STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676091	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sagecrest Alzheimers Care Center	438 Houston-Harte San Angelo, TX 76903

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)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable disease and infections for one (Resident #1) of three residents reviewed for infection control practices. CNA A failed to perform proper hand hygiene and glove changes while providing incontinence care to Resident #1. This failure could place residents at risk for the spread of infection. Review of Resident #1's face sheet dated 07/24/25, revealed an 86- year- old male admitted to the facility on [DATE] with diagnoses including covid-19, acute upper respiratory infection, constipation, abnormalities of gait and mobility. Review of Resident #1's MDS assessment dated [DATE] revealed Resident #1 are was dependent on staffs for most activities of daily living (ADLs) and one-person physical assistance with transfer. Resident #1 was frequently incontinent of bowel and bladder. Review of Resident #1's Care Plan dated 07/03/25 revealed Resident #1 was frequently incontinent of bowel most of the time. Its The goal was to manage episodes of bowel incontinence as needed. Observation of incontinence care for Resident #1 on 07/23/2025 at 10:42 a.m. revealed CNA A washed her hands prior to donning gloves. CNA A removed Resident #1's brief that was soiled with urine and fecal matter. CNA A wiped the resident from front to back. She changed her gloves and repositioned Resident #1. CNA A continued to clean the resident. CNA A's gloves were visibly soiled with urine and fecal matter. She did not wash her hands, change gloves or perform hand hygiene before retrieving Resident #1's clean brief and placing it underneath the resident and fastening. She removed her gloves and picked up the trash. CNA A washed her hands before exiting Resident #1's room. In an interview on 07/23/2025 at 10:50 a.m. with CNA A, she revealed she should have washed her hands and changed her gloves before retrieving a clean brief and placing it underneath Resident #1. CNA A stated she has been employed in the facility for 16 years and received infection control training about 1 month ago. She stated cross contamination was mixing clean with dirty which happened while providing care to Resident #1. CNA A noted she was nervous which caused her not to follow standard precautions. She said the resident could acquire an infection when she did not follow good infection control practices including not changing gloves before retrieving Resident #1's clean brief. During an interview with the DON on 07/24/2025 at 11:49 a.m., he revealed he was aware of some of the concerns raised about infection control. He stated he expected the aides to follow the facility's protocols during care, one of which was to ensure hand washing and change of gloves as needed while providing care. He noted CNA A has been in the facility a long time and one of the best staffs. He said she must have been nervous. The DON stated the employees receive infection control training annually and periodically as needed. He explained the facility monitors the employees by observing them give care to the residents. Review of the facility's Hand hygiene policy revised November 26, 2024, reflected, Hand hygiene is the most important procedure for preventing the spread of infections. Hand hygiene should be performed:1) Upon arrival at the workplace and before going home2) After using the toilet, blowing nose, and covering a cough or sneeze3) Before and after eating4) Before and after client contact5) After removing gloves6) Before invasive procedures 7) After touching contaminated items.