STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675962	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southland Rehabilitation and Healthcare Center	501 N Medford Dr Lufkin, TX 75901

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received the appropriate treatment and services to prevent urinary tract infections for 1 of 3 (Resident #4) reviewed for incontinent care.The facility failed to ensure Resident #4 received proper incontinent care on 5/13/2026.This failure could place residents at risk of embarrassment, discomfort, and skin breakdown.Findings included:Record review of an admission Record for Resident #4 dated 5/13/2026 indicated he was [AGE] years old with diagnoses of BPH (enlarged prostate), UTI (infection in the urinary tract), dementia (a decline in thinking, behavior, and ability to perform everyday activities), and malignant neoplasm of prostate (cancer in the prostate).Record review of an admission MDS Assessment for Resident #4 dated 5/5/2026 indicated he did not have any impairment in thinking with a BIMS score of 15. He required substantial/maximal assistance with personal hygiene. He was always incontinent of urine/bowel.Record review of a care plan for Resident #4 dated 5/8/2026 indicated he had bowel/bladder incontinence related to disease process. Interventions included to check as required for incontinence. Wash, rinse, and dry perineum.During an observation on 5/13/2026 at 10:41 am, Resident #4 was in his room in bed. Staff had just placed him in bed to provide incontinent care. The ADON and CNA A were in the room, and both washed their hands and put on gloves. They removed his pants and Resident #4 said they were wet. Both staff said the pants were wet and they placed them in a plastic bag. CNA A opened Resident #4's brief and pulled it down between his thighs. CNA A removed her gloves, placed them in the trash, sanitized her hands, and put on clean gloves. Resident #4 had feces present inside the brief. CNA A removed wipes from a plastic bag and wiped his inner thighs using multiple wipes and placed the wipes inside the brief. CNA A removed her gloves and placed them in the trash, sanitized her hands, and applied clean gloves. The ADON removed her gloves and placed them in the trash and exited the room to get more gloves. The ADON reentered the room, sanitized her hands, and applied clean gloves. The ADON assisted with positioning Resident #4 onto his right side. CNA A did not clean Resident #4 properly around his penis which was uncircumcised and his inner thighs and left feces on his inner thighs. CNA A removed wipes from the plastic bag and wiped Resident #4's buttocks. Feces were still present on Resident #4's inner thighs and buttocks. CNA A removed Resident #4's brief and placed it in the trash. CNA A sanitized her hands and applied clean gloves. Resident #4 was not clean and had dried feces noted to his scrotum. CNA A applied a clean brief and placed barrier cream on her fingers to apply to his buttocks. Surveyor intervened and had staff look at Resident #4 to see if he was cleaned properly. CNA A with the help of the ADON completed care of Resident #4. CNA A secured the brief on Resident #4 and removed her gloves and placed them in the trash. CNA A removed the trash from the room and placed it in the dirty linen barrel that was in the hallway. The ADON removed her gloves and placed them in the trash. Both staff washed their hands and exited the room.During an interview on 5/13/2026 at 11:07 am, Resident #4 was sitting in a wheelchair in the room. He was alert to person and place. He said he had been at the facility for 3 weeks. He said he had been changed by staff earlier that morning but had been up since a little before breakfast. He said he could not remember (continued on next page)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	how often staff changed him during the day or night.During an interview on 5/13/2026 at 11:16 am, CNA A said she had been employed at the facility since January 2026. She said her shift was from 6 am to 6 pm. She said she should have paid more attention to how Resident #4 was cleaned. She said his pants were wet and had a bowel movement. She said she provided care for him that morning a little after 7 am. She said they were supposed to make rounds every 2 hours for incontinent care, but she had not gotten a chance to check on everyone that was assigned to her again. She said the feces were hard to see on Resident #4 during the care she provided to him. She said it would make her feel icky-disgusted if she was left dirty. She said he was uncircumcised and she should have cleaned his penis properly with pulling his foreskin back and cleaning and then placing the skin back in place.Record review of a CNA Comprehensive Clinical Competency Review Skills Checklist dated 1/6/2026 indicated she was observed by the ADON, and perineal care skills were met.During an interview on 5/13/2026 at 11:26 am, the ADON said she had been employed at the facility since December 2025. She said Resident #4 was really saturated in urine because his pants were wet. She said staff should check residents every 2 hours. She said there were two lines on the briefs they used to help indicate how saturated the briefs were. She said if the color change was not above 75%, they did not have to change the residents. She said the lines on the briefs were yellow and when they were wet, they changed to blue. She said Resident #4's brief was 100% saturated with urine and should have been changed before the time it was changed. She said feces were stuck to him and that indicated he had been sitting in it for a while. She said she did not notice it at the time that he was still dirty before the Surveyor intervened. She said a male resident should be cleaned in the front and back and both inner thighs. She said Resident #4 was uncircumcised and she did not clean his