STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the right to be free from misappropriation of property was provided for 1 of 9 residents reviewed for misappropriation of property. (Resident #1) The facility failed to ensure Resident #1 was free from misappropriation of property when Housekeeper A gave Resident #1's purse to an unidentified individual. This failure could place residents at risk for decreased quality of life, misappropriation of property, and dignity. Findings included: Record review of Resident #1's face sheet, printed on 10/31/24, indicated she was a [AGE] year-old female with diagnoses including fracture of fourth lumbar vertebra (break in the vertebrae that extends from the hips to the chest), major depressive disorder, hyperlipidemia (high cholesterol), and COPD (progressive lung disease that makes it difficult to breathe). Resident #1 is her own responsible party. Record review of Resident #1's resident assessment and care screening MDS dated [DATE] indicated Resident #1 had a BIMS score of 15, which indicated cognitively intact. She exhibited some disorganized thinking. Resident #1 required minimal assistance with ADL care. (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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's typed investigation summary dated 10/31/24 revealed Incident: Misappropriation; On the morning of 10/29/24, Senior ED was notified of an allegation of a missing purse belonging to patient Resident #1. Facility immediately launched investigation into allegation. Resident #1 was discharged to the hospital per physician order on the late evening of 10/23/24. Facility investigation notes Housekeeper A was assigned to deep clean Resident #1's room due to her discharge to the hospital. Housekeeping Supervisor noted seeing Housekeeper A holding the purse and the purse was bagged and tagged to identify it belonged to Resident #1 then placed in the Admissions Coordinators office for patient or family to retrieve. On the evening of 10/25/24 Admissions Coordinator stated employee Housekeeper A came to her office and requested the purse because the family was at the facility asking for it. Housekeeper A's statement confirms she retrieved the purse to give to the family of Resident #1. Housekeeper A then stated she gave to a resident accidentally. Facility suspended Housekeeper A pending investigation. Upon notification of missing purse, facility immediately notified the Local Police. Officer spoke to Housekeeper A, who stated the same story. Officer stated case would remain open. Facility leadership searched facility and was unable to locate the purse. SR ED spoke to patients family member who stated she did not have the purse and was unsure last time it was seen, but confirmed no usage on Resident #1's debit card since purse was missing. Facility investigation shows while employee Housekeeper A was the last facility employee in possession of the purse, there has been no indication her story of giving it to the wrong person is not true. However employee Housekeeper A was on a final write up for excessive tardiness and subsequently terminated 10/30.24. Facility investigation concludes allegation of misappropriation inconclusive. In an interview on 12/10/24 at 10:19 a.m. with Resident #1 she said she remembered her purse missing. She said she found the purse. She said the purse was left in the van (ambulance) she said her went to pick it up yesterday. She laughed and said don't quote me on that. Sometimes she cannot tell the difference in reality or dreams. In an interview on 12/10/24 at 10:25 a.m. with Housekeeping Supervisor, he said the purse was sent to the front of the building. When they discharged a resident, they take personal belongings to the front. He told surveyor she could get more information about the purse from the office staff. Housekeeper A was terminated due to attendance and tardiness not for the purse. He did not know if the purse was found later. It was bagged and tagged and taken to front. They searched for it and never found it. In a telephone interview on 12/10/24 at 2:17 pm with Housekeeper A, she said she found the purse in Resident #1's room and bagged the purse up and signed it and took to admissions front desk. About 2 or 3 weeks later the purse was still with the Admissions Coordinator and she saw a random lady she thought it was Resident #1's mother because she looked like Resident #1. Well, come to find out I gave the purse to another resident at the facility. Housekeeper A said she was so anxious to go back and get the clothes that belonged to Resident #1 to give to this lady, but when she came back the lady was gone. She said she gave it to resident name who was a resident. The room was searched and come to find out she had Dementia and the purse was nowhere to be found. She wrote her statement down. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/11/24 at 12:41 p.m. with current Administrator she said that the general policy and expectation, if the resident was a long-term care person, they try not to send personal valuables, unless residents want them, such as glasses, teeth, hearing aids, and purses to the hospital. Things were always lost in the ER. If they were a long-term care patient they did a bed hold and held all their stuff, if they were not returning, the resident and/or family would have to pick up their stuff. If they had valuables, they could lock it up. She did not want to be responsible for their stuff. She said she was not employed at the facility when this incident occurred and did not know any details. In an interview on 12/11/24 at 1:36 p.m. with Receptionist she stated that she was unaware of where Resident #1's purse is. She said that the family would call the facility looking for Resident #1's purse often. In an interview on 12/11/24 at 2:18 p.m. with Senior ED he said typically when someone discharged the building, and it depended on if they would come back, personal valuables were bagged and tagged until family came and picked them up. The valuables were kept in a locked closet. Identity of the person picking up items should be checked. He said it did not appear that there was any identification checked before giving Resident #1's purse to anyone. He stated that it was never recovered. If he correctly remembers correctly, Housekeeper A wrote in statement that she gave it to someone. In an interview on 12/12/24 at 1:53 p.m. with the Admissions Coordinator, she stated that the Housekeeping Supervisor came to her office and handed her the purse and the purse was wrapped up with a name tag and he asked to keep it in her office and she placed it in the closet. It was maybe a day or two later, she cannot remember how long, she thinks it was a Friday when Housekeeper A asked if anyone had seen the blue purse and Admissions Coordinator stated that she had it and the Housekeeper A said the family was there for it. She handed it over to Housekeeper A. She did not normally store the valuables in her office. Her office was at the front behind reception desk so Housekeeping Supervisor felt it was a safe place to keep it. She said she did not know if the purse was ever found. She did not know what Housekeeper A did, she just gave it to the family member asking for it. She did not really know for sure if identity should be checked. That was the first time she held valuables and had not done it since. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/12/ 24 at 6:16 p.m. with Resident #1 family member she said Resident #1 was concerned about not being able to find her purse. So, family member called the facility and according to the director of the facility, he said they remembered seeing the purse after leaving for the hospital and someone had asked for it and they gave it to them. He said a girl from housekeeping gave it to the female person asking for the purse. Family member also stated that Resident #1 told her later that someone contacted her and that they found her purse and it was going to be in the lost and found. The facility also called police and filed police report. Family member called the hospital and called the facility and she talked to the head of housekeeping, and he said that some housekeeper gave it to someone. She called the main transportation company that the facility used, and they did not have it. She called the receptionist at the facility and the receptionist said she would find out if the main transportation company used another service because sometimes, they had contracts . In the purse she knew for sure was Resident #1's driver's license, debit card and credit card. Family member was able to get into Resident #1's email and call the bank to let them know her purse was missing. She got a daily report from the bank via email and there had been no fraudulent charges. This made family member believe that Resident #1 was not dreaming and that someone did actually call, and the purse was sitting somewhere in a lost and found. The only family Resident #1 had was herself and her half-brother. No one went to the facility asking for the purse. Record review of revised abuse policy dated April 2019 revealed The Patient has the right to be free from Abuse, neglect, mistreatment of resident property, and exploitation.Misappropriation of Patient property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a Patient's belongings or money without the Patient's consent.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 2 of 3 residents (Resident #2, #3) reviewed for ADL care. The facility failed to provide timely incontinence care to Resident #2 and Resident #3. The noncompliance was identified as PNC. The noncompliance began on 4/6/24 and ended on 11/11/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for poor hygiene, diminished quality of life, and possible skin infections. The findings included: Record review of Resident #2's face sheet, dated 12/12/2024, reflected a [AGE] year-old female resident initially admitted on , 01/22/2024 with diagnoses including diarrhea, abnormalities of gait and mobility, epileptic seizure related to external causes, dementia (group of neurological conditions that cause a decline in mental abilities that affects daily life), disorder of urinary system, and cognitive communication deficit (communication difficulty caused by a cognitive impairment). Record review of Resident #2's MDS Assessment, dated 12/12/2024, reflected Resident #2 had a BIMS score of 9, suggesting moderate impairment. Resident #2 has been diagnosed with dementia, although the diagnosis was not present on the MDS assessment. Resident #2 MDS assessment indicated that Resident #2 was fully dependent for assistance with toileting hygiene and shower/bathe. Record review of Resident #2's Care Plan, updated, reflected interventions stating the resident had an ADL self-care performance deficit related to diagnosis of disorder of urinary system, abnormalities of gait and mobility, and diarrhea. In a telephone interview with Resident #2's family member on, 