STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675423	A. Building B. Wing	10/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Gardens	7210 Northline Dr Houston, TX 77076

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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 0604 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 ensure residents were free from any physical restraints imposed for purposes of convenience and not required to treat the resident's medical symptoms for 1 (Residents #5) of 9 residents reviewed for restraints. The facility failed to ensure that bedrails were not used on the side of Resident #5's bed. This failure could place residents at risk of having physical restraints used that limited their movement without being evaluated for the medical need.Findings included: Record review of Resident #5's face sheet, dated 10/21/2025, reflected a [AGE] year-old female, admitted [DATE], with diagnoses including type 2 diabetes mellitus without complications (high blood sugar), hypertension (high blood pressure), disease of stomach and duodenum (a disease in two important organs in the digestive system), pain, constipation, hyperlipidemia (high cholesterol), and atrial fibrillation (abnormal heart rhythm). Record review of Resident #5's quarterly MDS Assessment, dated 10/03/2025, reflected a BIMS score of 10 indicating moderate impairment. The MDS also indicated Resident #5 was dependent on staff for bed mobility, and repositioning and transfers. Record Review of Resident #5's physician orders revealed, dated 10/21/2025, there were no orders for the half bed rails. Record Review of Resident #5's care plan, dated 07/12/2025, revealed Resident #5 did not have any information about bed rails in her care plan. Resident #5 also did not care about planned as being a fall risk. The care plan stated, Resident #5 was at risk for self-care deficit related to limited physical mobility. Observation of Resident #5 on 10/21/2025 at 09:13 a.m., revealed that Resident #5's bed had 1/2 bed rails that were positioned from the top of her bed to the middle of her bed. The 1/2 bed rails were up on both sides of Resident #5's bed. Observation of Resident #5 on 10/21/2025 at 11:15 a.m., revealed that Resident #5's bed had 1/2 bed rails that were positioned from the top of her bed to the middle of her bed. The 1/2 bed rails were up on both sides of Resident #5's bed. During an interview on 10/21/2025 at 11:36 a.m., Resident #5 revealed staff had been using the bed rails on her bed for about six months. She said she did not ask the staff to use the bed rails. She said she was told the bed rails were used to keep her in the bed. She said staff had also told her not to get up. She said the bed rails did prevent her from getting up. She said that she had not been hurt on the bed rails. She had not had any falls and had not attempted to get out of bed herself. She said she did not use the bed rails to reposition herself. She said she did not care if staff used the bed rails or not. During an interview on 10/21/2025 at 11:58 a.m., CNA E revealed she was trained on restraints. She said the policy was absolutely no restraints. She said the policy on bed rails depended on the resident. She said the bed rails were used to keep the resident in bed. She said if a resident was a fall risk staff would use three of the four bed rails that were on the bed. She also said she would put a wedge under the resident to keep the resident from falling. She said a risk of using bed rails were the resident could get stuck in the bed rail and hurt themselves. She said the bed rails were used depending on the resident's care. She said that the resident had to have a doctor's order for the bed rails before using the rails. She said Resident #5 did not have an order for bed rails. She said the facility started using two bed rails on Resident #5's bed about a month ago. She said the rails were used on Resident #5 to keep her in the bed. She said the bed rails were not a restraint because the facility did not use all four rails. She said Resident #5 did not have a decline due to the bed rails being used. She said Resident #5 could advocate for herself. During an interview on 10/24/2025 at 1:03 p.m., RN O revealed she was trained on restraints. She said the facility had a procedure for the bed rails. She said the procedure was staff could use the rails for four hours at a time. She said the facility had to have a doctor's order to use the bed rails. She said the risk of using the bed rails was that the resident could get hurt. She said the benefits were that the resident could not get out of bed and fall. She said she was not sure who monitored to ensure the resident's had a doctor's order for the bed rails. She said she did not know when the staff started using the bed rails for Resident #5. She said she did not know why the bed rails were being used for Resident #5 without a doctor's order. During an interview with the DON on 10/25/2025 at 12:45 p.m., she said she and staff were trained on resident rights. She said the policy for bed rails was staff were to do an assessment on the resident, and if the facility was going to use bed rails staff needed to get a doctor's order. She said the facility did not utilize full bed rails. She said the facility used assist rails, and staff needed to get consent from the resident and the RP. She said she was not sure when staff started using the bed rails on Resident #5. She said for the half bed rails the facility needed a doctor's order. She said the nurse was responsible for monitoring to ensure the facility had orders for the half bed rails. She said a resident could get hurt if staff