penis. She said she would expect the staff to take care of her timely and not be left in feces or urine. She said residents could be at risk of skin break down or infections if they were left dirty.During an interview on 5/13/2026 at 2:34 pm, the DON said the facility had invested money in a different brand of briefs and if the lines on the briefs were 75% or less, then they would not change the briefs. She said ADL care should be done every 3-4 hours because of the briefs the facility used. She said residents should be cleaned properly when incontinent care was provided and a male resident that was uncircumcised should cleaned properly. She said there could be risk of infections if staff did not follow policy and procedures.During an interview on 5/13/2026 at 3:23 pm, the Administrator said the clinical staff and nurse administrators were responsible for training staff in the facility. He said it would not make him feel great if staff left him dirty or did not clean him properly. He said he expected the staff to follow policy and procedures.Record review of a facility policy titled Incontinence Care dated 3/2017 indicated, .It is the policy of this facility to provide incontinence care for those residents requiring assistance with bladder and/or bowel incontinence. Staff 4. Wash peri-area using front to back strokes, rinse, pat dry.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, 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 2 of 4 residents (Resident #3 and Resident #7) and 3 of 5 staff (CNA A, CNA B and ADON) reviewed for infection control.1.The facility failed to ensure CNA A wore the appropriate PPE when she provided care to Resident #3 who was on EBP on 5/13/2026.2.The facility failed to ensure CNA B and the ADON wore the appropriate PPE when they provided care to Resident #7 who was on enhanced barrier precautions (EBP) on 5/13/2026.These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices.Findings included:1.Record review of a Face Sheet for Resident #3 dated 5/13/2026 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of UTI (urinary tract infection), extended spectrum beta lactamase (ESBL) resistance (bacteria that is resistance to many common antibiotics), and chronic kidney disease (a condition where the kidneys are damaged or lose function over time).Record review of active physician orders for Resident #3 dated 5/13/2026 indicated a physician order for catheter care every shift that started on 5/8/2026.Record review of an admission MDS Assessment for Resident #3 dated 5/12/2026 indicate it was in progress and not completed.Record review of a care plan for Resident #3 dated 5/11/2026 indicated she had bowel/bladder incontinent related to disease process. She had a foley catheter secondary to the ESBL sepsis.During an observation on 5/13/2026 at 8:48 am, CNA A entered the room of Resident #3 and put gloves on her hands. There was not a sign on the door or PPE noted in the hallway or hanging on the door. Resident #3 was in bed awake. CNA A pulled the linens down and opened the brief. Resident #3 had a urinary catheter that was draining into a drainage bag. CNA A looked and asked Resident #3 to roll onto her left side so she could check to make sure she was dry. CNA A told Resident #3 she was dry and closed her brief. CNA A went into the restroom and brought out a urinal, drained the urinary bag, flushed the urine in the toilet, and placed the urinal in a plastic bag in the bathroom. CNA A removed her gloves and placed them in the trash and washed her hands in the bathroom and exited the room.2. Record review of a Face Sheet for Resident #7 dated 5/13/2026 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of COPD (a group of lung diseases that affect breathing), gastrostomy status (tube placed in the stomach for feeding) and chronic atrial fibrillation (an irregular heartbeat).Record review of active physician orders for Resident #7 dated 5/13/2026 indicated an order for enteral feedings dated 5/8/2026. He had unstageable wounds to his left and right heels that started on 5/8/2026.Record review of a Quarterly MDS Assessment for Resident #7 dated 4/2/2026 indicated he did not have any impairment in thinking with a BIMS score of 14. He required partial/moderate assistance with personal hygiene. He was frequently incontinent of urine/bowel.Record review of a care plan for Resident #7 dated 12/2/2025 indicated he had wound management. Interventions included to monitor for signs of infection. The care plan did not reflect the need for EBP.During an observation on 5/13/2026 at 9:58 am, at the room of Resident #7 there was a sign on the door for EBP and PPE was hanging on the outside of the door. The ADON and CNA B were in the room to provide incontinent care. Resident #7 was sitting in a wheelchair with a lift pad under his buttocks with his g-tube infusing. The ADON disconnected his feeding, and both staff sanitized their hands and put on gloves. A mechanical lift was used to transfer Resident #7 from his chair to his bed by both staff. Neither staff put on a gown before the transfer. Resident #7 was positioned in bed and CNA B removed her gloves and placed them in the trash and sanitized her hands. The ADON removed her gloves and placed them in the trash and sanitized her hands and applied gloves. Resident #7 was rolled and the lift pad was removed along with his pants, and both were placed in a plastic bag. Resident #7's brief was opened and pulled down between his thighs. CNA B removed her gloves and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	placed them in the trash and sanitized her hands. The ADON assisted with turning and positioning Resident #7. CNA B placed gloves on her hands and removed a wipe from the plastic bag and wiped across his lower abdomen and placed the wipe in the trash. CNA B removed another wipe and wiped down both inner thighs and placed the wipes inside