STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675901	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Health and Rehabilitation Center	1106 Golfview Richmond, TX 77469

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents had the right to personal privacy for 2 (Resident #1 and Resident #2) of 7 residents review for personal privacy. CNA A failed to cover Resident #1 and Resident #2 body when she left the room on 03/25/26 to get assistance. This failure could place residents at risk of feeling uncomfortable or embarrassed. Findings included: Record review of Resident #1's face sheet dated 03/25/26 revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #1's diagnoses included the following: hemiplegia (severe or total paralysis affecting one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (when blood flow to the brain) affecting the left non-dominant side, contracture (permanent tightening of muscles, tendons, skin, or tissue resulting from injury, lack of movement, or nerve damage) of knee, and dysphagia (difficulty swallowing). Record review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 0 indicating that resident cognition was severely impaired. Section GG-Functional Abilities revealed that resident was dependent upon staff for mobility. Record review of Resident #1's Comprehensive Care Plan reflected resident being care planned for ADL self-care performance deficit created 06/18/23 and revised 04/29/24. An intervention included requiring staff participation to dress resident. Observation on 03/20/26 at 10:39AM revealed of Resident #1's door was open and curtain not pulled. Resident was resting in bed on her back with the head of the bed lowered. There was a Hoyer lift sling underneath the resident's upper body torso. Resident #1 was uncovered and covers were at the foot of bed. Resident #1 was wearing a gown Resident #1 had contractures to the upper and lower body on both sides. Resident #1 was not interview able. Resident did not appear to be in any distress. Resident #2 Record review of Resident #2' s face sheet dated 03/25/26 revealed a [AGE] year-old female admitted to the facility on [DATE] and again on 12/19/17. Resident diagnoses included the following: dementia, osteoarthritis, anxiety, and contracture of joints. Record review of Resident #2's MDS dated [DATE] reflected that resident BIMS score was 3 indicating that resident cognition was severely impaired. Section GG-Functional Abilities reflected that resident was dependent upon staff with ADL care. Record reviews of Resident #2's comprehensive care plan dated 11/17/25 reflected that resident was being care planned for the right to health, safety, and dignity. An intervention included close curtain while providing care. Observation on 03/20/26 at 10:40 AM revealed Resident #2's door was open with curtain not pulled. Resident #2 was resting in bed on her back with the head of bed lowered. Resident #2 was wearing gown with the Hoyer sling underneath the resident's upper body torso. Resident #2 was not covered. Resident #2's covers were at the foot of the bed. Resident was not inter-viewable and did not appear to be any distress. Observation on 03/20/26 at 10:43AM revealed CNA A entered the room of Resident #1 and Resident #2. Interview and observation on 03/20/26 at 10:45AM with CNA A said she had been working at the facility for a year. CNA A said both residents should have been covered for privacy reasons and their dignity. CNA A lowered the head of the bed for Resident #1 and Resident #2 and began to cover both residents. CNA A said she had left the room to get assistance with getting Resident #1 and Resident #2out of bed. Interview on 03/25/26 at 12:14PM with the ADON said the DON was on leave. The ADON said resident should be covered and (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not exposed to promote their dignity. Record review of the facility policy on Resident Rights/Dignity and Respect revised May of 2007 reflected in part: .It is the policy of this facility that all residents be treated with kindness, dignity and respect.privacy of a resident's body shall be maintained during toileting, bathing and other activities.A closed door or drawn curtain shields the resident from passers-by.