

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676336	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Continuing Care at Eagles Trace		STREET ADDRESS, CITY, STATE, ZIP CODE 14703 Eagle Vista Drive Bldg 601b Houston, TX 77077	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement. 2-Staff were observed without hair restrains. 1 small transparent square container was observed in the dry storage room which held multiple (unable to count)insects. 1 live insect was observed in the dry storage room. These failures could place residents at risk of foodborne illness and disease. Findings Included: On 9/17/25 at 11:51 AM a delivery driver was observed in the kitchen preparation area; there was no hair restraint donned (worn).Observation and interview on 9/17/25 at 11:54 AM of Chef A in the food preparation area, there was no hair restraints donned. Chef A said he was aware of the importance of donning (wearing) hair restraints to avoid cross contamination and for infection control. He said that the negative outcome could be someone getting sick. On 9/17/25 at 11:55 AM, observation and interview with the General Manager of Dietary Services, she said that Everyone that is in the kitchen should have on a hairnet/hair restraint to prevent cross contamination and for infection control, to prevent residents of getting sick. Chef A was then observed placing a hair restraint on. The General Manager of Dietary Services said she also explained to the delivery driver the requirements of wearing a hair restraint. Interview on 9/18/2025 at 12:20 PM with the DON regarding hair restraints and pest control in the kitchen while preparing foods all staff in the kitchen were responsible to avoid cross contamination and follow infection control practices, a negative outcome could be foodborne illness. On 9/18/25 at 2:30 PM, observation and interview with the Dietary Services Manager of the facility policies Uniform Dress Code, Department: Dining Services dated 06/2025 and Food Handlers - Employee Health policy dated 01/2020, she said that the purpose of wearing hair restraints/coverings was to prevent cross contamination and for infection control. She said that the facility followed the guidelines of the Texas Food Code. Interview on 9/18/25 at 3:43 PM with the Administrator, her expectations were for all staff to wear hair restraints to avoid any cross contamination and for infection control to prevent illness. All staff were responsible for wearing hair restraints when in the kitchen.Record review of the facility policy entitled Uniform Dress Code, Department: Dining Services dated 06/2025 revealed in part. Company approved hair covering: baseball cap, hair net or skull cap.Beard guard must be worn if beard is visible. Record review of the facility policy entitled Food Handlers - Employee Health dated, 01/2020, revealed in part. Purpose / Scope: Prevention of transmission of disease-carrying organisms and food borne illness. Personal Hygiene 1. The dress code policy will be enforced, including the following. hair nets and caps worn at all times.		

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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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 and interview the facility failed to ensure the residents' rights to privacy for 1 (Resident #17) of 7 residents reviewed for personal privacy. The facility failed to ensure that certified nursing assistant (C.N.A.) A and Program Assistant (PA) A maintained Resident #17's privacy while resident received a shower from private caregiver. This failure place residents at risk of having their bodies exposed to the public, resulting in low self-esteem and a diminished quality of life. The findings included: Record review of Resident 17's Facesheet dated 09/17/2025 reflected resident was an [AGE] year-old female who admitted to the facility on [DATE] with diagnosis that included but were not limited to dementia, severe behavioral psychosis mood disorder, obsessive compulsive disorder, muscle weakness, unspecified lack of coordination, and anorexia. Record review of Resident #17's Care Plan undated had not revealed that the resident required her bathroom door open while receiving Activities of Daily Living (ADL) care, specifically showers. Record review of Resident #17's Minimum Data Set Assessment (MDS) dated [DATE] revealed that Resident #17 had a Brief Interview for Mental Status (BIMS) of 13 suggesting that the resident's cognition was intact. Further review revealed for Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower, resident required partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. During an observation on 09/16/2025 at 9:46 a.m. PA A was observed knocking, opening the room door of Resident #17's room, quickly closing the door giving only enough space for her to reach her arm into the room and placed a piece of paper on a dresser near the entrance of the room door before closing the resident's door. During an observation on 09/16/2025 at 9:47 a.m. C.N.A. A was observed knocking, entering, and exiting Resident #17's room. During an observation on 09/16/2025 at 9:48 a.m. Resident #17 was observed in the shower of her room fully unclothed while receiving a shower by resident's