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 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 interview and record review, the facility failed to establish and follow a written policy on permitting residents to return to the facility after being hospitalized for 1 resident (Resident #1) of 5 residents reviewed for transfer/discharge. The facility failed to ensure Resident #1, was given his medication when he went out on pass. Resident #1 had behavior and mental illness issue that required medication. This failure could place residents at risk for serious injury, harm, and/or death due to lack of appropriate supervision.The findings included:Record review of Resident #1's, face sheet, dated 10/22/2025, revealed a [AGE] year-old male, admitted [DATE]. Resident #1's diagnosis included metabolic encephalopathy (reversable brain dysfunction caused by metabolic imbalances such as liver failure, kidney failure or severe electrolyte disturbances), psychosis (a severe mental condition in which thoughts and emotions are so affected that contact is lost with external reality), schizophrenia (a chronic mental health condition characterized by a combination of symptoms that affect a person's thoughts, perceptions, emotions, and behavior), and schizoaffective disorder, bipolar type (mental health condition that causes extreme mood swings). Record review of Resident #1's entry MDS, dated [DATE], revealed a BIMS of 14 which indicated intact cognitive functions. The MDS revealed Resident #1 was a smoker.Record review of Resident #1 care plan, dated 08/18/2025, revealed Resident #1 was a smoker and at risk of injury with the following interventions, assisted to smoking area on request, check for burns (clothing, fingers, skin); report to the nurse. Keep matches/lighters at the Nurses Station. Perform smoking assessment according to facility policy. Post smoking schedule for residents to refer to facility smoking times.Record review on 10/22/25 of Resident #1's electronic medical record for smoking assessment and policy acknowledgement revealed Resident #1 did not have a smoking assessment uploaded to his medical records.During an interview with Resident #1's PCP on 10/24/2025 at 12:46 p.m., it revealed if Resident #1 left the facility without medications he was at risk for increased psychotic episodes and may have increased hallucinations. She stated he would not be safe in making any type of judgements for himself. PCP stated he was not safe to be on the streets or anywhere without his medications being administered. She stated he did not have any homicidal or suicidal issues in the past, however, there was a possibility he may become homicidal or suicidal without the proper medication to treat his mental issues. During an interview with RN O on 10/24/2025 at 12:50 p.m., it was revealed that she had been trained on signing out on pass. She said the policy was the residents had to sign out when they were leaving the facility. She said when a resident leaves the facility overnight the nurse was supposed to give the resident their medication if the resident was cognitive. She said if the resident was going out on pass overnight with family the nurse was to give the medication and instructions to the family. She said if a resident does not have their medications when they are out on pass the resident could have become unstable from not having their medications. She said the nurse was responsible for ensuring the resident signed out on pass and give the resident his medication. She said she did not think Resident #1 was cognitive enough to follow the directions to take the medication. She said the nurses had to educate him on his medication for him to take them. She said the resident had been sent to the hospital in the past for his behavior. She said she did not think it was a good idea Resident #1 was out in the community without his medication. She said she believed Resident #1 might hurt himself or someone else. She said she did not know why Resident #1's medication was not sent with him. During an interview with the DON on 10/24/2025 at 1:12 p.m. it was revealed the policy was the residents were allowed to leave but they had to sign out before leaving. She also said that the residents were to sign back in when they returned to the facility. She said that when the residents were going to sign out the resident was to notify the nurse. She also said the residents would have their medication sent with them. She said several things could happen. She also said the residents could have issues if they did not have their medication. She said the nurse was responsible for ensuring the resident signed out and the resident had their medication when they left. She said she did not know who monitored to ensure the signing out policy was being followed. She said she thought that Resident #1 left before the nurse was notified. She said she thought he was safe and functional. She also said she felt that Resident #1 needed his medication. Record review of Resident #1's progress notes from the SW dated 10/22/2025 revealed Resident #1 walked up to SW while I was standing at the Nursing station and asked why he was being held prisoner. SW explained that he is not being held prisoner. Resident #1 asked why he could not leave. SW explained that Resident #1 has the right to leave but SW would like to assist him with

