STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676435	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Houston Transitional Care	8550 Jason Street Houston, TX 77074

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 1 of 7 residents (Resident #1) reviewed for infection control. 1. The facility failed to ensure CNA A changed gloves and completed hand hygiene when providing care to Resident #1.2. CNA B failed to don appropriate PPE (disposable gown) prior to providing direct care to Resident #1, who was on EBP. These failures could place residents at risk for cross contamination, infections, and unwanted hospitalization.Record review of Resident #1's face sheet, dated 05/28/26, reflected an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included osteomyelitis (infection of the bone) right ankle and foot, muscle weakness, and non-pressure chronic ulcer part of right foot. Record review of Resident #1's quarterly MDS, dated [DATE], reflected a BIMS score of 15, which indicated the resident's cognition was intact. Section GG-Functional Abilities reflected the resident was dependent for personal hygiene. Section H-Bowel and Bladder reflected Resident #1 was frequently incontinent with urine and bowel. Record review of Resident #1's Comprehensive Care Plan, dated 05/05/26, reflected the resident was care planned for Enhanced Barrier Precautions: Resident requires enhanced barrier precautions during high-contact care activities due to the presence of indwelling device Permacath (a specialized tunneled catheter used for long-term, high-flow blood treatments) for dialysis. An intervention included utilizing PPE (gown and gloves; face shield as indicated) during high-contact resident care activities (e.g, dressing, bathing/showers, transferring, hygiene, linen changes, brief changes, toilet assistance, device care, and wound care). Record review of Resident #1's Physician Order Summary Report for the month of May 2026 reflected the following orders:-Dated 04/25/26, Resident to receive dialysis 3 times a week Monday, Wednesday, and Friday.-Dated 04/27/26, Enhanced Barrier Precautions during high contact resident care activities secondary to dialysis and wound every shift.Observation on 05/28/26 at 9:46 AM revealed Resident #1 had EBP signage at the door entrance with a plastic bind at the door entrance with PPE (gloves and disposable gowns) inside of it. Observation was made of CNA A coming out of another resident's room across the hall with gloves on going to Resident #1's room to assist CNA B with providing incontinent care for Resident #1. CNA B had washed her hands and placed on gloves prior to CNA A entering Resident #1's room. Both CNA A and CNA B did not place on a disposable gown. Resident #1's brief was not soiled but the staff provided perineal care by cleaning the resident with disposable wipes. During care, CNA A left the room with gloves on and returned to the resident room with gloves on bringing back some pillowcases. When both CNAs completed care for Resident #1, CNA A left the room without removing her gloves or washing her hands, taking the soiled material out of the room. CNA B removed her gloves and washed her hands.Interview on 05/28/26 at 10:05 AM, CNA B said she worked at the facility PRN since February of 2026 on various shifts but normally worked the morning shift. CNA B said initially she did not see a reason to place on a gown. CNA B said she forgot to place on a disposable gown. She said her last in-service on infection control was about 3 months ago. She said (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by not placing on the correct PPE when providing direct care for residents with wounds, Foley catheters, or intravenous lines, placed the resident at risk for cross contamination and infections. Interview on 05/28/26 at 10:05 AM, CNA A said she had been working at the facility for almost 5 months full time from 7AM-7PM. CNA A said she received in-service on infection control but could not recall if they mentioned enhanced barrier precautions. CNA A said she should not have been going from room to room with gloves on because it placed the resident at risk for infections. Interview on 05/28/26 at 10:26 AM, the DON said she was the Infection Control Preventionist. The DON said residents who were placed on Enhanced Barrier Precautions consisted of residents who had intravenous ports/lines, Foley catheters, or any artificial openings on their body. The DON said the staff should be wearing gloves and disposable gowns when proving direct care for residents on EBP. The DON said staff needed to be practicing hand hygiene prior to and after providing care of a resident and not going from room to room with gloves on. The DON said if the staff did not take these precautions, it would place the residents at risk of infections. Record review of the facility's policy on Handwashing/Hand Hygiene, revised October 2023, reflected in part: .This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.Hand hygiene is indicated: immediately before touching a resident.after touching a resident; after the resident's environment.immediately after glove removal. Record review of the facility's Infection Control policy, revised October 2018, reflected in part: .This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and help prevent and manage transmission of diseases and infections. Record review of the facility's Enhanced Barrier Precaution policy, revised December 2024, reflected in part: .Enhanced barrier precautions are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents.EBPs employ targeted gown and gloves use in addition to standard precautions during high contact resident care activities.