personal caregiver. During an interview on 09/16/2025 at 2:01 p.m. C.N.A. A stated that she had entered Resident #17's room earlier in the day while the resident was receiving a shower. She stated that she knocked at the resident's door, poked her head into the room, and the resident told her to come in. She stated that she observed the resident nude being given a shower by the resident's personal caregiver. She stated that she believed the resident had a bathroom door, but that there was a clear view from the entrance of the resident's room to the resident inside her shower. She stated she does not know why she did not close the bathroom door. She stated that the bathroom door should have been closed so that the resident's dignity and respect would be maintained while the resident was receiving a shower. She stated that the resident had a high mental cognitive function and should have understood her nakedness was exposed and visible from the door entrance but did not know why she did not close the door. She stated from her experience; the resident would tell anyone who knocked at the door to come inside whether she was in the shower or not. She stated that the facility received ongoing training in-services on maintaining a resident's privacy, dignity and respect. She stated that it had been her responsibility to ensure that the resident's nakedness was not exposed during showers. During an interview on 09/16/2025 at 2:24 p.m. PA A stated that morning while passing out the facilities in-house newsletter, she knocked at the door of Resident #17. She stated when she did not hear anything, she opened the door to announce herself when she immediately seen the resident naked in the shower receiving ADL care from the resident's C.N.A. She stated when she seen that the resident's nakedness had been exposed, she immediately closed the door leaving only enough space to place the newsletter on a table near the door entrance and quickly closed the door. She stated that the resident should have been covered with at least a towel to cover the top part of the resident's body to allow the resident to maintain some level of privacy while receiving her shower. She stated that the simple solution would have been to close the resident's bathroom door while giving the (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident a shower but did not know why she did not close the door. She stated that she received training on maintaining a resident's privacy and dignity during her onboarding training 3 months ago. During an interview on 09/16/2025 at 03:26 p.m. Registered Nurse, RN A stated Resident #17 received private home health support for showers and on shower days, the private C.N.A. provided the resident with a shower. She stated that it was her expectation that no matter if a private staff or a facility staff assisted the resident with a shower that the resident was not exposed during showers. She stated it had been the facility's privacy issue protocol that all resident doors were to remain closed to a resident's room during ADL care to maintain privacy and dignity. She stated if it had been the resident's preference to keep the bathroom door open during showers, that should have been care planned and an additional measure should have been in place to ensure that the resident's nakedness was not exposed simply upon opening their resident's room door during shower times. She reviewed the resident's care plan and found no indication that the resident was care planned to keep her bathroom door open during showers, and by not care planning, the facility was allowing an invasion of the resident's privacy. She stated that it was all staff members responsibility to ensure that the private caregiver practiced and promoted privacy and ensured that the caregiver practice closed the resident's bathroom door during ADL care. She stated that she would create a sign for the private caregiver to place on the outside of the resident's room door during shower times to ensure the resident received privacy. She stated that the facility staff received on-going in-service training on maintaining a resident's privacy, dignity, and respect and she received said training during her onboarding 6 months ago. During an interview on 09/18/2025 at 12:31 pm, the Director of Nursing (DON) stated that Resident #17's bathroom door should be closed during ADL care such as during showering. She stated if the resident had chosen not to keep the bathroom door closed and it had not allowed for privacy in the room; it should have been care planned. She stated if that incident was a one-time occurrence, care planning was not needed. She stated when C.N.A. A and PA A entered the resident's room, they could have offered to close the resident's bathroom door to preserve the resident's privacy. She stated that training on privacy/dignity was provided at a staff members on-boarding during after hire, as needed if they feel like there had been a pattern, and during the facilities annual skills training fair. During an interview on 09/19/2025 at 3:43 pm. The Administrator (ADM) stated that it had been her expectation that staff provided Resident #17 with privacy and ensured that the resident's dignity was preserved based on the resident's