STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676335	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadmoor Medical Lodge	5242 Medical Drive Rockwall, TX 75032

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 observations, interviews, and record reviews, the facility failed to ensure residents who were incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections for 1 of 4 residents (Resident #1) reviewed for catheter care.The facility failed to ensure CNA A and the ADON place the catheter bag below bladder level while providing incontinent care. This failure could result in infection.Findings included:Record review of Resident #1's face sheet, dated 4/22/2026, revealed the resident was a [AGE] year-old female admitted on [DATE] with diagnoses of stroke, type 2 diabetes, bladder dysfunction, and stage 4 pressure ulcer of sacrum.Record review of the resident's care plan, dated 7/17/2024, revealed the following was care planned for the resident: The resident has a Foley Catheter and is at risk for UTI R/T Stage 4 to her sacrum with one of the listed interventions included position catheter bag and tubing below the level of the bladder and away from entrance room door. The care plan also stated that the resident was At increased risk of multidrug-resistant organism acquisition related to present of a wound.In an observation on 4/22/2026 at 9:45 AM, CNA A and the ADON were providing peri care for Resident #1. PPE was donned on both staff. Both staff performed hand hygiene prior to entering the resident's room. The resident had a bowel movement. Both CNA A and the ADON failed to perform hand hygiene in between three glove changes after touching the resident's fecal matter and body fluid. Observation also revealed that the resident's urinary catheter bag was sitting on the resident's bed at the same level as the urinary bladder. The urinary catheter was covered with a privacy bag. Both staff washed hands after the procedure.In an interview with the ADON on 4/22/2026 at 10:15 AM, she stated, she realized she had not performed hand hygiene towards the end when she was putting barrier cream on the resident's buttock. She stated she should have used hand sanitize in between gloves changes. She stated the risk to the resident was infection. She also stated the catheter bag should always be below bladder level. She stated she noticed the bag was on the bed and should not have been placed on the bed. She stated to prevent the tube to be pulled, she should have moved the bag to the other side of the bed while repositioning the resident. She stated the risk of the catheter bag not staying below bladder level included infection. She stated it was her mistake, she stated she also just provided her staff an in-service on infection control 2 weeks ago.In an interview with the DON on 4/22/2026 at 10:22 AM, she stated her expectation of her staff was to perform hand hygiene between glove changes to prevent infection. She stated catheter bags should always be kept below bladder level to prevent the urine to backflow which could cause infection. Record review of the facility's Catheter Care policy, revised January 3, 2023, revealed the policy stated the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	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 maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections for 1 of 4 residents (Resident #1) reviewed for infection control.The facility failed to ensure CNA A and the ADON performed hand hygiene in between glove changes while providing peri care for Resident #1.The facility failed to ensure CNA and the ADON placed Resident #1's catheter bag below bladder level while providing peri care.These failures could place residents at risk for infections.Findings included:Record review of Resident #1's face sheet, dated 4/22/2026, revealed the resident was a [AGE] year-old female admitted on [DATE] with diagnoses of stroke, type 2 diabetes, bladder dysfunction, and stage 4 pressure ulcer of sacrum.Record review of the resident's care plan, dated 7/17/2024, revealed the following was care planned for the resident: The resident has a Foley Catheter and is at risk for UTI R/T Stage 4 to her sacrum with one of the listed interventions included position catheter bag and tubing below the level of the bladder and away from entrance room door. The care plan also stated that the resident was At increased risk of multidrug-resistant organism acquisition related to present of a wound.In an observation on 4/22/2026 at 9:45 AM, CNA A and the ADON were providing peri care for Resident #1. PPE was donned on both staff. Both staff performed hand hygiene prior to entering the resident's room. The resident had a bowel movement. Both CNA A and the ADON failed to perform hand hygiene in between three glove changes after touching the resident's fecal matter and body fluid. Observation also revealed that the resident's urinary catheter bag was sitting on the resident's bed at the same level as the urinary bladder. The urinary catheter was covered with a privacy bag. Both staff washed hands after the procedure.In an interview with CNA A on 4/22/2026 at 10:00 AM, she stated she should have hand sanitize in between glove changes. She said she did not have the hand sanitizer with her and did not think of getting it. She stated the risk to the residents included infection. She stated last in-service on infection control was about 2 weeks ago.In an interview with the ADON on 4/22/2026 at 10:15 AM, she stated, she realized she had not performed hand hygiene towards the end when she was putting barrier cream on the resident's buttock. She stated she should have used hand sanitize in between gloves changes. She stated the risk to the resident was infection. She also stated the catheter bag should always be below bladder level. She stated she noticed the bag was on the bed and should not have been placed on the bed. She stated to prevent the tube to be pulled, she should have moved the bag to the other side of the bed while repositioning the resident. She stated the risk of the catheter bag not staying below bladder level included infection. She stated it was her mistake, she stated she also just provided her staff an in-service on infection control 2 weeks ago.In an interview with the DON on 4/22/2026 at 10:22 AM, she stated her expectation of her staff was to perform hand hygiene between glove changes to prevent infection. She stated catheter bags should always be kept below bladder level to prevent the urine to backflow which could cause infection. Record review of the facility's Hand Hygiene policy, dated in 2001, revealed the policy stated Use an alcohol-based handrub. or soap and water for the following situations:.After contact with blood or bodily fluid,. after removing gloves.Record review of the facility's Catheter Care policy, revised January 3, 2023, revealed the policy stated the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.