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence for 1 (Resident #4) of 7 residents observed for incontinent care. Resident #4's brief was heavily soiled in urine along with clothing on 03/20/26. This failure placed residents at risk for unwanted skin breakdown. Findings included: Record review of Resident #4's face sheet dated 03/20/26 revealed a [AGE] year-old female admitted to the facility on [DATE] and again on 12/13/25. Resident diagnoses included anxiety, assistance with personal care, history of falling, osteoarthritis (joint disease that cause cartilage {support bones by allowing the bones to move smoothly over one another}on the bones to wear down, and dementia (progressive brain disorders causing a cognitive decline such as memory loss, confusion, and behavior changes). Record review of Resident #4's quarterly MDS dated [DATE] revealed a BIMS score of 3 indicating that Resident #4 cognition was severely impaired. Section G-Functional Abilities revealed that resident required substantial/maximal assistance with toileting hygiene and lower body dressing. Section H-Bladder and Bowel revealed that resident was always incontinent of both urine and bowel. Record review of Resident #4's Comprehensive Care Plan dated 05/01/24 and revised 07/28/24 reflected that resident was being care planned for ADL self-care performance deficit r/t cognitive deficit, dementia, and history of falls. An intervention included: requires staff participation with personal hygiene and oral care. Observation on 03/20/26 at 4:16PM of Resident #4 revealed the resident was sitting in a recliner in her room. Interview on 03/20/26 at 4:16PM with Resident #4 revealed the resident was alert to name but not place or time. Resident #4 said she believed that her brief was wet and then said she did not know. There was no offensive urine odor detected at this time. Interview on 03/20/26 at 4:26PM with CNA D said she had just taken Resident #4 to the bathroom about 30 minutes ago. CNA D said that Resident #4 could stand with the assistance of one person. The surveyor asked CNA D if she could check Resident #4's brief because the resident said she was wet and then said she did not know. Observation on 03/20/26 at 4:35PM revealed CNA D assisting Resident #4 to the bathroom via wheelchair. When CNA D assisted Resident #4 to stand from recliner to transfer to w/c, the surveyor observed the back of resident pants were wet. Resident #4 was able to use handrail in the bathroom to stand with the w/c behind her. When CNA D began to pull resident pants down, it was observed that Resident #4 was wearing a pull up brief as well as a brief underneath the pull up brief. The brief was heavily soiled with urine. Resident skin was intact. Interview on 03/20/26 at 4:50PM with CNA D said Resident #4 was a heavy wetter and that it was Resident #4's family member that doubled briefed resident. CNA D said she only took Resident #4's family member to the bathroom and that the family member had taken Resident #4 to the bathroom. CNA D said she did check with the family member of Resident #4 to see if the family member had taken Resident #4 to the bathroom. CNA D said she did not check Resident #4 to see if the resident required incontinent care or needed to use the bathroom. CNA D said she stopped by Resident #4's room and asked if everything was ok. CNA D said Resident #4 had a doctor appointment earlier in the morning and that she had given Resident #4 a shower prior to going to her doctor's appointment. CNA D said Resident #4's doctor's appointment was at 11:00AM and that the family member took Resident #4 to the doctor's appointment. CNA D said the family member brought Resident #4 back to the facility around 2 or 3PM. CNA D said she checked on residents that required assistance with care about 1-1/2 to 2 hours. CNA D said it was important to provide incontinent care every 2 hours to avoid rashes due to moisture and avoid the residents from soiling their clothes. Interview on 03/24/26 at 12:35PM with the family member of Resident #4 said she took Resident #4 to a dental appointment for 10:30AM on 03/20/26. The family member said Resident #4 returned to the facility around 11:30AM or 12:00PM. The family member said she took Resident #4 to (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the bathroom around 12:30PM. The family member said Resident #4 wanted to be doubled brief because the resident did not want her clothes to get wet. The family said when she was at the facility, she did everything for Resident #4. The family member said it was a problem with staff not changing Resident #4's brief in a timely manner. The family member said she looked at the camera in the room and would notice that sometimes the staff do not come in the room for hours to change Resident #4. The family member said she had called this to the facility's attention. The family said it would improve for a little while and then go back to them doing the same thing. Interview on 03/25/26 at 12:14PM with the ADON said the facility DON was on leave. The ADON said if a resident family member tells staff they will take the resident to the bathroom, the staff should still be following up to see if this was done. The ADON said the staff should ensure that the resident's needs were met because the residents were still under the care of the facility. The ADON said staff should be providing incontinent care at least every 2 hours. Record review of the facility policy on Incontinence references: Centers for Medicare & Medicaid Services revised 2025 reflected in part: .Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. Record review of the facility policy on Quality-of-Life revised October 2009 reflected in part: .Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain, and 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 infections for 2 of 7 (Resident #3, Resident #4) reviewed for infection control. CNA A failed to change Resident #4's brief every 2 hours. Resident #4 brief was observed being heavily soiled in urine and resident clothing was soiled on 03/20/25. CNA B and CNA C failed to wear full PPE when providing incontinent care for Resident #3. CNA B used hand sanitizer to disinfect Resident #3's bedside table. CNA B took linen from another resident's room to Resident #3's room to provide incontinent care. CNA B and CNA C cleaned Resident #3 back and forward instead of front to back during incontinent care. These failures placed residents at risk for unwanted infections and decrease in quality of life. Findings included: Record review of Resident #4's face sheet dated 03/20/26 revealed a [AGE] year-old female admitted to the facility on [DATE] and again on 12/13/25. Resident diagnoses included anxiety, assistance with personal care, history of falling, osteoarthritis (joint disease that cause cartilage {support bones by allowing the bones to move smoothly over one another}on the bones to wear down, and dementia (progressive brain disorders causing a cognitive decline such as memory loss, confusion, and behavior changes). Record review of Resident #4's quarterly MDS dated [DATE] revealed a BIMS score of 3 indicating that Resident #4 cognition was severely impaired. Section G-Functional Abilities revealed that resident required substantial/maximal assistance with toileting hygiene and lower body dressing. Section H-Bladder and Bowel revealed that resident was always incontinent of both urine and bowel. Record review of Resident #4's Comprehensive Care Plan dated 07/28/24 and revised on 05/19/25 reflected resident being care planned for bowel/bladder incontinence that included the following interventions: -Use disposable briefs, check and change as indicated.-Monitor/document for s/sx of UTI: altered mental status, change in behavior, change in eating patterns. Record review of E-INTERACT dated 03/24/25 done for Resident #4 reflecting resident was difficult to arouse despite several attempts and had not eaten or taken medications. Record review of Resident #4's discharge hospital records dated 03/24/26 reflected the principal complaint: Altered mental status. Further review revealed that a urinalysis was collected on 03/24/26 that revealed bacteria in urine. Record review of Resident #4's Physician Order Summary Report for the month of March 2026 reflected the following orders: -Dated 03/25/26 UA C& S-Dated 03/25/26 Nitrofurantoin (antibiotic used to treat bladder infections) give 100mg by mouth two times day for UTI until 03/31/26. Record review of Resident #4's MAR for the month of March 2026 revealed that the medication Nitrofurantoin 100mg by mouth was initiated at 10:00AM on 03/25/26. Observation on 03/20/26 at 4:16PM of Resident #4 sitting in a recliner chair. Interview on 03/20/26 at 4:16PM with Resident #4 who was alert to name but not place or time. Resident #4 said she believed that her brief was wet and then said she did not know. Interview on 03/20/26 at 4:26PM with CNA D said she had just taken Resident #4 to the bathroom about 30 minutes ago. CNA D said that Resident #4 could stand with the assistance of one person. The surveyor asked CNA D if she could check Resident #4's brief because resident said she was wet and then said she did not know. Observation on 03/20/26 at 4:35PM of CNA D assisting Resident #4 to the bathroom via wheelchair. When CNA D assisted Resident #4 to stand from recliner to transfer to w/c, the surveyor observed the back of resident pants were wet. Resident #4 was able to use handrail in the bathroom to stand with the w/c behind her. When CNA D began to pull resident pants down, it was observed that Resident #4 was wearing a pull up brief as well as another brief underneath the pull up brief. The brief was heavily soiled with urine. Resident skin was intact. Interview on 03/20/26 at 4:50PM with CNA D said Resident #4 was a heavy wetter and that it was Resident #4's family member that doubled briefed resident. CNA D said she only took Resident #4's spouse to the bathroom and that the family member had taken Resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#4 to the bathroom. CNA D said she did check with the family member of Resident #4 