STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician was consulted regarding a need to alter treatment for 2 of 13 residents reviewed for notification of changes. (Resident #16 and Resident #24) The facility did not consult with Resident #16's physician about the pattern of low blood pressure over consecutive days and of the blood pressure medication being held for 52 of 60 opportunities in July 2025 or 9 of 12 opportunities for August 2025. The facility did not consult with Resident #24's physician about the pattern of low blood pressure over consecutive days and of the blood pressure medication being held for 7 of 31 opportunities in July 2025 or 3 of 6 opportunities for August 2025. This failure could place residents at risk for complications due to delayed or failed physician intervention. Findings included: 1. Record review of the face sheet dated 08/06/25 Resident #16’s indicated Resident #16 was [AGE] year-old female admitted on [DATE] with diagnoses including end stage renal disease and high blood pressure. Record review of physician orders date July 2025 and August 2025 indicated the orders for Resident #16 included the Coreg 3.125 mg twice a daily for high blood pressure. Parameter set by physician were to hold Coreg 3.125 mg if SBP less than 100, DBP less than 60 and HR less than 60 with a start date of 08/17/2024. Record review of a quarterly MDS assessment dated [DATE] for Resident #16 included diagnoses of high blood pressure and renal disease. Her BIMS was 09 which indicated moderately impaired cognition. Record review of the care plan dated 05/22/25 for Resident #16 indicated she had hypertension. The interventions included to monitor for side effects hypotension and increased heart rate. Report significant changes to the physician. Record review of the “Record of Medication Regimen and Chart Review” dated 07/10/2025 indicated Resident #16’s clinical record was reviewed by the Pharmacy Consultant and there were no recommendations. Record review of the MAR dated July 2025 indicated Coreg 3.125 mg twice daily for Resident #16 and to hold the medication when SBP less than 100, DBP less than 60 and HR less than 60 with a start date of 08/17/2024. On the following times and dates, the dose of the Coreg 3.125 mg was held: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/01/2025 at a.m., B/P 99/55 and at p.m., B/P 92/44; 07/02/2025 at a.m., B/P 95/53 and at p.m., B/P 95/48; 07/03/2025 at a.m., B/P 95/53 and at p.m., B/P 98/57; 07/04/2025 at a.m., B/P 92/56 and at p.m., B/P 98/58; 07/05/2025 at a.m., B/P 91/50; 07/06/2025 at a.m., B/P 89/50; 07/07/2025 at a.m., B/P 97/56 and at p.m., B/P 98/48; 07/08/2025 at a.m., B/P 96/82 and at p.m., B/P 95/46; 07/09/2025 at a.m., B/P 94/57and at p.m., B/P 97/76; 07/10/2025 at a.m., B/P 94/54 and at p.m., B/P 98/53; 07/11/2025 at a.m., B/P 93/53 and at p.m., B/P 90/48; 07/12/2025 at p.m., B/P 90/49; 07/12/2025 at p.m., B/P 90/49 HR 53; 07/13/2025 at a.m., B/P 93/53 and at p.m., B/P 90/49 HR 48; 07/14/2025 at a.m., B/P 93/53 and at p.m., B/P 105/52; 07/15/2025 at a.m., B/P 92/56 and at p.m., B/P 92/46; 07/16/2025 at a.m., B/P 93/46 and at p.m., B/P 90/46; 07/17/2025 at a.m., B/P 94/52 and at p.m., B/P 94/54; 07/18/2025 at a.m., B/P 90/80 and at p.m., B/P 97/54; 07/20/2025 at p.m., B/P 91/52 HR 58; 07/21/2025 at a.m., B/P 92/52 and at p.m., B/P 90/40; 07/22/2025 at a.m., B/P 92/52 and at p.m., B/P 90/40; 07/23/2025 at a.m., B/P 95/50 and at p.m., B/P 95/50; 07/24/2025 at a.m., B/P 95/55 and at p.m., B/P 87/50; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/25/2025 at a.m., B/P 94 and at p.m., B/P 84/53; 07/26/2025 at p.m., B/P 92/56 HR 59; 07/27/2025 at p.m., B/P 91/56; 07/28/2025 at p.m., B/P 90/48. 07/29/2025 at a.m., B/P 96/56 and at p.m., B/P 90/48; 07/30/2025 at a.m., B/P 93/56 and at p.m., B/P 98/50; and 07/31/2025 at a.m., B/P 96/56 and at p.m., B/P 89/48. Record review of the MAR dated August 2025 indicated Coreg 3.125 mg twice daily for Resident #16 and to hold the medication when SBP less than 100, DBP less than 60 and HR less than 60 with a start date of 08/17/2024. On the following times and dates, the dose of the Coreg 3.125 mg was held; 08/01/2025 at a.m., B/P was 94/58; 08/02/2025 at a.m., B/P was 97/55 and at p.m., B/P was 90/45; 08/03/2025 at a.m., B/P was 91/53 and at p.m., HR was 43; 08/04/2025 at a.m., B/P was 92/56 and at p.m., B/P was 96/53; 08/05/2025 at a.m., B/P 94/42 and at p.m., B/P was 90/45; and 08/06/2025 at a.m., B/P was 96/42. During an interview and record review on 08/06/2025 at 12:05 p.m., the DON reviewed Resident #16's July 2025 and August 2025's MAR with surveyor. The DON acknowledged the Coreg was documented as held due to the prescribed parameters. She said best practice would be for nursing staff to notify physician when medications with parameters were held 3 times, or even immediately. The DON