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	675423	A. Building B. Wing	10/25/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed make sure that drugs are stored properly and only authorized persons have access for 5 of 5 medication carts (MC #1, MC #2, MC #3, OFMC #4, and MC #5) reviewed for drug storage and labeling.The facility failed to ensure MC #1, MC #2, MC #3, MC #4, MC #5, and OFMC #6 were locked, and medications were secured, and not accessible to other staff, residents, or visitors.This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications. Findings included:During an observation on 10/21/2025 at 8:56 a.m., of MC #5, revealed the MC was near the nurse's station on the second floor between 2300 hall and 2400 hall. MC #5's bottom drawer was not closed completely and was unlocked. The bottom drawer consisted of pain relief lidocaine patches, MiraLAX and other medications. MC #5 also had the reconciliation binder with information about residents and their medications. During an observation on 10/22/2025 at 4:10 p.m., MC #1 on 1300 hall was near the front of the right side of the hallway. MC #1 appeared to be locked but when surveyor pushed the lock downward on the MC. The MC was not locked, and the surveyor was able to open all the drawers on the MC. MC #1 had over the counter medications belonging to residents.During an observation on 10/22/2025 at 4:26 PM, MC #2 was toward the end of 1100 hall. The Surveyor touched the locking device on MC #2, when the surveyor touched the device the medication cart unlocked. During an observation on 10/23/2025 at 7:40 AM while entering the facility, MC #3, and OFMC #4 were unlocked. MC #3 was displaying the red on the MC that was visible when the MC was unlocked. MC #3 had residents' prescription drugs, and over the counter medications. The surveyor opened OFMC #3 and there was a resident's medication in the cart for nausea, vomiting, and needles for insulin, medical supplies, and enema. During an interview with CMA S on 10/21/25 at 9:15AM, it was revealed that CMA S did lock MC #5, but she did not notice the bottom drawer was not all the way closed before she locked MC #5. She said the medication carts were supposed to always be locked when not in use. She said if a medication cart was left unattended and unlocked residents and visitors could potentially get into them and take some medication that was stored in the medication cart. She said the medication aide and the nurses were responsible for ensuring the medication carts were locked. She said she overlooked the bottom drawer and thought the cart was locked. During an interview on 10/21/25 at 10:15 AM, the DON revealed all medication carts were to be always locked when not in use. She also said some medication carts needed to be repaired, and the issue was reported to the MS. She said the medication carts had a battery on the back of the cart and when the CMA's or nurses hit the medication cart against the wall sometimes, it would affect the battery, and the medication cart will not lock properly. She said she was not aware MC #1 and MC #2 were not locked properly. She said if a resident had taken medications there was a possibility a resident may have an allergic reaction to the medications or potentially harm the resident. She also said she could not know exactly what could happen to the resident because she would not know what medication the resident ingested. During an interview on 10/22/2025 at 4:05 PM, the MS revealed he had fixed some of the medication carts before. He said he also had replaced the batteries on the back of the medication carts. He said there were times the staff would bang the medication carts against the walls, and the batteries would get loose. He said because of the batteries coming loose, the code for opening and locking the medication carts did not work. He said the DON was responsible for training nursing staff on how to lock and unlock the medication/nursing carts. The MS said he was responsible for repairing the medication carts. He said in this case the medication carts' batteries just needed to be adjusted on the back of the medication carts. He said staff were trained on how to replace the batteries and how to check them. He said the nursing staff should have known how to check the batteries. During an interview on 10/22/2025 at 4:14 PM, CMA BB revealed the medication carts were to always be locked unless the nurse or CMA was dispensing medications. She said MC #1 was not locking. She said there was a code staff needed to enter to unlock MC #1. She also said only the nurses knew the code for MC #1. She said she did not remember if she had reported to anyone the medication cart was not locking. She said she was responsibility to ensure the medication cart was locked and secured. She said if a resident had accessed the medication cart the resident could have overdosed, taken the wrong medication, had an allergic reaction, and possibly could have been admitted to the hospital. She said MC #1 contained residents' prescription medication. Interview on 10/22/2025 at 4:29 PM, CMA CC revealed MC #2 did not lock. She said MC #2 looked like it was locked but it would not lock. She said she did not recall who she told about the medication cart not remaining locked. She said all medication carts were to