preferences especially if there would be any compromised activities going on in the room. She stated that it had been her expectation that the bathroom door would remain closed while the resident was provided a shower but again deferred to the resident preferences. She stated that staff received on-going and as needed in-service training on resident's privacy, dignity, and respect. Resident was unavailable for an interview. Record review of training dated 02/13/2025 reflected showers and ADL documentation in-service had been provided. Record review of training dated 03/04/2025 reflected compliance in-service had been provided in the area of showers. Record review of training dated 03/06/2025 reflected completing showers and completing shower sheet in-service was provided. Record review of in-service training dated 09/17/2024 unsigned reflected: Showering/Bathing follow resident preferences from care plan. Honor Privacy & Dignity. - Ensure privacy (close doors/curtains), - Limit body exposure. Record review of undated Policy titled Activities of Daily Living reflected Identifying The Residents' Functional Abilities Through Measurements of Their Activities of Daily Living. The 11th Activities of Daily Living. Bathing - How the resident - Takes a full body bath/shower or sponge bath. Policy on Resident Rights was asked for and not received.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain grooming and personal hygiene for one (Resident#3) out of 4 residents reviewed for ADLs. The facility failed to provide timely incontinent care for Resident #3 which resulted in the resident's brief, towel on top the drawsheet, draw sheets and bed linen to be soaked with urine. This deficient practice could place residents at risk of skin breakdown and reduced feelings of self-worth. Findings included: Record review of Resident #3's face sheet revealed a [AGE] year-old female resident who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included diabetes mellitus (high blood sugar), cerebral infraction (brain stroke), and dysphagia (difficulty swallowing). Record review of Resident #3's quarterly MDS assessment, dated 8/27/25, revealed a BIMS score of 4 out of 15 indicating severely impaired cognition. Resident #3 was totally dependent on staff for all ADL care with one to two staff assist. Record review of Resident #3's care plan dated 08/19/25 revealed in part . resident was incontinent of bowel and dependent on one staff for care. interventions: to pull up and down my garment, to manage garments, and or continence products. During an observation on 09/17/25 at 2:05 p.m., revealed Resident #3 was lying in bed in her room on her back. Resident #3's pants, the draw sheet, and a towel on top of the draw sheet and bed linen were wet with urine, and the bed linen had a ring on it. When CNA K opened Resident #3's incontinent brief, the inside of the incontinent brief was brown, and the wet indicator on the incontinent brief was completely faded out. During an interview on 09/17/25 at 2:56 p.m., LNV B said CNA K was supposed to make rounds every two hours for incontinent care for Resident #3. She said she monitored the aides to see if they had made their rounds every two hours. LNV B said she did not ask CNA K today if she had made her rounds because she was busy, and CNA K knew to make her rounds every two hours to check and change Resident #3. LNV B said Resident #3 was up in the wheelchair by the nursing station when she came to work this morning at 7:00 a.m. LNV B stated if CNA K did not change Resident #3's wet incontinent brief for an extended time, the resident's skin would break down. LNV B said she had training on incontinent care, and the trainer said the staff should check the residents every two hours and change the residents' incontinent briefs to prevent rashes, skin breakdown, and infection. During an interview on 09/17/25 at 3:18 p.m., CNA K said Resident #3 was already up when she came to work today at 7:00 a.m., and she was sitting at the nurse's station. CNA K said she changed Resident #3 after breakfast before she went to lunch. CNA K said she went to lunch between 11:00 and 11:30 a.m. She said Resident #3 was a heavy wetter and her brief was always wet. CNA K said Resident #3's pants were soaked, the brief had a brown color, and the wet indicator was faded entirely, and she said Resident #3's brief was always wet. She said she had in-service training on how to make rounds and provide incontinent care. She said she was supposed to make rounds every two hours but sometimes would not be able to check on residents every two hours because the morning shift was fast-paced, and she was kind of behind today. CNA K said if Resident #3 was left in a wet incontinent brief for an extended period, then Resident #3's skin could break down. She said she had an in-service on making rounds every two hours. During an interview on 08/18/24 at 11:31 a.m., the DON said CNA K was supposed to have made rounds on Resident #3 when she came in at the start of her shift, before and after each meal for incontinent care. She said CNA K should have checked Resident #3 more often since she knew Resident #3 was a heavy wetter. She said if Resident #3 was left on a wet incontinent brief, the resident's