said potential negative outcomes for residents could be dizziness or weakness. She said the physician or NP were able to see in residents electronic record to review the vital signs. The DON said the nursing staff document in the resident's electronic record when notifying physician of medications being held. During an interview on 08/06/2025 at 1:45 p.m., LVN B said Resident #16's BP was low most days and Coreg was held more than it was given. LVN B said she thought she had notified the physician in the past and would have documented in the nurse notes. LVN B said possible negative outcomes could be dizziness, weakness, or falls leading to injuries. She said the physician needed to be notified in case the physician wanted to make changes with medications or new orders. Record review of the nurse’s notes for Resident #16 dated from 07/03/25 to 08/06/25 indicated no documentation of the physician being notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #24’s face sheet indicated admission to facility on 05/02/2025 with a diagnosis of hypertensive heart disease with heart failure (a condition where high blood pressure has caused structural and functional changes in the heart, leading to heart failure). Record review of physician orders dated 05/02/2025 indicated Resident #24’s orders included metoprolol succinate ER 50mg tablet – Give one tablet daily related to hypertension (high blood pressure). Parameters set by physician were to hold for SBP less than 100, DBP less than 60 or HR less than 60. Record review of an admission MDS dated [DATE] for Resident #24 included diagnoses of heart failure and high blood pressure. Resident #24’s BIMS score was 11, indicating moderately impaired cognition. Record review of the care plan dated 05/08/2025 indicated Resident #24 had altered cardiovascular status related to hypertensive heart disease. Interventions included monitor vital signs daily. Notify physician of significant abnormalities. Monitor/document report PRN any signs/symptoms of altered cardiac output such as dizziness, shortness of breath, fatigue, or confusion. Record review of the July and August 2025 MARs indicated Resident #24 was prescribed Metoprolol Succinate ER 50 mg - one tablet by mouth related to hypertension - hold for SBP less than 110, DPB less than 60 or HR less than 60. Record review of the “Record of Medication Regimen and Chart Review” dated 07/10/2025 indicated Resident #24’s clinical record was reviewed by the Pharmacy Consultant and there were no recommendations. Record review of the MAR dated July 2025 for Resident #24 indicated on the following dates, Resident #24's metoprolol succinate ER 50 mg was held when the vitals were outside the prescribed parameters: 07/01/2025 – B/P 109/62; 07/02/2025- B/P 90/63; 07/03/2025 – B/P 99/58; 07/14/2025 – B/P 99/66; 07/15/2025 – B/P 100/72; 07/16/2025 – B/P 99/63; and 07/17/2025 – B/P 98/56. Record review of the MAR dated August 2025 for Resident #24 indicated on the following dates, Resident #24's metoprolol succinate ER 50 mg was held when the vitals were outside the prescribed parameters: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	08/04/2025 – B/P 99/60; 08/05/2025 – B/P 99/56; and 08/06/2025 – B/P 98/56. Record review of Nurse Notes dated 07/03/2025 through 08/06/2025 for Resident #24 gave no indication or documentation of physician notification of Resident #24’s metoprolol succinate ER 50 mg being held on 10 occasions from 07/01/2025 through 08/06/2025. During an interview and record review 08/06/2025 at 12:05 p.m., the DON reviewed Resident #24's July 2025 and August 2025's MAR with surveyor. The DON acknowledged the metoprolol succinate ER was documented as held due to the prescribed parameters. She said best practice would be for nursing staff to notify physician when medications with parameters were held 3 times, or even immediately. The DON said potential negative outcomes for residents could be dizziness or weakness and physician unaware of change in condition. She said the physician or NP were able to see in residents electronic record to review the vital signs. The DON said the best practice would be for nursing staff to document in the resident's electronic record when notifying physician of medications being held and document the response. During an interview on 08/06/2025 at 1:43 p.m., LVN A said Resident #24's B/P tended to fluctuate and the metoprolol was held more than it was given. LVN A said she believed she had notified the physician in the past and would have documented in the nurse notes. LVN A said possible negative outcomes could be dizziness, weakness, or falls leading to injuries. During an interview and record review of Resident #24's nurse notes on 08/06/2025 at 1:45 p.m., LVN A said she had been mistaken and had not documented any notifications of Resident #24's medications as being held multiple