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**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 control 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 and follow accepted national standards. 1. The facility failed to ensure CNA Q followed standard precautions by leaving soiled gloves and gowns in a clear plastic bag and leaving soiled linens on top of the chest of drawers and on the floor in Resident # 6 on enhanced barrier precautions. 2. The facility failed to ensure CNA R followed enhanced barrier precautions when providing assistance with toileting for Resident # 6. These failures could place residents at risk for developing infection from cross contamination.Findings included: Record review of Resident # 6 face sheet, dated 10/21/2025, reflected a [AGE] year-old female who was admitted on [DATE] with a diagnoses which included dependence on renal dialysis (a situation where a person's life depends on the ongoing use of treatment to survive because their kidneys have failed), chronic kidney disease (a condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood), and encephalopathy (any disease or damage that affects the brain's function, resulting in a decline in mental ability and brain function), and other cirrhosis of liver (a chronic condition in which the liver becomes permanently damaged and scarred). Record review of Resident # 6's admission MDS dated [DATE] was in process. Record review of Resident # 6 Baseline Care Plan, dated 10/17/2025, reflected Resident # 6 had an intravenous access device dialysis catheter for the purposes of receiving hemodialysis (a medical treatment that removes waste products and excess fluid from the blood when the kidneys are unable to do so). Interventions: were to administer Resident #6's intravenous fluids as prescribed. Change Resident # 6's tubing and site dressing every 72 hours. Check Resident # 6's IV site every two hours. Observe for signs of infection (redness, swelling, pain at site), and infiltration (swelling, blanching at site). Resident #6 was on enhanced barrier precautions (an infection control intervention) due to hemodialysis catheter, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Observation on 10/20/2025 at 8:51 a.m. in Resident #6's room there were not any staff in the room. Resident # 6 was lying in bed. There was a clear plastic bag with soiled gloves, garbage, and soiled gown in the bag beside the bedside table. There were dirty sheets lying on the floor near Resident 's foot of her bed. There was a soiled bedspread and blanket lying on the chest of drawers. CNA Q entered Resident 's room without washing her hands and without wearing a gown. CNA Q picked up the soiled linens and placed them in a clear plastic bag. CNA Q gathered a clear plastic bag and exited Resident # 6's room. CNA Q walked down the hall and entered room [ROOM NUMBER]'s and placed both clear plastic bags on the floor in room [ROOM NUMBER]. CNA Q was in room [ROOM NUMBER] approximately 7 minutes and exited room [ROOM NUMBER] and carried the clear plastic bags with dirty gloves, gowns and garbage in the garbage can located in soiled room and carried the dirty linens to the laundry (the part of laundry where dirty soil was stored). Interview on 10/20/2025 at 9:10 AM CNA Q stated she did change Resident # 6 clothes and gave ADL care to Resident # 6. CNA Q was asked what type of ADL care she provided for Resident # 6. CNA Q did not respond to the question. She stated she was in a hurry to get all her work finished and forgot to pick up the dirty linens and the garbage. She stated she did leave it in the room, and she knew she was to take the dirty linens and the garbage out of Resident # 6 room when she finished giving care. CNA Q stated it was infection control issue leaving dirty linens on floor and on the chest of drawers. She stated there was a possibility Resident # 6's roommate may contract some type of infection from Resident #6. CNA Q stated there was dirty gloves, dirty gown, and garbage in the clear plastic bag on the floor. She stated that was her gown and gloves she was wearing when she was giving care to Resident # 6. She stated she was not to take garbage bags full of soiled linens, dirty gowns, gloves, and garbage into another resident's room. She stated she was in a hurry and forgot to take the garbage in the appropriate garbage area and the soiled linen to the laundry area where soiled linen is kept until the laundry staff can place them in the washer. She stated she was expected to place gown on and gloves on when in Resident #6 room when she entered the room to pick up the soiled linen and place the linen in the clear garbage bag. CNA Q stated she had been in-service on Enhanced Barrier Precautions and Infection control. She stated she did not remember the date of the in-service. Interview on 10/20/2025 at 9:25 AM Infection Control Nurse stated CNA Q did not follow the facilities infection control protocol. She stated that anyone on Enhanced Barrier Precautions whose soiled linens was