skin could break down. The DON said if Resident #3's incontinent brief was brown, and the wet indicator faded out it could mean CNA K did not change Resident #3 in over 2 hours. She was not aware Resident #3 refused the aides to change her. The DON said the aides had a checklist which the aide completed upon hire, and it had ADL rounding. During an interview on 09/18/25 at 3:45 p.m., the Administrator said CNA K was supposed to make rounds according to (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3's plan of care. The Administrator said CNA K should make rounds upon the start of shifts and at different intervals throughout the shift. The Administrator said if Resident #3 was left on a wet incontinent brief for an extended period of time, the resident's skin could break down. Record review of the facility undated urinary incontinence management revealed in part .maintenance Program is utilized whenever a resident cannot benefit from or is unable to participate in toileting programs. The goal is to maintain the residents' dignity and to prevent any skin breakdown or other negative consequence related to UI. The Maintenance program includes; Pad and brief change every 2-4 hours, more frequently as needed cleansing, rinsing, and drying of skin during pad/brief change. skin inspection for areas of redness, excoriation, infection, skin breakdown.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #25) out of 7 residents reviewed for adequate supervision. The facility failed to ensure Resident #25 who required supervision and assistance while receiving a shower was left unattended. This deficiency exposed residents living in the facility to potential harm, injury or death due to not being adequately monitored. Record review of Resident 25's Facesheet dated 09/16/2025 reflected she was an [AGE] year-old female who admitted to the facility on [DATE] with diagnosis that were limited to muscle weakness, other abnormalities of gait and mobility, hereditary and idiopathic neuropathy (disorder affecting nervous system causing discomfort from pain, tingling and numbness of limbs or extremities), unspecified Poly osteoarthritis (arthritis in the joints causing pain, stiffness, inflammation, and limited motion), unspecified lack of coordination, anemia (not having enough health blood cells to carry an adequate amount of blood to the lungs resulting in fatigue, shortness of breath, and lightheadedness), and cognitive communication deficit (impaired cognitive functions, such as attention, memory, reasoning, and problem-solving). Record review of Resident #25's Care Plan dated 06/24/2025 3h. Bathing - Functional Status. Goals: I may need assistance with - Bathing. Getting in and out of shower/tube washing my hair. Washing my back. Washing my legs/feet. Putting on cream/lotion, drying myself. I require the following support: one-person physical assistance. My preferred days Tuesday, Thursday, Saturday. I need the following devices to be as independent as possible: Shower chair/stool. Record review of Resident #25's Minimum Data Set Assessment (MDS) dated [DATE] reflected that Resident #25 had a Brief Interview for Mental Status (BIMS) of 09 suggesting that the resident's cognition was moderately impaired. Further review revealed for Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. During an interview on 09/16/2025 at 10:43 a.m. Resident #25 stated that she was left alone in the shower earlier in the day by C.N.A. B and was ready to come out of the shower and called for the C.N.A. who did not respond. She stated she called out several times and then yelled out, Help, Help, but no one came, so she pushed the call light and Registered Nurse (RN) A came into the room and C.N.A. B followed thereafter. She stated she told the two staff that she was ready to get out of the shower. She stated that she could not get herself in and out of the shower alone and had not wanted to be left alone and that had not made her feel safe. She stated if she happened to fall while in the shower, it would be difficult for her to crawl over to the call light cord to summon help. During an interview on 09/16/2025 at 02:59 p.m. Certified Nursing Assistant (C.N.A.) B stated that she had given Resident #25 a shower on that day and while the resident showered herself, she had changed out the resident's bed sheets and made-up the resident's bed. She stated that she only washed the resident's back, as the resident was able to wash all other parts of her body. She stated that she would not consider the resident being left alone in the shower, because she was right in the room at the resident's bed. She stated that while the resident was in the shower, RNA came into the resident's room and turned off the resident's call light that C.N.A. stated she had forgotten to turn off when the resident had let her know earlier that she was ready for her shower. She stated that the resident had not made any concern to her or RN A about being left alone in the shower. During an interview on 09/16/2025 at 03:09 p.m. LVN C stated that this morning she entered Resident #25's room because the call light had been going off and seen that resident was in the shower. She stated that C.N.A. B was in the room and stated that she must have