeks ago (continued on next page)		

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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 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 establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 (Resident#1 Resident #2, Resident #3) of 3 residents reviewed for infection control. The wound care nurse failed to change gloves, sanitize her hands and place on a new set of gloves before applying a clean dressing to Resident #3's sacral wound. CNA A and CNA B failed to wash hands prior to providing incontinent care for Resident #3 on 07/22/26. CNA A and CNA B failed to don (put on) full PPE on 07/22/26 when providing incontinent care for Resident #3 who was on enhanced barrier precautions. CNA C failed to wash/sanitize hands prior to, during, and after providing incontinent care for Resident #2 on 07/22/26. The facility failed to ensure Resident #1's Foley bag was not on the floor on 7/22/2026 and 7/24/2026 These failures place residents at risk for cross contamination and unwanted infections. Record review of Resident #3's face sheet dated 07/22/26 revealed a [AGE] year-old female admitted to the facility on [DATE] and again on 07/12/26. Resident #3's diagnoses included: altered mental status, depression, and anxiety. Record review of Resident #3's admission MDS dated [DATE] revealed a BIMS score of 9 indicating the resident's cognition was moderately impaired. Section M-Skin Condition revealed the stage 4 is a deep opening where the bone, muscle and tendon are visible through the opening)at resident had a pressure ulcer/injury over bony prominence and being at risk of developing pressure ulcer with 1 stage 4 (pressure ulcer that was present upon admission. Record review of Resident #3's Physician's Order Summary Report for the month of July 2026 reflected the following order: -Dated 06/28/26 Enhanced Barrier Precautions-PPE: gloves and gowns during high contact resident care activities Record review of Resident #3's Comprehensive Care Plan revealed that resident was being care planned for Enhanced Barrier Precautions dated 06/28/26. An intervention included PPE: gown and gloves during high-contact resident care activities (dressing, bath/showering, transferring, providing hygiene, changing, changing briefs, assisting with toileting, device care, and wound care). Observation of incontinent care on 07/22/26 at 9:48AM by CNA A and CNA B for Resident #3 revealed there was EBP signage outside of the room entrance door. CNA A entered the room with gloves in hand. CNA B, who was already in the room, left the room to go and gather supplies for incontinent care. CNA B returned to the room at 9:50AM with a plastic bag. Inside of the plastic bag was resident care supplies that consisted of gloves and disposable wipes. CNA A put on gloves without washing or sanitizing hands. CNA A did not don (put on) a disposable gown. CNA B began to place on gloves but not a disposable gown and began to assist with incontinent care for Resident #3. Further observation was made of Resident #3 having an EBP signage over the head of bed. Resident #3's brief was heavily soiled with urine. Resident #3 had a towel on top of the draw sheet, and both the towel and drawsheet were heavily soiled with urine. Resident #3's dressing to the sacral region (a flat triangle shaped bone at the base of the spine) was not intact and the wound was exposed. The wound was approximately the size of coin (quarter). The wound bed was a pale pink color with small amount of redness with no drainage or odor detected. When done providing care for Resident #3, CNA A left the room without washing or sanitizing her hands, and had passed by a hand sanitizer dispenser that was mounted on the right side of the wall, continuing to take soiled materials to the soiled utility room. After CNA A placed the soiled bag of linen inside of the soiled utility room. CNA A proceeded to remove clean linen off clean linen cart and went inside of another resident's room. Observation of wound care on (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/22/26 at 10:20AM for Resident #3 by the Wound Care Nurse revealed the Wound Care Nurse was observed in the resident's room standing at the foot of resident bed with PPE donned (putting on an item of clothing) that consisted of a gown and gloves and holding wound care supplies to do Resident #3's dressing change. Resident #3's dressing to the sacral region had come off during incontinent care. The wound bed was pale pink in color with no drainage or odor detected. The Wound Care Nurse began to clean the resident's wound to the sacral region with normal saline. After cleaning the resident's wound bed, the Wound Care Nurse did not remove her gloves or sanitize her hands and instead proceeded to provide care to the other wound with the same gloves on. After patting dry the wound bed with dry gauze, the wound care nurse applied collagen (wound treatment to increase tissue growth, manage drainage) to the wound bed and covered the wound with a gauze border dressing. When the Wound Care Nurse was done providing dressing change, she then removed her gloves along with remaining PPE and placed the soiled materials inside of a red biohazard bag and washed her hands. The Wound Care Nurse disposed of the soiled materials inside of the soiled utility room. Interview on 07/22/26 at 3:31PM the Wound Care Nurse said she should have changed her gloves