12/12/2024 at 12:31pm, he said he witnessed the facility being short staffed, which was why Resident #2's brief would constantly be soiled. The family member said he always had to find staff to change Resident #2 because they did not check on her often, and she was non-verbal and did not understand what the call light was for. Record review of Resident #3's undated face sheet revealed she was admitted to the facility on [DATE] with diagnoses of acute respiratory failure (not enough oxygen in the lungs), hemiplegia (paralysis) affecting right side from a stroke, stroke, dementia (group of neurological conditions that cause a decline in mental ability), weakness, and macular degeneration (disease that damages part of the retina that controls central vision). Record review of Resident #3's Quarterly MDS assessment from 11/28/24 revealed a BIMS of 11 out of 15, which indicated moderately impaired cognition. Resident #7 had impairment on one side of their upper and lower extremities and used a wheelchair. According to the MDS, the resident was dependent with toileting hygiene, showers/baths, lower body dressing, putting on/taking off footwear, and personal hygiene. Resident #7 was always incontinent of bowel and bladder. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's Care Plan dated 12/4/22 revealed Resident required extensive assistance with ADLs and mobility. Goal: Resident would maintain dignity by being clean, dry, and odor free for the next 90 days. Interventions: Assist with ADLs as needed. On 12/11/24 at 11:18am, the previous DON was called but he did not answer, and he never called back. In an interview with LVN V on 12/11/24 at 2:05pm, she said she had been with the facility for about 4 months. She said since the new Administration started, she had not found any resident soiled. She said they had enough staff to complete all their daily tasks. LVN V said they had in-services on customer service, call lights, and incontinence care. In an interview with LVN N on 12/12/24 at 8:57am, she said she had been with the facility for the past 2 years. She said the facility was short staffed previously and she would come to her shift at 6am and find residents completely soiled. She said the staffing is much better now with the new Administration. LVN V said they had in-services on customer service, call lights, and incontinence care. Record review performed on 12/12/24 of in-services provided by the DON on 11/18/24 revealed Customer Service, Call Lights, Incontinence Care, ANE, and Infection Control. In an interview with Resident #3 on 12/12/24 at 12:49pm, she said earlier in the year she had to wait several hours to be changed. She said she never had any skin breakdown from it. She said she would always have to wait to be changed, they would not answer call lights or the telephone. She said it was starting to get better with the new Administration. In an interview with LVN N on 12/12/24 at 8:57am, she said the facility was short staffed earlier in the year, and she would come on to her shift at 6am and find residents who were soiled and not changed. She said the staffing was much better now and she could go home on time now at 6pm. She said the new Administration had helped so much already. In an interview with the DON on 12/12/24 at 11:15am, she said she started at the facility on 11/11/24. She said she was not sure what was going on prior to her being there or what the staffing was like. She said her expectations were that staff were to put their eyes on the residents at least every 2hrs. She expected everyone to answer call lights, even housekeeping because everyone could help the resident. The DON said if a CNA was busy and could not assist the resident, then she expected someone else to help because the resident's come first. She said she in-serviced all the staff on call lights, customer service, and incontinence care on 11/18/24. The DON said to ensure the residents were taken care of she had open communication with the residents/families, she would make herself available, make rounds, call families, and be present. She said she would come to the facility on off hours as well to check on staff and residents. In a telephone interview with EMS K on, 12/12/2024 at 12:12pm he said he had responded to multiple calls for the Nursing Facility. EMS K stated he had witnessed on several occasions residents that were soiled because they were unable to get in contact with staff, so they would call 911 for help. EMS K stated when he arrived on the scene he would have to search for staff. He said he would ask the staff why residents were not being changed in a timely manner, and staff would answer that they were short staffed, or they had just changed shifts. EMS K stated the majority of the calls he responded to from the facility, were from 11pm to 1am. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a telephone interview with Chief H on 12/14/2024 at 9:46am he said he had been to the facility several times. Chief H stated he saw residents who had soiled through their adult diaper, and he had to track down staff to assist the residents. Record review of the facility's policy and procedure on Activities of Daily Living (ADL), Supporting (Revised March, 2018) read in part: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: Hygiene (bathing, dressing, grooming, and oral care) .elimination (toileting) .