forgotten the light was on. Resident did not make any complaints or mention that she was left alone in the shower area or felt afraid. She stated that the resident was (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	able to wash certain parts of her own body, and she was encouraged to wash other parts but had some limited mobility due to arthritis in her right knee. She stated it would have been her expectations that while residents were in the shower, that staff should be right there at the resident's side as a safety precaution. She also stated that it would not be her professional experience to make a resident's bed while they were in the shower and that C.N.A. B should have waited until the shower was complete to make the resident's bed to keep an observation and make sure that the resident's care needs were met. She stated that the resident made no complaints or comments about being left alone in the shower. She stated that C.N.A. B should receive in-service training because the resident had not felt safe without C.N.A. B present. During an interview on 09/19/2025 at 3:43pm. The Administrator (ADM) stated that it had been her expectation that staff provided Resident #25 with adequate supervision to ensure that the resident had been safe and felt safe while receiving ADL assistance. Record review of training dated 02/13/2025 reflected showers and ADL documentation in-service had been provided. Record review of training dated 03/04/2025 reflected compliance training for providing showers. Record review of training dated 03/06/2025 reflected completing shower sheet and completing showers in-service was provided. Record review of in-service training dated 09/17/2024 unsigned reflected: Showering/Bathing follow resident preferences from care plan. Honor Privacy & Dignity . - Do with, not for - Be present, engaged - not task focused. Record review of undated Policy titled Activities of Daily Living reflected Identifying The Residents' Functional Abilities Through Measurements of Their Activities of Daily Living 11 Activities of Daily Living. Key activities important to self-care include 1st - Measuring Self Performance. - What is the residents' participation in this activity? - Measured from the perspective of how much the staff person assists the resident with the activity. The 11th Activities of Daily Living. Bathing - How the resident - Takes a full body bath/shower or sponge bath - Transfers in/out of the bath/shower. Step 2 - Measuring support Provided - Self Performance - Measures the resident's level of involvement in completing the task - Support Provided - Measures the stat person's level f support provided to the resident so they could complete the task - Did you participate? If so, what did the participation look like? - Did you arrange items (set-up) so the resident could complete the task? - Did you provide physical assistance of any type? If so, how many staff persons were involved.		

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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 residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 4 residents (Resident #3) reviewed for incontinent care. The facility failed to ensure CNA K properly cleaned Resident #3 during incontinent care. This failure could place residents at risk for pain, infection, injury, and hospitalization. Findings included: Record review of Resident #3's face sheet revealed a [AGE] year-old female resident who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included diabetes mellitus (high blood sugar), cerebral infraction (brain stroke), and dysphagia (difficulty swallowing). Record review of Resident #3's quarterly MDS assessment, dated 8/27/25, revealed a BIMS score of 4 out of 15 indicating severely impaired cognition. Resident #3 resident was totally dependent on staff for all ADL care with one to two staff assist. Record review of Resident #3's care plan dated 08/19/25 revealed in part . resident was incontinent of bowel and dependent on one staff for care. interventions: to pull up and down my garment, to manage garments, and or continence products .During an observation on 09/17/25 at 2:10 p.m., revealed incontinent care for Resident #3 was provided by CNA K. CNA K did not separate Resident #3's labia when she cleaned the resident's peri area. CNA K also wiped from back to front while she provided care. CNA K was about to apply barrier cream on Resident #3's private area, and the surveyor intervened. CNA K separated Resident #3's labia and wiped the area three times, and the wipes had a significant amount of yellow substance. During an interview on 9/17/25 at 3:08 p.m., LVN B said CNA K should not have wiped Resident #3 from back to front to prevent contaminating the peri with germs or bowel movement. LVN B said when CNA K cleaned Resident #3's peri area, CNA K was supposed to separate the labia and clean each side and middle from front to back. LVN B said the labia should be separated and cleaned to prevent infection. LVN B said she had in-service training, and the aides, too, had in-service training on incontinent care for a female resident, and they were educated to separate the labia. During an interview on 9/17/25 at 3:33 p.m., CNA K said she wiped Resident 3's buttocks