the brief. The ADON removed her gloves and placed them in the trash and exited the room to get more wipes. CNA B removed her gloves and placed them in the trash and sanitized her hands. The ADON reentered the room with wipes in a plastic bag and placed gloves on her hands. CNA B placed gloves on her hands and removed a wipe and wiped down his inner thighs again and placed the wipes in the brief. Resident #7 was rolled onto his right side and CNA B removed her gloves and placed them in the trash and sanitized her hand. CNA B applied gloves and rolled the brief underneath Resident #7's buttocks and removed it and placed it in the trash. CNA B removed her gloves and placed them in the trash and sanitized her hands. CNA B applied gloves, removed wipes, and wiped Resident #7's buttocks and a small amount of fecal material was present. CNA B removed her gloves; placed them in the trash; sanitized her hands and applied gloves. A clean brief was applied under Resident #7's buttocks and barrier cream was applied to his buttocks. CNA B removed her gloves and placed them in the trash; sanitized her hands; and applied gloves. Resident #7 was rolled onto his back, and brief was secured and he covered back up with his linens. The ADON and CNA B both removed their gloves and placed them in the trash. The ADON gathered the trash, exited the room, and placed the trash in the dirty linen barrel. The ADON and CNA B both washed their hands in the bathroom.During an interview on 5/13/2026 at 10:32 am, CNA B initially said she did not know what residents were on EBP and did not know what EBP was for. She said there was a sign for EBP on the door of Resident #7's room that she read and said it indicated staff to wear a gown and gloves for high contact. She said Resident #7 had a wound dressing and a feeding tube. She said she should have worn a gown during the care she provided to him. She said there was PPE on the door that included gowns. She said when she saw the sign after care was completed, she recognized it and had seen the signs in the facility and followed the precautions. She said there was a risk of spreading infections to other residents if they did not follow EBP. She said she had been at the facility for 6 months and was trained on EBP.During an interview on 5/13/2026 at 11:16 am, CNA A said she should have put on a gown when she provided care to Resident #3 because she had a urinary catheter. She said they were supposed to wear a gown and gloves when caring for a resident that was on EBP. She said there was usually signage on the doors and PPE should have been on a shelf outside of the door. She said there was a risk of infections if they did not wear gowns and gloves.During an interview on 5/13/2026 at 11:26 am, the ADON said she had been employed at the facility since December 2025. She said the DON was the IP for the facility but they both trained the staff on infection control. She said during the care that was provided to Resident #7 she did not wear the appropriate PPE that included a gown and gloves. She said Resident #7 was on EBP and it just slipped her mind. She said residents on EBP included any that had tubes such as urinary catheters, PICC lines, g-tubes, colostomies, or any tube coming out or going into the resident's body. She said staff were supposed to wear a gown and gloves when a resident was on EBP during contact care. She said the nurse aides would have knowledge about which residents were on EBP and they had signs and PPE on the doors. She said Resident #3 did not have a sign on her door earlier that morning, but a sign had been placed since then. She said there could be a risk of infections being spread to other residents if the appropriate PPE was not worn to protect the residents and staff.During an interview on 5/13/2026 at 2:34 pm, the DON said she was the IP for the facility. She said but she along with the ADON trained staff often with random checks. She said EBP was for residents who had urinary catheters, tubes, colostomies, wounds, or IVs. She said any resident who was in isolation staff were to wear a gown and gloves also. She said there could be a risk of infections if staff did not follow facility policy and procedures.During an interview on 5/13/2026 at 3:23 pm, the Administrator said the clinical staff and nurse administrators were responsible for training staff on infection control. He said EBP included residents with certain types of infections, wounds, g-tubes, or urinary (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	catheters. He said staff should wear the appropriate PPE that was on the doors of the rooms according to policy. He said there was a risk of spreading contaminants.Record review of a facility policy titled Enhanced Barrier Precautions revised 1/2026 indicated, .The facility implements Enhanced Barrier Precautions to reduce transmission of multidrug-resistant organisms (MDROs) in residents, while maintaining quality of life and minimizing unnecessary isolation. 1. Enhanced Barrier Precautions (EBP): expand the use of PPE and refer to the use of gowns and gloves during high contact resident care activities. a. PPE: the use of gown and gloves for high contact resident care activities is indicated with: i. wounds and/or indwelling medical devices regardless of MDRO colonization as well for residents. C. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: iii. Transferring; iv. Providing hygiene; vi. Changing briefs or assisting with toileting; vii. Device care or use-indwelling urinary catheter. 3. Implementation a. The facility will implement a system to alert staff, residents, and visitors that a resident is on TBP. ii. For Enhanced Barrier Precautions, signage should also clearly indicate high contact resident care activities that require the use of gowns and gloves. B. Make PPE including gowns and gloves, available immediately outside of the resident room.