occasions. Following surveyor intervention, the physician was notified by LVN A on 08/06/2025 at 1:48 p.m. of Resident #24’s BP trending 99/60 – 99/58. During an interview on 08/06/02025 at 3:30 p.m., the Pharmacy Consultant said she had not been aware of Resident #16's Coreg and Resident #24’s Metoprolol Succinate ER 50 mg having been held frequently when the B/P had fallen outside the prescribed parameters. She said she would modify the regime of performing the review of vital signs and documentation of medications that were held. During an interview on 08/06/2025 at 4:15 p.m., the Administrator said her expectation was for the physician to be notified each time a resident’s medications were held, or at least every few times. She said possible negative outcomes for the residents could be B/P going lower, possibly leading to falls, injuries, or dizziness. The Administrator said she expected nursing staff to always follow physician orders, to notify of any changes in condition, and to document notifications. Record review of policy dated February 2023 titled Medication Administration” indicated the following: . Policy Explanation and Compliance Guidelines: … “8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician’s prescribed parameters.”

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 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 2 of 7 residents (CR #1 and CR #2) reviewed for pharmacy services. The facility failed to ensure 20 boxes of Fiberone chocolate donuts that expired 06/08/25, (58 days expired) were removed from use. The facility failed to ensure discharged residents' (CR #1 and CR #2) medications were removed from use. This failure could place residents at risk of not receiving medications as ordered by their physicians and exacerbations of their medical conditions.Findings included:During an observation and interview on 08/05/25 at 10:45 a.m. of the facility medication storage room with LVN A, indicated on a shelf there were 20 boxes of Fiberone chocolate donuts (each box had 4 donuts) with a manufacture expiration date of 06/08/25 (expired for 58 days). LVN A said no resident was receiving the Fiberone donuts and eating the expired donuts could lead to food poisoning or sickness. During an observation and interview on 08/05/25 at 11:00 a.m. of the facility medication storage room with LVN A, it was observed in the medication refrigerator two unused insulin pins with a pharmacy fill date 6/27/25 labeled for CR#2. On a cabinet in the medication room were 2 boxes (30 vials in each box) of the breathing treatment medication Ipratropium Bromide/Albuterol Sulfate pharmacy labeled for CR#1. LVN A said CR#1 and CR#2 had discharged about a month ago. She said the nurses were responsible for removing discharged residents' medication from the storage area to decrease the risk of someone using it for another resident. Record review of CR#1 face sheet indicated she was discharged from the facility on 07/22/25. Record review of CR#2 face sheet indicated she was discharged from the facility on 06/29/25. During an interview on 08/05/25 at 1:10 p.m., the DON said there should be no expired medications inside the medication room or inside the medication carts. The DON said the ADON checked the medication storage room on a weekly basis for expired medications and discharged residents' medication to be removed for disposal. The DON said she was responsible in ensuring that the ADON was checking the medication room for disposal medications. She said the effects of expired medications could range from reduced effectiveness to unfavorable side effects and keeping medication of residents no longer in the facility increases the risk of drug diversion. During an interview on 08/05/25 at 1:15 p.m., the ADON said the Fiberone donuts were expired and should not be inside the medication room. She said she was not aware of any resident ever receiving the donuts and they were supposed to be disposed of so they would not be used for the residents. She said she was responsible in auditing the medication room, but she had not had time to do so because of her working as a floor nurse. During an interview on 08/05/2025 at 1:13 p.m., the Administrator said expired medications lose their effectiveness and would not address the medical needs of the residents. She said the expectation was for the staff to be compliant with the policies regarding medication storage to ensure a safe medication administration. Record review of the facility undated policy titled Medication Storage reflected in part:. Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security.5. Staff should observe proper storage and labeling requirements for all medications and vaccines during the performance of their daily task and should demonstrate safety in regards to the medication's integrity such duties should include but are not limited to: a. Report improper refrigeration storage temperatures. c. Remove any expired medications from active stock and discard medications according to facility policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure any drug regimen irregularities were accurately reported by the pharmacist consultant for 2 of 13 residents reviewed for pharmacy services. (Resident #16 and Resident #24) The Pharmacy Consultant failed to thoroughly review the medication regimen and identify possible and/or actual irregularities in the blood pressure and heart rate for Residents #16 and #24. The failure could place residents at risk of receiving inaccurate administration of medications which could result in possible adverse effects or residents not receiving therapeutic benefits of medications. Findings included: 1. Record review of the face sheet dated 08/06/25 Resident #16’s indicated Resident #16 was [AGE] year-old female admitted on [DATE] with diagnoses including end stage renal disease and high blood pressure. Record review of physician orders date July 2025 and August 2025 indicated the orders for Resident #16 included the Coreg 3.125 mg twice a daily for high blood pressure. Parameter set by physician were to hold Coreg 3.125 mg if SBP less than 100, DBP less than 60 and HR less than 60 with a start date of 08/17/2024. Record review of a quarterly MDS assessment dated [DATE] for Resident #16 included diagnoses of high blood pressure and renal disease. Her BIMS was 09 which indicated moderately impaired cognition. Record review of the care plan dated 05/22/25 for Resident #16 indicated she had hypertension. The interventions included to monitor for side effects hypotension and increased heart rate. Report significant changes to the physician. Record review of the “Record of Medication Regimen and Chart Review” dated 07/10/2025 indicated Resident #16’s clinical record was reviewed by the Pharmacy Consultant and there were no recommendations. Record review of the MAR dated July 2025 indicated Coreg 3.125 mg twice daily for Resident #16 and to hold the medication when SBP less than 100, DBP less than 60 and HR less than 60 with a start date of 08/17/2024. On the following times and dates, the dose of the Coreg 3.125 mg was held: 07/01/2025 at a.m., B/P 99/55 and at p.m., B/P 92/44; 07/02/2025 at a.m., B/P 95/53 and at p.m., B/P 95/48; 07/03/2025 at a.m., B/P 95/53 and at p.m., B/P 98/57; 07/04/2025 at a.m., B/P 92/56 and at p.m., B/P 98/58; 07/05/2025 at a.m., B/P 91/50; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/06/2025 at a.m., B/P 89/50; 07/07/2025 at a.m., B/P 97/56 and at p.m., B/P 98/48; 07/08/2025 at a.m., B/P 96/82 and at p.m., B/P 95/46; 07/09/2025 at a.m., B/P 94/57and at p.m., B/P 97/76; 07/10/2025 at a.m., B/P 94/54 and at p.m., B/P 98/53; 07/11/2025 at a.m., B/P 93/53 and at p.m., B/P 90/48; 07/12/2025 at p.m., B/P 90/49; 07/12/2025 at p.m., B/P 90/49 HR 53; 07/13/2025 at a.m., B/P 93/53 and at p.m., B/P 90/49 HR 48; 07/14/2025 at a.m., B/P 93/53 and at p.m., B/P 105/52; 07/15/2025 at a.m., B/P 92/56 and at p.m., B/P 92/46; 07/16/2025 at a.m., B/P 93/46 and at p.m., B/P 90/46; 07/17/2025 at a.m., B/P 94/52 and at p.m., B/P 94/54; 07/18/2025 at a.m., B/P 90/80 and at p.m., B/P 97/54; 07/20/2025 at p.m., B/P 91/52 HR 58; 07/21/2025 at a.m., B/P 92/52 and at p.m., B/P 90/40; 07/22/2025 at a.m., B/P 92/52 and at p.m., B/P 90/40; 07/23/2025 at a.m., B/P 95/50 and at p.m., B/P 95/50; 07/24/2025 at a.m., B/P 95/55 and at p.m., B/P 87/50; 07/25/2025 at a.m., B/P 94 and at p.m., B/P 84/53; 07/26/2025 at p.m., B/P 92/56 HR 59; 07/27/2025 at p.m., B/P 91/56; 07/28/2025 at p.m., B/P 90/48. 07/29/2025 at a.m., B/P 96/56 and at p.m., B/P 90/48; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/30/2025 at a.m., B/P 93/56 and at p.m., B/P 98/50; and 07/31/2025 at a.m., B/P 96/56 and at p.m., B/P 89/48. Record review of the MAR dated August 2025 indicated Coreg 3.125 mg twice daily for Resident #16 and to hold the medication when SBP less than 100, DBP less than 60 and HR less than 60 with a start date of 08/17/2024. On the following times and dates, the dose of the Coreg 3.125 mg was held; 08/01/2025 at a.m., B/P was 94/58; 08/02/2025 at a.m., B/P was 97/55 and at p.m., B/P was 90/45; 08/03/2025 at a.m., B/P was 91/53 and at p.m., HR was 43; 08/04/2025 at a.m., B/P was 92/56 and at p.m., B/P was 96/53; 08/05/2025 at a.m., B/P 94/42 and at p.m., B/P was 90/45; and 08/06/2025 at a.m., B/P was 96/42. During an interview and record review on 08/06/2025 at 12:05 p.m., the DON reviewed Resident #16's July 2025 and August 2025's MAR with surveyor. The DON acknowledged the Coreg was documented as held due to the prescribed parameters. She said best practice would be for nursing staff to notify physician when medications with parameters were held 3 times, or even immediately. The DON said potential negative