from back to front, but she was supposed to wipe from front to back. CNA K said the resident should not be wiped from back to front to prevent infection or mistakenly transfer germs from the buttocks to the peri area. CNA K said she was supposed to wipe Resident #3's labia by separating the area and wiping to prevent infection and irritation, but she forgot to separate the labia. CNA K said she did not separate the labia when she wiped Resident #3, but when she wanted to apply the barrier cream, the surveyor intervened, and she separated Resident #3's labia and wiped three times, and she wiped out a substantial amount of yellow substance. CNA K said she had in-service training on how to provide incontinent care for a female resident, and the trainer stated the female labia should be separated and wiped. During an interview on 09/18/25 at 11:42 a.m., the DON said the aides had a skills -check off upon hire, and it included peri care. The DON said CNA K should have wiped from front to back and opened Resident #3's labia and wiped side to side, then middle, also inspect the area for any skin impairment, and ensure she cleaned the area properly to prevent infection. The DON said CNA K should have wiped from front to back, which meant CNA K should have cleaned from the cleanest to the dirtiest area. That would prevent any bowel movement from contaminating the front (peri area), thereby preventing infection. Record review of the facility undated urinary incontinence management revealed in part .maintenance Program is utilized whenever a resident cannot benefit from or is unable to participate in toileting programs. The goal is to maintain the residents' dignity and to prevent any skin breakdown or other negative consequence related to UI. The Maintenance program includes; Pad and brief change every 2-4 hours, more frequently as needed cleansing, rinsing, and drying of skin during pad/brief change. skin inspection for areas of redness, excoriation, infection, skin breakdown.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676336	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Continuing Care at Eagles Trace		STREET ADDRESS, CITY, STATE, ZIP CODE 14703 Eagle Vista Drive Bldg 601b Houston, TX 77077	
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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interviews and record review, the facility failed to maintain an effective pest control program so that the facility is free of for rooms in 1 of 1 kitchen reviewed for environment.1 small transparent square container was observed in the dry storage room which held multiple fruit flies. 1 live insect was observed in the dry storage room. These failures could place residents at risk of foodborne illness and disease. Findings included: On 9/16/25 at 8:35 AM an observation and interview with the Director of Dietary Services, revealed inside of the dry storage room was a small, a clear square container that had a clear light brown liquid inside and several, (unable to count), small insects. The Director identified the liquid as apple cider vinegar and the insects as fruit flies. He said it was a fruit fly contraption and that it was not supposed to be there. He said the contraption would cause no harm, but it was just not the best look. He said the Chef would be in later to discuss who placed the contraption there. One live insect flew away from the container when the Director of Dietary Services removed the container. On 9/16/25 at 12:12 PM, interview with the General Manager of Dietary Services, she said she was made aware of the container with vinegar and fruit flies and that the fruit flies came with the summer heat. She said that the contraption should not have been there at all. She said all staff were aware of cross-contamination and infection control. On 9/17/25 at 1:40 PM an interview with the Maintenance Director, he said that pest control came to the facility every Wednesday and as needed by request. He said that the facility had not had any major issues with fruit flies. He said that pest control was important to prevent residents from getting sick and could cause cross contamination if a fruit fly landed on food. Interview on 9/18/25 at 3:43 PM with the Administrator, regarding pests, any pest around food could cause contamination. She said as the Administrator she was responsible while general services managed pest control contracts and made sure they were effective to prevent illness. Record review of the facility policy entitled Integrated Pest Management, dated 3/17/2025 revealed in part.Purpose: The purpose of this policy is to establish guidelines for the prevention, monitoring, and control of pests in a manner that protects the health and safety of residents, staff, and visitors.our approach will include monitoring, prevention strategies, and control methods that align with health, safety, and sustainability standards. Objectives: Prevention: Prevent the introduction of pests by eliminating favorable conditions. Monitoring: Conduct regular inspections to detect pest activity early. Control: Implement non-toxic, environmentally safe measures for managing pests when necessary. Education: Educate staff, residents, and contractors on pest prevention and management.		