

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675495	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Laurel Court		STREET ADDRESS, CITY, STATE, ZIP CODE 3830 Mustang Road Alvin, TX 77511	

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (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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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that each resident who was incontinent of bowel/bladder and each resident with an indwelling catheter received appropriate treatment and services to prevent urinary tract infections, for 1 of 6 residents (Resident #95) reviewed for incontinent care and for indwelling urinary catheters. The facility failed to ensure Resident #95's indwelling catheter (a tube into the bladder to drain urine) securement device used to stabilize the catheter was in place. This failure could place the residents at risk for pain, dislodgement, or infection. Findings included: Record review Resident #95's (undated) face sheet revealed a [AGE] year-old female readmitted to the facility on [DATE]. Her diagnoses included chronic kidney disease, acute kidney failure, and neuromuscular dysfunction of bladder disorder (condition that affects the muscles and nerves that controls the bladder). Record review of Resident #95's quarterly MDS assessment dated [DATE] revealed a BIMS was scored as 11, which indicted moderately impaired cognition. Resident #95's self-care assessment revealed she required substantial/maximal assistance with toileting, showering, lower body dressing, and putting on/taking off footwear. She was also noted to be incontinent to both bowel and bladder. Record review of Resident #95's care plan revealed she had a Foley catheter related to neuromuscular dysfunction of the bladder with a goal to remain free from catheter related trauma. Resident #95's interventions included positioning the catheter bag and tubing below the level of the bladder and away from the entrance room door, checking tubing for kinks each shift, monitoring and documenting pain/discomfort due to catheter, and monitoring/recording/reporting s/sx of UTI to MD. Record review of Resident #95's physician orders dated 07/11/25 indicated to change Foley catheter anchor every night shift starting on the 15th and ending on the 15th every month. During an observation on 07/16/2025 at 9:31 AM Resident #95 did not have a strap or device to secure the catheter tube to the resident's thigh. Resident #95 was alert and oriented, and said she never had a Foley securement device. During an interview on 07/16/2025, at 9:35 AM, CMA K, who was at Resident #95's bedside, said residents are supposed to wear a leg strap to secure their catheter. She said she did not know why the resident did not have a leg strap and referred the surveyor to Resident #95's nurse. During an interview on 07/16/2025 at 10:13 AM, LVN V said Resident #95's catheter should have been secured in place with a leg strap. She said the nurses and CNAs were responsible for ensuring the catheter was properly secured. LVN V said the risk of the catheter tubing not being secured was the tube could be pulled out and cause injury to the resident's urethra. During an interview on 07/17/2025 at 1:10 PM, the DON stated LVN V informed her that Resident #95 did not have a strap to secure the tubing. The DON said Resident #95's catheter strap should be on her thigh, per physician's orders. The DON said the risk of not having the strap was the tubing could cause injury/trauma and/or infection . During an interview on 07/18/2025 at 1:03 PM, the Administrator said she expected all residents with catheters to have leg straps or a securing device to prevent the catheter tube from pulling. The administrator said the risk could cause injury, pain, and/or lead to an infection. Record review of the facility policy titled Catheter Care, Urinary, revised September 2014 read in part: . Steps in the Procedure 18. Secure catheter utilizing a leg band .</p>		

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

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 1 of 6 residents (Resident #6) reviewed for infection control practices. 1. The facility failed to ensure CNA J applied enhanced barrier precautions while providing incontinent/catheter care to Resident # 6. 2. The facility failed to ensure that CNA J sanitized their hands when providing incontinent/catheter care to Resident #6. These failures could place residents at risk of cross-contamination and infections leading to illness. Findings included: Record review of Resident #6's undated face sheet indicated the resident was a 66-year- old male who was readmitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis affecting right dominant side (paralysis or severe weakness on one side of the body), Benign prostatic hyperplasia (prostate gland enlargement that can cause urinary difficulty), and Neuromuscular Dysfunction of Bladder (condition that affects the muscles and nerves that controls the bladder). Record review of Resident #6's MDS assessment, dated 4/07/2025, revealed a BIMS summary score of 12, indicating cognitively intact. The MDS also indicated Resident #6 required maximal/substantial assistance with showering, lower body dressing, personal hygiene, and removing lower body dressing. Record review of Resident #1's care plan initiated on 4/04/2025, indicated Resident #6 had a catheter. The goal was for Resident #6 to show no s/sx of urinary infection. Interventions included checking for kinks, monitoring and documenting for pain/discomfort due to catheter, and monitoring/recording/reporting too MD for s/sx of a UTI. Record review of physician's orders dated 06/11/25 revealed Resident #6 was also on enhanced barrier precautions (infection control interventions designed to reduce transmission of multidrug-resistant organism). During an observation on 7/17/2025 at 9:43 AM, enhanced barrier precautions signage was posted on the outside door, and PPE was noted outside the room. CNA J was observed performing incontinent/Catheter Care on Resident #6 without wearing proper personal protective equipment (gown). The resident was lying on his right side, and she was observed cleaning stool on the resident's buttocks using the same soiled gloves that held the dirty wipes to reenter the multi-wipe package. She continued to use the soiled gloves and applied a new brief to the resident. She doffed her gloves and left the room to retrieve soap, water, and new linen for catheter care, without sanitizing her hands. She returned to the resident's room, sanitized her hands, applied new gloves, and proceeded to start catheter care. She cleaned the resident's penis per policy and began wiping the catheter tubing from the urethra opening downward per policy; however, she did not doff gloves, sanitize hands and don new gloves after handling the soiled towels. She used the same soiled gloves and applied a new brief. She doffed her gloves and sanitized her hands after applying the new brief and adjusting Resident #6's linen and bed. She was observed using the same gloves throughout the entire Cath care procedure. During an interview on 7/17/2025 at 10:04 AM, CNA J said she forgot to put on her protective personal equipment (PPE) before performing incontinent/catheter care. The CNA said she was aware that she was supposed to wear PPE when performing incontinent care for Resident #6, based on previous infection control in-services/training and the signage posted on the door. CNA J also said she should have changed her gloves after discarding the dirty brief. She said she should have sanitized her hands and donned new gloves before applying the new brief or touching his linen and bed remote. She said the risk of not wearing PPE or not performing hand hygiene could spread germs and lead to infection. During an interview on 7/17/2025 at 10:04 AM, LVN V said all staff had been in-serviced on enhanced barrier precautions (EBP). She said PPE should be worn when providing direct care by wearing gowns and gloves. She said all staff should change gloves and sanitize their hands before, during, and after incontinent/catheter care. LVN V said the risk of not following EBP and not sanitizing hands could cause a cross-contamination and lead to a UTI. During an interview on 7/17/2025 at 1:10 PM, the DON said the facility had frequently in-serviced staff on enhanced barrier precautions (EBP) and infection control. The DON said she expected her staff to wear proper PPE when providing care, as per protocol. She also said her expectation was for staff to wash their hands before, during and after incontinent/Cath care. She said the risk was cross contamination and infection. During an interview on 7/18/2025 at 1:03 PM, the Administrator said she expected the nurses and staff to adhere to the enhanced barrier precautions/infection control policy. The Administrator said the risk of not following the infection control policy puts staff and residents at risk of spreading infection, which could lead to a decline in</p>		