to see if indeed the family member had taken Resident #4 to the bathroom. CNA D said she did not check Resident #4 to see if resident required incontinent care or needed to use the bathroom. CNA D said she stopped by Resident #4's room and asked if everything was ok. CNA D said Resident #4 had a doctor appointment earlier in the morning and that she had given Resident #4 a shower prior to going to her doctor's appointment. CNA D said Resident #4's doctor's appointment was at 11:00AM and that the family member took Resident #4 to the doctor's appointment. CNA D said the family member bought Resident #4 back to the facility around 2 or 3PM. CNA D said she checked on residents that required assistance with care about 1-1/2 to 2 hours. CNA D said it was important to provide incontinent care every 2 hours to avoid rashes due to moisture and avoid the residents from soiling their clothes. Interview on 03/24/26 at 12:35PM with the family member of Resident #4 said she took Resident #4 to a dental appointment for 10:30AM on 03/20/26. The family member said Resident #4 returned to the facility around 11:30AM or 12:00PM. The family member said she took Resident #4 to the bathroom around 12:30PM. The family member said Resident #4 wanted to be doubled brief because resident did not like want her clothes to get wet. The family said when she was at the facility, she did everything for Resident #4. The family member said it was a problem with staff not changing Resident #4's brief in a timely manner. The family member said she looked at the camera in the room and would notice that sometimes the staff did not come in the room for hours to change Resident #4. The family member said she had called this to the facility's attention. The family said it would improve for a little while and then the staff would go back to them doing the same thing. The family member said Resident #4 had been lethargic for the past 3 days and now not taking fluids well. The family member said Resident #4 might be dehydrated and may have a UTI. The family member said she was going to return to the facility on [DATE] and if the facility had not done anything, she was going to take resident to the hospital herself. Resident #3 Record review of Resident # 3's face sheet dated 03/25/26 revealed a [AGE] year-old female admitted to the facility on [DATE] and again on 01/19/26. Resident #3's diagnoses included cerebral infarction (decreased blood flow to the brain), fracture of lower end of left femur (longest, strongest, and heaviest bone in the human body, extending from the hip to the knee), reduced mobility, need assistance with personal care, and muscle weakness. Record review of Resident #3's quarterly MDS dated [DATE] revealed a BIMS score of 13 indicating that resident cognition was intact. Section GG-Functional Abilities revealed that Resident #3 was dependent for toileting hygiene. Section H-Bladder and Bowel revealed that Resident #3 was always incontinent of urine and bowel. Record review of Resident #3's Comprehensive Care Plan dated 01/16/24 and revised 01/07/26 reflected resident being care planned for bowel and bladder incontinence r/t disease process, impaired mobility and colostomy. An intervention included check as required for incontinence. Record review of Resident #3's Physician Order Summary Report for the month of March 2026 did not reflect an order for EBP. Observation on 03/25/26 at 11:17AM of incontinent care for Resident #3 by CNA B with the assistance of CNA C was made. Observation revealed an enhanced barrier precaution signage at the door entrance. There was a PPE hanger on the outside of the door. The PPE hanger had a container of micro-kill 2 germicidal wipes, gloves, mask, and disposable gowns. CNA B went across the hallway into another residents room and came out with linen that consisted of large towels and took them to Resident #3's room. CNA B and CNA C washed their hands with soap and water and put on gloves but did not put on disposable gowns. CNA B after removing Resident #3's personal belongings off the bedside table began to clean the resident table with hand sanitizer. CNA B proceeded to place the large towels on top of the bedside table. At 11:20AM CNA B left the room and returned with extra supplies for incontinent care. CNA B washed her hands again and put on a clean set of gloves and began to change Resident #3's brief. Resident #3 was incontinent of urine, and the brief was not heavily soiled. It was observed during incontinent care that Resident #3 had a colostomy bag. The colostomy bag was observed with brown soft feces inside of the bag. While CNA B was cleaning the resident groin and perineal area, she did not clean resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with one wipe at a time consistently instead would use the same