

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/31/2026
NAME OF PROVIDER OR SUPPLIER Midlothian Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 George Hopper Rd Midlothian, TX 76065	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections for 2 of 5 residents (Resident #1 and Resident #2) reviewed for infection control. The LVN did not properly use EBP personal protective equipment during wound care for Resident #1. CNA A did not sanitize his hands between glove changes during peri-care for Resident #2. These failures could place the residents at risk of infection transmission, sepsis (a life-threatening medical emergency that occurs when the body's response to an infection causes damage to its own organs and tissues), and hospitalization. The findings included: Record review of Resident #1's face sheet, dated 1/31/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included hemiplegia (paralysis affecting one side of the body, caused by brain damage from conditions like stroke and traumatic brain injury), hypotension (abnormally low blood pressure, where blood pressure), and dementia (a progressive decline in mental ability, including memory, language, and problem-solving). Record review of Resident #1's quarterly MDS assessment, dated 12/30/2025, revealed Resident #1's BIMS score of 2 indicating severe cognitive impairment. Further review of Resident #1's assessment revealed she was treated for pressure ulcers with application of dressings to feet. Record review of Resident #1's Care Plan, revised on 01/18/2026, reflected Resident #1 had stage 4 pressure ulcer (the most severe type, involving full-thickness tissue loss where skin, fat, and deeper tissues are gone, exposing muscle, tendon, or bone) of the left heel with interventions included weekly visits and treatment with wound care physician. Record review of Resident #1's order, dated 12/24/2025, revealed Resident #1 was on enhance barrier precautions (PPE required for high resident contact care activities) for suprapubic catheter and heel wound. Resident #1's wound care order, started on 1/08/2026, revealed Clean stage 4 wound to left heel with normal saline with pat dry, apply collagen powder, abdominal (ABD) pad and wrap with gauze roll secured with tape daily and as needed if becomes soiled or displaced. Observation on 1/31/2026 at 3:04 p.m., revealed the LVN performed the wound care for Resident #1. She did not don the PPE (gown) before she started the wound care procedure for Resident #1. An interview on 1/31/2026 at 3:11 p.m. with the LVN revealed that she was trained on following EBP protocol for all invasive procedures including wound care about a month ago. She stated that nurses were responsible for following the EBP policy. She stated that she forgot to wear a gown during Resident #1's wound care. She stated that she was aware of potential risk if not following the EBP protocol could be cross contamination and passing the infection to other residents which is detrimental for vulnerable populations in long term care facility. Record review of Resident #2's face sheet, dated 1/31/2026, revealed a 78-years-old female admitted on [DATE] and readmitted on [DATE]. Resident's #2's diagnoses included type 2 diabetes Mellitus (a chronic metabolic disorder characterized by high blood sugar resulting from insulin resistance), repeated falls and neuropathic bladder (a condition where nerve damage</p> <p>(continued on next page)</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>disrupts normal bladder control, leading to issues like incontinence). Record review of Resident #2's quarterly MDS assessment, dated 1/19/2026, revealed BIMS score of 15 indicating intact cognition. Further review of Resident #2's assessment revealed she had frequent incontinence (7 or more episodes of urinary incontinence). Record review of Resident #2's Care Plan, revised on 01/09/2026, reflected Resident #2 had recurrent urinary tract infections - Resident currently takes antibiotics for preventative. Resident #2 has ADL self-care performance deficit related to need for assistance with personal care and interventions indicated to check for incontinence. Wash, rinse and dry soiled areas. An observation on 01/31/2026 at 2:25 p.m. of peri-care for Resident #2 revealed CNA A did not conduct hand hygiene between gloves changes during and after cleaning Resident #2's front perineum area and before moving to the back (anal) area. The CNA A touched Resident #2's bedding and her clothes while assisting Resident #2 with repositioning after taking his gloves off without sanitizing hands. CNA B assisted CNA A with handing wipes to him during the peri-care for Resident #2. An interview with CNA A on 1/31/2026 at 02:32 p.m., revealed he received a hand hygiene and peri care in-service a month ago. He stated that he was not aware of the need to sanitize his hands between changing gloves during peri care. He stated that washing before and after completing peri-care was all he needed to do for hand hygiene during peri-care for residents. CNA A stated that potential risk to residents if not following proper hand hygiene could be a cross contamination. An interview with CNA B on 1/31/2026 at 02:36 p.m., revealed she received hand hygiene and peri care in-service a few months ago. She stated that she was trained on sanitizing hands between gloves changes during peri care procedure. She stated nursing staff was responsible for following proper infection control and hand hygiene to prevent spread of infection to residents and staff at the facility. An interview on 1/31/2026 at 4:19 p.m. with the ADON, revealed she was an Infection Preventionist at the facility. She stated that she received training on the EBP policy a month ago which required all nursing staff to wear PPE including gowns and gloves while performing high-contact resident care (e.g., wound care) to prevent cross contamination. The ADON stated that all nursing staff was responsible for following proper hands hygiene policies including sanitizing hands between gloves changes during residents' peri- care procedure. The ADON stated the training on infection control and hand hygiene for all staff was conducted last month and during annual skills training sessions, weekly audits, and in huddles. The ADON stated a potential negative outcome for residents if not followed proper infection control procedures could be cross contamination. An interview on 1/31/2026 at 4:36 p.m. with the DON revealed she was trained on the facility's policy on EBP which required all nursing staff to wear PPE including gowns and gloves to prevent transmission of infections to other vulnerable residents. She stated that proper hand hygiene protocol during peri care procedure included sanitizing hands between changing gloves. The DON stated the last training on infection control and hand hygiene was conducted last month and during annual skills training sessions. She stated that ADONs and DON were responsible for monitoring nursing staff in following proper infection control policies. The DON stated a potential negative outcome for the residents could be cross contamination. An interview on 1/31/2026 at 4:40 p.m. with the ADM revealed all nursing staff were trained on the infection control policy, hands hygiene and following enhanced barriers precautions on an annual basis and periodic clinics with returned demonstrations. The ADM stated that hand hygiene during residents' peri care included sanitizing hands between changing gloves. She stated the DON and clinical managers provided training to nursing staff on following facility's infection control policy and were responsible for monitoring nursing staff during random observations. She stated that it was very important to follow infection control policies to prevent cross contamination. Record review of Peri care and Hand Washing Policy/Procedure,</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>dated 07/2013, indicated that It is the policy of this facility to cleanse hands to prevent transmission of possible infectious material and to provide clean, healthy environment for residents and staff. This policy did not indicate donning/doffing of gloves before, during, and after the peri-care procedure including sanitizing hands between changing gloves which was clarified during interviews. Record review of facility's Infection Control policy, revised 3/2024, indicated that Enhanced Barrier Protection: used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (e.g., residents with wounds and indwelling medical devices are especially high risk of both acquisition of and colonization with MDROs).</p>		