| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676435 | A. Building<br>B. Wing | 06/24/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Houston Transitional Care | 8550 Jason Street<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 2 of 2 residents (Resident#1 and Resident#2) and 1 of 1 staff (Wound Care Nurse) reviewed for infection control. - The facility failed to ensure the Wound Care Nurse washed or sanitized her hands and performed glove changes appropriately while providing wound care to Resident #1 and Resident #2 on 06/24/26. This failure placed residents with wounds or infection at risk for cross contamination and the spread of infection.Record review Resident # 1's face sheet dated 6/24/2025 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included peripheral vascular disease (narrowing of the blood vessels), anemia (having few healthy blood cells), hypertension (high blood pressure), aneurysm of artery of lower extremities (abnormal bulge in the wall of the blood vessels in the leg) and multiple sclerosis (an autoimmune disease that affects the central nervous system). Record review of Resident #1's baseline care plan dated 6/17/2026 revealed she was admitted to the facility with a surgical incision to left groin. Record review of Resident #1's care plan initiated 6/17/2024 revealed the followingFocus: Surgical incision to R- groin and is at risk for dehiscence, delayed healing, infection and pain.Goal: Pain will be alleviated with appropriate interventions. Surgical incision will heal without complications. Will show signs of healing.Interventions: Administer medications as ordered. Administer treatments as ordered. Assess for signs and symptoms of infection, notify physician if observed. Follow up with surgeon as indicated. Labs as ordered, report abnormal findings to physicians. Surgical wound care as ordered. Utilize Enhanced Barrier Precautions (EBP) during high-contact resident care. Record review of physician's order dated 6/17/2026 for treatment to right groin/post-surgical: Clean with normal saline, pat dry, cover with dry gauze, ABD pad and cover with bordered gauze dressing or secure with tape QD and prn until resolved. Observation on 6/24/2026 at 11:05am of wound care for Resident #1 revealed the Wound Care Nurse removing the solid dressing from Resident #1 wound to the right groin and disposed of it in a red bag. She changed her gloves and washed her hands and put on clean gloves. She then cleaned Resident#1's wound to the groin area and disposed of the gauze in the red bag. Without changing her gloves or washing her hands she applied the clean dressing to the wound and covered the wound and dated it. She then changed the gloves and washed her hands. Record review Resident # 2's face sheet dated 6/24/2025 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included sepsis (the body's extreme life-threatening response to an infection), hypertension (high blood pressure), benign prostate hyperplasia without lower urinary tract infection (the prostate has grown large but not compressing the urethra enough to cause urinary issues like urgency to urinate. Record review Resident #2's MDS dated [DATE] revealed the resident was coded has having a BIMS score of 14 indicating the resident was cognitively aware for decision making. For bowel and bladder, he was coded as incontinent. For skin condition he was coded as having one unhealed pressure sore. Record review of physician's order dated 6/18/2026 for treatment to right heel, clean with normal saline, pat dry, apply xeroform and cover with dry bordered gauze dressing QD and prn until resolved every day<br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | shift, and as needed. Observation on 6/24/2026 at 11:30 am revealed Wound Care Nurse providing treatment for Resident #2. The Wound Care Nurse washed her hands and put gloves on and removed the soiled dressing form Resident#2's right heel and disposed of it in the red bag. She then washed her hands and put clean gloves on and cleaned the resident's right heel. Without changing gloves or washing her hands, she then dry, the heel and applied dressing and covered and dated the bandage. She then pulled the cover over Resident #2 and took an alcohol swab and wiped the marker and then changed her gloves. In an interview on 6/24/2026 at 11:44 am with the Wound Care Nurse in reference to changing her gloves during the treatment she said she should have changed the gloves between cleaning the wound and applying the dressing. She said she was just nervous that was why she did not change her gloves and wash her hands. She said not changing her gloves and washing hands could result in infection or the spread infection. She said moving forward she would ensure she washed her hands and change gloves during wound care between dirty and clean processes. In an interview on 6/24/2026 at 5:30 pm with the Regional Nurse revealed his expectations of the nurses when they were doing wound care was to change gloves and wash hands between dry and clean procedures. He said he will be in-serving the staff about washing hands and changing gloves during wound care. They will also be in-serviced on infection control, and he was going to ensure they follow the infection policies and procedures. Record review of the facility Wound Care Level III documentation dated 2001 read in part. Purpose The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. 2. Provide for privacy.3. Perform hand hygiene.4. Establish a clean field on resident's overbed table.5. Place all items to be used during procedure on the clean field.6. Position the residents so they are comfortable.7. Place disposable cloth next to the resident to protect the bed linen and other body sites.8. Put on exam gloves.9. Loosen tape and remove the old dressing.10. Pull one glove over the dressing and discard into appropriate receptacle. Remove the second glove.11. Perform hand hygiene.12. Put on clean gloves. Use additional PPE as indicated by transmission-based precautions.3. Remove gloves and perform hand hygiene. Clean the Wound1. Apply clean gloves.2. Place a piece of gauze over the wound, leaving the margins of intact skin exposed.3. Clean the area around the wound usually covered by the dressing, tape, or gauze with antiseptic or soap and water.4. Remove dry gauze from the wound.5. Clean and apply treatments as ordered.6. Apply appropriate dressing. [NAME] tape with initials, date, and time and apply to dressing.7. Remove the disposable cloth next to the resident and discard into the designated container.8. Discard disposable items into the designated container.9. Place all soiled laundry, linen, towels, and washcloths into the soiled laundry container.10. Remove disposable gloves and discard into designated container.11. Perform hand hygiene.12. Reposition the bed covers.13. Make the resident comfortable. Use supportive devices as instructed.14. Place the call light within easy reach of the resident.15. Use clean field saturated with alcohol to wipe overbed table.16. Return the overbed table to its proper position.17. Wipe reusable supplies with alcohol as indicated (i.e., outsides of containers that were touched by uncleanhands, scissor blades, etc.). Return reusable supplies to residents' drawer in treatment cart.18. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them they may now enter the room. |