wipe going back and forward over the skin repeatedly. When Resident #3 was repositioned to her left side, CNA C began to clean resident buttocks back and forward with the same wipe. Resident #3 did not have any skin breakdown to her buttocks or perineal area. When CNA B and CNA C were done providing incontinent care, they both placed all soiled material inside of a plastic bag, washed their hands and removed the soiled material from the room and took it to the soiled utility room. Interview and observation on 03/25/26 at 11:43AM with CNA B, she said the reason she did not put on a disposable gown when providing care for Resident #3 was because she did not need to wear a disposable gown. CNA B was asked why was the EBP signage at door entrance and why was there a PPE hanger on door with PPE inside? CNA B said the EBP sign and PPE hanger was on the door when Resident #3 was sick. When CNA B read the EBP signage instructing on what PPE to wear, she then said she needed to wear a disposable gown to protect herself as well as the resident from any type of bacteria. CNA B said the reason she took linen from another resident room and brought in Resident #3's room was because the room had a bag of linen inside the room. CNA B said it was not okay to take linen from room to room to avoid cross contamination. CNA B said she did this because it wound have taken too much time to go and get linen to provide care for Resident #3. CNA B said she used the hand sanitizer to disinfect Resident #3's bedside table because it was in the room and to her this was sufficient in disinfecting resident bedside table. When CNA B observed the germicidal wipes on the PPE door hanger she said she forgot to use the germicidal wipes to disinfect the table. CNA B said when providing incontinent care, she was supposed to wipe resident with one wipe at a time from front to back moving downward and not back to front. CNA B said she was taught this to avoid bacteria and to prevent giving the residents any type of infection. CNA B said she had been working at the facility for 1 year and had been a CNA for 17 years. CNA B said she had received in-service on infection control about a month ago, but did not recall if she had been in-served on EBP. Interview on 03/25/26 at 12:14PM with the ADON said she was the Infection Control Preventionist and that the DON was on leave. The ADON said the last time she had in-service staff on infection control, handwashing, cleaning and disinfecting surfaces and to use the purple top container germicidal wipes. The ADON said she in-serviced the staff last on EBP on 03/19/26. The ADON said it was not okay for the staff to use hand sanitizer to disinfect hard surfaces because it would not correctly kill bacteria and was not approved to clean hard surfaces. The ADON said it was important that the staff wear the correct PPE when providing direct care to residents on EBP to decrease exposure of any type of MDRO. The ADON said the staff should be providing incontinent care at least every 2 hours to prevent skin breakdown and infections. The ADON said it was not okay to take linen from one resident room and take to another resident room for infection control purposes. The ADON said when providing incontinent care, the staff should be cleaning the resident from front to back to prevent infections. The ADON said staff should be practicing EBP on resident's that had the following: wounds, gastrostomy tubes, tracheotomy, Foley catheter, intravenous lines, and colostomies by wearing PPE that consisted of gloves and disposable gown. Interview on 03/25/26 at 2:53PM with CNA C said she worked at the facility from7AM-7PM full time and had been working at the facility on and off for 10 years. CNA C said when providing incontinent care she was supposed to clean the resident buttocks upward and away and not back and forward for infection control and to prevent introducing bacteria in the vaginal area which could cause a urine infection. CNA C said she was not aware that she was cleaning Resident #3 in the wrong direction. CNA C said she must have been nervous. CNA C said when a resident was on EBP the staff had to wear gowns and gloves while providing care. CNA C said this was done for infection control. CNA C said residents that were on EBP were residents with wounds, colostomies, and Foley catheter. CNA C said she believed the last time she received in-service on infection control was a week ago. CNA C said once linen was placed inside a resident's room it should not be removed and taken to another resident room to prevent cross contamination. Record review of the facility last in-service given to staff on EBP was done 03/10/26 with CNA B signing she was in-service. Record review of (continued on next page)

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