after cleaning Resident #3's wound to prevent cross contamination of the wound bed. The Wound Care Nurse said she became nervous. Record review of the facility on Dressing Changes: Wound revised June 2019 reflected in part: It is the policy of this facility that dressing changes will follow specific manufacture's guideline and general infection control principles. Wash hands before and after donning gloves. Put on gloves, remove old dressing and packing (if present), remove gloves and wash hands, put on clean gloves, cleanse the wound bed of drainage, debris, or dressing/filler residue, remove gloves and wash hands, put on clean gloves. Record review of Resident #2's face sheet dated 07/22/26 revealed an [AGE] year-old female admitted to the facility on [DATE] and again 10/27/25. Resident #2's diagnoses included the following: chronic (a long time) multifocal (different areas) osteomyelitis (infection within the bone) of the left ankle and foot, age related osteoporosis (when the bones become weak and easy to break), and gastrostomy (surgical opening from the outside of the belly directly into the stomach used to place a feeding tube so a person can receive food, liquids, and medicine when they cannot swallow). Record review of Resident #2's annual MDS dated [DATE] Section C-cognitive Patterns reflected that resident cognitive skills were severely impaired. Section H-Bladder and Bowel revealed that Resident #2 was always incontinent with urine and bowel. Record review of Resident #2's Physician's Order Summary Report for the month of July 2026 included the following order: -Dated 05/22/26 Enhanced barrier precautions. Record review of Resident #2's Comprehensive Care Plan dated 07/21/26 reflected that resident was care planned for incontinent care r/t impaired mobility with an intervention that included to monitor/document for s/sx of UTI. Further review revealed that resident was being care planned for Enhanced Barrier Precautions dated 05/22/26 with an intervention to monitor for s/s of infection. Observation on 07/22/26 at 11:15AM of incontinent care for Resident #2 by CNA B and CNA C revealed on the outside of resident room door was an EBP signage. CNA C began to place a disposable gown on outside Resident #2's room in the hallway. CNA C while in the hallway, placed on gloves without washing or sanitizing her hands. CNA B went into Resident #2's room, washed her hands, put on a pair of gloves, and a disposable gown. CNA C began to provide incontinent care for Resident #2. At 11:35AM CNA C removed her PPE and said she needed to get more supplies to finish incontinent care because she had discovered the resident was also incontinent of bowel as well. CNA C left the room without washing her hands. CNA C returned to room at 11:38AM with extra linen. CNA C placed on a disposable gown and a new set of clean gloves without washing her hands first and resumed care for Resident #2. When CNA B and CNA C had finished providing incontinent care for (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	before entering a resident room, during care for the resident, and after administering care for a resident for infection control. In an interview on 7/23/2026 at 10:30am CNA B said she was not Resident #1's aide. She said she was in-serviced on infection control, peri care, abuse neglect, Foley care and mechanical lift transfers. She said with regards to Resident #1's Foley bag, it should not be on the floor. She said it should be attached to the bed rail and should be off the floor. She said the Foley bag directly on the floor placed residents at risk of infection. Interview on 7/24/2026 at 10:20 am with the DON regarding the Foley bag directly on the floor, she said the Foly bag should not be on the floor and she was going to fix it. She said all staff needed to do was just lift the bed a little higher so the bag could be off the floor. She said she was going to in-service the staff and do an audit to ensure no Foley bags were directly on the floor. The facility policy on Infection Control Program revised December 2024 reflected in part: .The facility will establish a comprehensive infection control program encompassing essential elements to safeguard the health and safety of residents, staff, and visitors. The facility is dedicated to maintaining a safe and healthy environment by implementing and effective infection control program that adheres to state and federal regulations and follows evidence-based practices recommended by the CDC. Record review of the facility policy on Enhanced Barrier Precautions revised March 2024 reflected in part: .EBP's is an infection control intervention designed to reduce the transmission of multidrug-resistant organisms and employs target gown and gloves use during high-contact resident care activities for targeted residents.EBP are indicated for residents with any of the following: wounds and/or indwelling medical devices.EBP should be employed for the following high resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing briefs, assisting with toileting, device care, and wound care. Record review of the facility policy on Hand Hygiene revised December 2024 reflected in part: .It is the policy of the facility to prioritize hand hygiene as a fundamental practice in preventing the spread of infections. All staff must perform hand hygiene.When to utilize hand hygiene: before/after resident contact, after removing gloves or PPE.		