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility's assessment tool for 5 of 6 days (2/14/24, 2/15/24, 4/6/24, 4/7/24, and 4/9/24) reviewed for sufficient staff. The facility failed to have adequate staff to provide appropriate care to residents, resulting in multiple complaints of residents sitting in soiled briefs for 4-5 hours on 2/14/24, 2/15/24, 4/6/24, 4/7/24, and 4/9/24. The noncompliance was identified as PNC. The noncompliance began on 2/14/24 and ended on 11/18/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of skin breakdown, pain, and infection. Findings included: Record review of Resident #3's undated face sheet revealed she was admitted to the facility on [DATE] with diagnoses of acute respiratory failure (not enough oxygen in the lungs), hemiplegia (paralysis) affecting right side from a stroke, stroke, dementia (group of neurological conditions that cause a decline in mental ability), weakness, and macular degeneration (disease that damages part of the retina that controls central vision). Record review of Resident #3's Quarterly MDS assessment from 11/28/24 revealed a BIMS of 11 out of 15, which indicated moderately impaired cognition. Resident #7 had impairment on one side of their upper and lower extremities and used a wheelchair. According to the MDS, the resident was dependent with toileting hygiene, showers/baths, lower body dressing, putting on/taking off footwear, and personal hygiene. Resident #7 was always incontinent of bowel and bladder. Record review of Resident #3's Care Plan dated 12/4/22 revealed a Focus: Resident required extensive assistance with ADLs and mobility. Goal: Resident would maintain dignity by being clean, dry, and odor free for the next 90 days. Interventions: Assist with ADLs as needed. Focus: Resident requires extensive assistance with toileting. Goal: Resident would have toileting needs met with the assistance of 1-2 people. Interventions: Provide hygiene after urinating/having a BM. Focus: Resident was always incontinent of bowel. Goal: Resident would have incontinence managed over the next 90 days. Interventions: Patients who are incontinent of bladder and/or bowel will have incontinent care provided every 2 hours as needed. Focus Resident was always incontinent of urine. Goal: Resident would have intact skin for the next 90 days. Interventions: Check for incontinence and change if wet or soiled. Record review of the facility's most recent assessment tool, performed on 12/31/22 revealed staffing ratios were 4 nurses during the day and 4 nurses at night. The staffing ratios for CNAs were 7 during the day and 5 at night. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the electronic clock-ins conducted on 12/12/24, for 2/14/24, 2/15/24, 4/6/24, 4/7/24, and 4/9/24 revealed the following information: - 2/14/24 day shift had 4 CNAs. Night shift had 4 CNAs and 3 nurses. The census for 2/14/24 was 103. - 2/15/24 day shift had 5 CNAs. - 4/6/24 day shift had 5 CNAs and 3 nurses. - 4/7/24 day shift had 6 CNAs and 3 nurses. - 4/9/24 day shift had 5 CNAs. Record review of the staff schedules for 12/10/24 and 12/11/24 revealed the following: - 12/10/24 day shift had 8 CNAs and 4 nurses. Night shift had 7 CNAs and 5 nurses. The census was 92. - 12/11/24 day shift had 8 CNAs and 5 nurses. Night shift had 7 CNAs and 5 nurses. The census was 92. Record review performed on 12/12/24 of in-services provided by the DON on 11/18/24 revealed Customer Service, Call Lights, Incontinence Care, ANE, and Infection Control. In an interview with the Senior ED on 12/11/24 at 2:43pm, he said the facility assessment was the one that was used for staffing from December 12/31/22 until the most recent one completed with the new administration. He said there could be potential negative outcomes if they had less than the number of staff they should have. He said he was not aware of any staff shortages. (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN V on 12/11/24 at 2:05pm, she said she had been with the facility for about 4 months. She said since the new Administration started, she had not found any resident soiled. She said they had enough staff to complete all their daily tasks. LVN V said they had in-services on customer service, call lights, and incontinence care. In an interview with LVN N on 12/12/24 at 8:57am, she said she had been with the facility for the past 2 years. She said the facility was short staffed previously and she would come to her shift at 6am and find residents completely soiled. She said the staffing is much better now with the new Administration. LVN V said they had in-services on customer service, call lights, and incontinence care. In an interview with the DON on 12/12/24 at 11:35am, she said she started on 11/11/24 and immediately started implementing new policies and education. She said on 11/18/24 she gave in-services to the whole facility on infection control, customer service, incontinence care, and several others. She said she would schedule 4-5 nurses per shift and 6-7 CNAs per shift, depending on the census and the acuity of the residents. The DON said she expected her staff to call her if someone called in or they felt they were short staffed so she could fix the situation, because if she did not know she could not fix the problem. She said she would work the floor if they were short staffed. The DON said to ensure the residents were taken care of she had open communication with the residents/families, she would make herself available, make rounds, call families, and be present. She said she would come to the facility on off hours as well to check on staff and residents. In an interview