STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675633	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holland Lake Rehabilitation and Wellness Center	1201 Holland Lake Dr Weatherford, TX 76086

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to 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 disease and infection for two (Resident #1 and, Resident #2) of three residents reviewed for infection control in that:-LVN A failed to perform hand hygiene and changed her gloves at the appropriate times while providing urostomy care for Resident #1.-CNA B failed to perform hand hygiene and change his gloves at the appropriate times while providing incontinence care for Resident #2.These deficient practices could place residents at risk for infection due to improper care practices.Findings included: Review of Resident #1's face sheet, dated 10/16/25, revealed a 90- year- old male admitted to the facility on [DATE] with diagnoses of urinary tract infection, neuromuscular dysfunction of bladder (occurs when an injury or disease disrupts the electrical signals between the nervous system and bladder function), muscle weakness and Alzheimer's disease (a degenerative brain disorder that leads to a progressive and irreversible decline in memory and cognitive abilities). Review of Resident #1's MDS assessment, dated 09/01/25, revealed Resident #1 required total dependence with most ADLs and one-person assistance with transfer. Resident #1 had a urostomy (a device that redirects the ureter (transport tube) to the abdomen to bypass the bladder after bladder or urinary tract problems). Review of Resident #1 's care plan, dated 09/18/25, revealed Resident #1 had urostomy due to diagnosis of bladder obstruction. The Its goal was to show no signs and symptoms of urinary infection through review date of 09/28/25. Observation of urostomy care on Resident #1 on 10/15/25 at 1:30 p.m. revealed LVN A washed her hands and put on gloves before the start of care. She prepared a clean field on a bedside table. LVN A removed Resident #1's brief. She emptied the urine from the pouch and removed the whole pouching system. The drained urine was clear yellow without sediments. She cleansed the stoma (a surgically created opening in the skin). There was no swelling, irritation or redness noted on the stoma area. LVN A's gloves were visibly soiled. She did not change gloves, washed her hands, or performed hand hygiene. She retrieved a new pouching system with the same soiled gloves. She prepped the skin area before inserting a new pouch system. LVN A used the same soiled gloves throughout the urostomy care. She removed her gloves and washed her hands. LVN A picked up the trash before exiting Resident #1's room. During In an interview on 10/15/25 at 1:46 p.m., LVN A said she was employed by the facility since February 2025 and received infection control training about 3 months ago. LVN A stated she should have washed her hands and performed hand hygiene before picking up the new and clean pouching system for the urostomy. LVN A said she was nervous., She said that was the reason she failed to follow a good infection control practice. She noted Resident #1 could get an infection and become sick. Review of Resident #2's face sheet, dated 10/16/25, revealed the resident was an 81- year- old female admitted to the facility on [DATE] with diagnoses of retention of urine, neuromuscular dysfunction of the bladder ((occurs when an injury or disease disrupts the electrical signals between the nervous system and bladder function), presence of urogenital implants (a medical device used to treat various conditions of urinary incontinence), constipation, muscle weakness, and dementia (a general term for a decline in cognitive functions that interferes with daily activities). Review of Resident #2's quarterly MDS assessment, dated 09/09/25, revealed Resident #2 required moderate assistance with most ADLs and one person assistance. Resident #1 was always continent of bowel and bladder. Review of Resident #2's care plan, dated 10/14/23, revealed a diagnosis of neuromuscular dysfunction of bladder with history of retention. During an observation of incontinence care for Resident #2] on 10/16/25 at 12:45 a.m., CNA B did not wash his hands but put on gloves before the start of care. He removed Resident #2's fecal matter soiled brief. CNA B wiped the resident from front to back. He made five strokes of cleaning with the same soiled wipes. CNA A did not change his gloves and continued to clean Resident #2. CNA B's gloves were visibly soiled with fecal matter. He did not wash his hands, change gloves, or perform hand hygiene before putting on Resident #2's clean brief, and placing it underneath the resident, and fastened.it. CNA B retrieved the trash and walked out of Resident #2's room without washing his hands. During In an interview on 10/16/2052 at 12:58a.m, CNA B stated he was employed by the facility for about two 2 years. CNA B stated he could not remember the last time he received infection control training. He noted that night shift employees don't receive much training on infection control. CNA B stated cross contamination meant mixing clean with dirty. He stated he should have washed his hands and