outcomes for residents could be dizziness or weakness. She said the physician or NP were able to see in residents electronic record to review the vital signs. The DON said the nursing staff document in the resident's electronic record when notifying physician of medications being held. During an interview on 08/06/2025 at 1:45 p.m., LVN B said Resident #16's BP was low most days and Coreg was held more than it was given. LVN B said she thought she had notified the physician in the past and would have documented in the nurse notes. LVN B said possible negative outcomes could be dizziness, weakness, or falls leading to injuries. She said the physician needed to be notified in case the physician wanted to make changes with medications or new orders. Record review of the nurse’s notes for Resident #16 dated from 07/03/25 to 08/06/25 indicated no documentation of the physician being notified. 2. Record review of Resident #24’s face sheet indicated admission to facility on 05/02/2025 with diagnosis including hypertensive heart disease with heart failure (a condition where high blood pressure has caused structural and functional changes in the heart, leading to heart failure). Record review of physician orders dated 05/02/2025 indicated Resident #24’s orders included metoprolol succinate ER 50mg tablet – Give one tablet daily related to hypertension (high blood pressure). Parameters set by physician were to hold for SBP less than 100, DBP less than 60 or HR less than 60. Record review of an admission MDS dated [DATE] for Resident #24 included diagnoses of heart failure and high blood pressure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the care plan dated 05/08/2025 indicated Resident #24 had altered cardiovascular status related to hypertensive heart disease. Interventions included monitor vital signs daily. Notify physician of significant abnormalities. Monitor/document report PRN any signs/symptoms of altered cardiac output such as dizziness, shortness of breath, fatigue, or confusion. Record review of the July and August 2025 MARs indicated Resident #24 was prescribed metoprolol succinate ER 50 mg - one tablet by mouth related to hypertension - hold for SBP less than 110, DPB less than 60 or HR less than 60. Record review of the “Record of Medication Regimen and Chart Review” dated 07/10/2025 indicated Resident #24’s clinical record was reviewed by the Pharmacy Consultant and there were no recommendations. Record review of the MAR dated July 2025 for Resident #24 indicated on the following dates, Resident #24's metoprolol succinate ER 50 mg was held when the vitals were outside the prescribed parameters: 07/01/2025 – BP 109/62; 07/02/2025- BP 90/63; 07/03/2025 - BP 99/58; 07/14/2025 – BP 99/66; 07/15/2025 – BP 100/72; 07/16/2025 – BP 99/63; and 07/17/2025 – BP 98/56. Record review of the MAR dated August 2025 for Resident #24 indicated on the following dates, Resident #24's metoprolol succinate ER 50 mg was held when the vitals were outside the prescribed parameters: 08/04/2025 – BP 99/60; 08/05/2025 – BP 99/56; and 08/06/2025 – BP 98/56. During an interview on 08/06/02025 at 3:30 p.m., the Pharmacy Consultant said she had not been aware of Resident #16's Coreg 3.125 mg and Resident #24’s metoprolol succinate ER 50 mg having been held frequently when the BP had fallen outside the prescribed parameters. She said she would modify the regime of performing the review of vital signs and documentation of medications that were held and give recommendations to the physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/06/2025 at 4:15 p.m., the Administrator said her expectation was for the Pharmacy Consultant to also be held accountable due to failure to recognize medications being held when outside the prescribed parameters on a frequent basis. The Administrator said she did not have a policy regarding the Pharmacy Consultant.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 0759 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 that the medication error rate was not five percent or greater. The facility had a medication error rate of 10%, based on 3 errors out of 29 opportunities, which involved 1 of 3 residents reviewed (Resident # 18) and 1 of 2 staff (LVN A) reviewed for medication errors. LVN A failed to administer Resident #18's senna (vegetable laxative) 8.6mg, hydromorphone (opioid pain medication used to treat moderate to severe pain) and artificial tears 1 drop to both eyes according to the physician's order. These failures could place residents at risk for decline in health and decreased quality of life. Findings include: Record review of a face sheet dated [DATE] indicated Resident #18 was a [AGE] year-old male admitted on [DATE]. His diagnoses included Parkinsonism (disorder of the central nervous system that affects movement, often including tremors), neurocognitive disorder with Lewy bodies (progressive brain disorder that causes a gradual decline in mental abilities), chronic pain, constipation, nonexudative age-related macular degeneration unspecified eye early dry stage (dry eye condition) and hypertension (high blood pressure). Record review of a care plan last revised [DATE] indicated Resident #18 had the following: -chronic pain related to old spinal surgery and received hydromorphone routine with interventions to administer hydromorphone and evaluate the effectiveness of pain interventions,-constipation and received senna,-impaired visual function and received artificial tears. Record review of a quarterly MDS dated [DATE] indicated Resident #18 had a BIMS score of 13 indicating his cognitive function was intact. During an observation on [DATE] at 08:25 a.m., LVN A administered medications to Resident #18 which included: 1. amlodipine 2.5 mg, 1 tablet, 2. buspirone 5 mg, 1 tablet,3. carbidopa-levodopa 25/100 mg, 2 tablets,4. finasteride 5 mg, 1 tablet,5. furosemide 20 mg, 1 tablet,6. Gemtesa 75 mg, 1 tablet,7. lisinopril 40 mg, 1 tablet,8. stool softener 100 mg, 1 softgel,9. meloxicam 7.5 mg, 1 tablet,10. pramipexole 0.5 mg, 1 tablet,11. alprazolam 0.5 mg, 1 tablet,LVN A did not administer senna 8.6 mg, hydromorphone 4mg, or artificial tears. Record review of Resident #18's [DATE] physician order summary indicated the following orders: -artificial tears ophthalmic solution, instill 1 drop in both eyes three times a day related to nonexudative age-related macular degeneration unspecified eye early dry stage, -hydromorphone oral tablet 4 mg, give 1 tablet by mouth four times a day for pain,-senna oral tablet 8.6 mg, give 1 tablet by mouth in the morning related to constipation. During an interview on [DATE] at 8:45 a.m., LVN A said she did not give artificial tears, hydromorphone 4 mg or senna 8.6 mg to Resident #18 during the medication pass. LVN A said the artificial tears on the cart were expired and she threw them away and had not replaced them. She said she did not give the hydromorphone 4mg morning dose because the medication had been reordered and had not arrived and the senna was not given because she did not have it on the cart to administer. LVN A said she told the ADON yesterday ([DATE]) that the medication was not available and that she would get them. She said she was nervous being watched and administering medications. She said the facility kept artificial tears and senna in stock, but she had not checked the medication room for the medications. She said Resident #18 did not receive all his medications as ordered by his physician. LVN A said she had worked at the facility for 2 years on the night shift and she had not been observed by the DON or Administration while giving medications. She said she had done education on the computer related to medication administration and medication errors if not administered. LVN A said omitting medications can lead to residents not having treatment of disease. During an interview [DATE] at 10:00 a.m., the ADON said she was the one responsible for ordering over the counter medications for the central supply in the medication room storage stock. The ADON said she had ordered senna 8.6mg a week ago and it was in stock but when she looked at it, she noticed it was not correct. The ADON said senna plus was delivered and it had docusate sodium in it, and she said it was not the same medication, and she would reorder it. She said artificial tears was available and the nurse just needed to look for it on the shelf and she was not sure why the hydromorphone had not arrived yesterday but that it was available today. The ADON said the only dose that was missed was the [DATE] morning dose but he got the next dose that was due around 12:00 p.m. She said she had been trained on medication and medication errors and the risk to the resident not getting the medication would cause their disease process to get worse. During an interview [DATE] at 10:20 a.m., the DON said the facility kept artificial tears in stock but did know why LVN A did not check the medication room over the counter stock. The DON said she expected the nurses to give medications as ordered and if the medication was not available to report it to her or the ADON so they could obtain it. She said she was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure all drugs and biological were labeled, stored under proper temperature controls and in accordance with currently accepted professional principles for 1 of 1 medication rooms and 1 of 1 medication refrigerators reviewed for storage of medication and biologicals. The facility failed to store medications within recommended temperature range in the medication refrigerator in the medication storage room. The facility failed to ensure that there were not 3-4 inches of ice build-up and no standing water in the medication storage refrigerator. The facility failed to ensure there was no stool specimen comingled with medications and stored in the medication room refrigerator. These failures could place residents at risk of adverse reactions to medications, not receiving therapeutic effects of medication and possibly cross-contamination.Findings included:During an observation and interview on 08/05/25 at 11:00 a.m. of the facility medication storage room with LVN A, it was observed in the medication refrigerator, a clear liquid substance had pooled on the bottom floor of the refrigerator and approximately 3-4 inches thick of ice coated the mini freezer area (located in the left upper corner of the medication refrigerator). The ice had build-up enough to close the entry area to mini freezer and the temperature reading was 50 degrees Fahrenheit in the medication refrigerator. Stored in the medication refrigerator were the following: - A brown to black formed substance in a specimen container. LVN A said it was a stool sample, and she did not know who put it there, how long it was there or that it was in the refrigerator because she had not been in the medication room refrigerator. LVN A said specimens were to be collected and placed in the specimen cooler with ice if needed to be cooled. She said storing the stool sample in the medication room refrigerator could cause cross contamination of medications.- A facility locked emergency insulin kit (a small tackle box with plastic numbered lock), contained 3 unused insulin pens sitting in 0.5 to 1 inch of a clear liquid. LVN A said it was approximately 100cc of condensation water built-up and collected in the insulin kit.- 15 wet, unused facility stock laxative stool suppositories,-1 vial wet box of unused facility stock TB vaccine,-17 wet, unused insulin pins. Record review of facility daily temperature log checks for the facility medication room storage refrigerator indicated from 07/1/25 to current 08/06/25 temperature ranges were 35 to 46 degrees F. During an interview on 08/05/25 at 1:10 p.m., the DON said no medications should be stored inside the refrigerator if the temperature was 50 degrees Fahrenheit and if there was water build up. She looked at the emergency insulin kit and said there was 20 ccs of water condensation pooling in the kit and medications would have to be replaced. The DON said the ADON checked the medication storage room on a weekly basis for any concerns like expired medications or damaged equipment. The DON said she was responsible in ensuring that the ADON was checking the medication room. She said the effects of poor temperature control could be or stored in the pooled water could range from reduced effectiveness to unfavorable side effects. She said aside from the risk of cross contamination, no specimen should be stored in the medication refrigerator because there was a small cooler for the specimens. She said the expectation was for the staff to always scan the medication room to make sure storage of medications were in line with company policy. During an interview on 08/05/25 at 1:15 p.m., the ADON said she was responsible for auditing the medication room, but she had not had time to do so because of her working as a floor nurse. She said she did not know the medication room refrigerator was needing defrosting or that a stool specimen was being stored in it. She said the nurses were to use the cooler for specimens and storing them in the refrigerator with medication could lead to cross contamination. During an interview on 08/05/2025 at 1:13 p. m., the Administrator said expired medications lose their effectiveness and would not address the medical needs of the residents. She said the expectation was for the staff to be compliant with the policies regarding medication storage to ensure a safe medication administration. She said she would coordinate with the DON to do an in-service about medication storage and have the medication room refrigerator replaced. Record review of the facility undated policy titled Medication Storage reflected in part:. Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security. 6. Refrigerator Products b. Temperatures are maintained at 36 to 46 degrees F. Charts are kept on each refrigerator and temperature levels are recorded daily by the charge nurse or other designee. Record review of the facility undated policy titled Storage of Medications Requiring Refrigeration reflected in part:.Policy: It is the policy of this facility to ensure proper and safe storage of medications requiring refrigeration to prevent the potential alteration of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 - Few	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

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 - Few	**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 2 residents (Resident #2) reviewed for infection control. The ADON failed to perform hand hygiene and change gloves while providing wound care to Resident #2's buttock area wound. CNA C failed to perform hand hygiene and change gloves while providing peri-care to Resident #2. These failures could place residents at risk for the spread of infection. Findings include:Record review of Resident 2's face sheet, dated 08/06/25, indicated a [AGE] year-old male who was admitted to the facility on [DATE], with diagnoses of having a pressure ulcer of his left buttock and hypertension (high blood pressure). Record review of Resident #2's admission MDS assessment dated [DATE] indicated Resident #2's skin conditions included an unhealed stage 2 and 3 pressure ulcer/injury over a bony prominence. Record review of Resident #2's care plan, dated 04/30/25, indicated the resident had a stage 2 pressure ulcer to outer his left buttock and stage 3 pressure ulcer to his left inner buttock, with interventions to .administer treatments as ordered and monitor for effectiveness. Resident #2 required enhanced barrier precautions related to his wounds, with interventions .to utilize ppe appropriate for enhanced barrier precautions: gown gloves Record review of physician orders for August 2025 for Resident #2 indicated: clean inner and outer left buttock with dermal wound cleanser and pat dry. Apply Medi-honey and calcium alginate and cover with dry dressing daily until healed. During an observation and interview on 08/06/25 at 8:15 a.m. of Resident #2's peri-care and pressure ulcer treatment, the ADON and CNA C washed their hands and donned gloves and gowns before the start of care. The ADON prepared a clean field before commencing care. The ADON took her supplies to the resident's room and placed on his bedside table. CNA C unfastened the brief and exposed Resident #2's peri-area. CNA C with the same soiled gloves on, entered the pack of cleansing wipes, obtained a wipe and wiped the resident's groin area and threw it in the trash. CNA C with the same soiled gloves re-entered the wipe pack to obtain a fresh wipe and wiped Resident #2's penis from base to the head of his penis, then on the other side of his penis wiped from head to base with the same wipe and threw the wipe in the trash. While wearing the same gloves, CNA C re-entered the wipe pack, obtained a fresh wipe and wiped Resident #2's head of his penis in a circular motion and threw the wipe in the trash. CNA C with the same soiled gloves on rolled Resident #2 on to his right side to expose his buttocks for wound care treatment. The ADON removed the old dressing that was contaminated with serosanguinous drainage and cleansed Resident #2's wounds with gauze and wound cleanser. Without removing her gloves to perform hand hygiene or change her gloves, the ADON touched items in her clean field and retrieved more gauze to cleanse Resident #2's buttock wounds. She did not wash hands, change gloves, or perform hand hygiene before going back into her now contaminated field to retrieve gauze to cleanse Resident #2's buttock wounds a second time. The ADON did not perform hand hygiene or change her contaminated gloves and retrieved the Medi-honey, Q-Tip and calcium alginate and placed them all in her left hand and applied to Resident #2's buttock wound. The ADON did not wash hands, change gloves, or perform hand hygiene before going back again into her now contaminated field to retrieve the dry dressing to cover Resident #2's buttock wound. The ADON with soiled wound care gloves and CNA C with the same soiled peri-care gloves placed a clean brief on Resident #2 without continuing per-care of his back side (buttocks) or inner thigh areas. CNA C then adjusted Resident #2's clothing and adjusted his bed linens while wearing the same soiled gloves. The ADON and CNA C removed there PPE and washed their hands before exiting Resident #2's room. During an interview on 08/06/25 at 8:20 a.m., the ADON said she should have washed her hands and changed her gloves during care. The ADON said she should have changed her gloves before retrieving a clean dressing and placing on Resident #2's wound. The ADON said she was wound care certified and was the Infection Control Preventionist for the facility. She said the resident could acquire an infection when she did not follow good infection control practices which included changing gloves, hand hygiene and washing hands when going from dirty to clean. During an interview on 08/06/25 at 8:30 a.m., CNA C said she did not realize that she used the same gloves to remove the soiled brief and apply the new brief. CNA C said she should have wiped Resident #2's penis from the head to the base of the shaft to decrease the risk of infection. CNA C also, said she should have changed her gloves before going into the pack of wipes, and should have continued peri-care to include the resident's back side