with EMS K on 12/12/24 at 12:12pm, he said he did not specifically remember the time from 3/26/24 when the resident called due to not being changed because there were numerous times he would come out and find residents soiled in their briefs. He said there were numerous complaints from residents when he would respond, about the staff and not being changed. EMS K said he asked staff why residents were not changed timely, and they would tell him they were short staffed. He said he had been reassigned and did not go to the facility anymore, so he did not know if it had gotten better or not. In an interview with Resident #3 on 12/12/24 at 12:49pm, she revealed she used to have to wait several hours to be changed. The resident stated it has gotten better since the new administration started. She said she never received any skin breakdown or sores from not being changed. In an interview with Chief H on 12/13/24 at 9:46am, he said he had been to the facility many times. He said it was common for residents to call 911 when they needed assistance because they could not get a staff member to help them. He said it was always hard to find staff at the facility and they were short staffed. Record review of the facility's policy and procedure on Staffing (revised April 2007) read in part: Our facility provides adequate staffing to meet needed care and services for our resident population. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, 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 one of three residents (Resident #4) reviewed for Infection Control. 1.The facility failed to ensure CNA D changed her gloves and performed hand hygiene while providing incontinent care to Resident #4 on 12/12/2024. This failure could place residents at risk of cross-contamination and development of infections. Findings include: Record review of Resident #4's Face Sheet dated 12/12/2024 revealed a [AGE] year-old female who admitted on [DATE]. Her diagnosis included hemiplegia following cerebral infarction (one-sided paralysis or weakness following a stroke), type 2 diabetes (body does not produce insulin or resists it), and major depressive disorder. Record review of Resident #4's quarterly MDS assessment, dated 11/12/2024, revealed a BIMS score of 9 out of 15 which indicated moderate cognitive impairment. She was always incontinent of both bowel and bladder and required substantial/maximal assistance from staff with toileting hygiene. In an observation and interview on 12/12/24 at 1:17 p.m. with CNA D as she performed incontinence care on Resident #4. CNA D was observed not doing any hand hygiene prior to care. She gathered one pair of gloves and entered the Resident #4's room. She used one pair of gloves during the entire incontinence care for Resident #4. She applied barrier cream, moved pillows on the bed, adjusted the sheets and the resident using the same pair of dirty gloves. She used water to wet the wipes and said it helped get the barrier cream off the resident better. She left the resident and sheets wet. In an interview on 12/12/24 at 1:32 p.m. CNA D said she normally changed her residents every 2 hours or more frequently if needed or if they ask. She acknowledged that she did not change her gloves throughout incontinent care. She said the Surveyor made her nervous and that was not her normal practice. She said she would change her gloves after touching any bowel or if the gloves got dirty. She said she received training on the floor and on the computer about one week ago. She said she did train with two other CNAs, and someone watched her do an incontinent care on a resident about two weeks ago. In an interview on 12/12/24 at 2:02 p.m. the DON said when providing incontinent care, hand hygiene should be done first, gather all the supplies, glove up, and provide privacy for the resident. The next step is to provide the incontinent care, wash hands again, change gloves, and put on a clean brief. She said to apply barrier cream if needed. She said staff should see if the resident is soiled and move through the task from clean to dirty. She said CNA D was a newer CNA and did receive training. She said infection control was important because it may put the resident at risk for infection such as an UTI. She said all staff were responsible for infection control. (continued on next page)

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	676357	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Incontinent Care Skills Checklist dated 12/12/24 read in part, .4. wash hands; apply gloves .6. Assist patient to supine position and remove soiled clothing and/or brief, if needed clean soiled areas first by wiping off fecal material with dry wipes .7. remove gloves, sanitize hands and apply new gloves .Female perineal care . 2. Clean outwards from front to side . 5. Wash labia major and skin folds . 9. Wash, wiping from vagina toward rectum with one stoke, front to back, repeat, if necessary, with a new wipe as all feces must be cleaned off . 11. Wash/sanitize hands. Apply clean gloves. 12. Position new brief under patient. Apply barrier cream to perineal and buttock area, position and fasten clean brief under patient and adjust clothing . Record review of the facility policy, Infection Control dated November 2017 read in part, .1. The facility must establish an infection prevention and control program (IPCP) that must include: a. a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all patients, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment .