STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Houston	6534 Stuebner Airline Road Houston, TX 77091

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 observations, interviews, and record review, the facility failed to ensure the residents environment remained free of accident hazards as is possible to ensure residents receiving adequate supervision to prevent accidents for 1 of 6 residents (Resident #46) reviewed for accidents and supervision.The facility failed to provide appropriate and sufficient supervision to prevent avoidable accidents when Resident #46, despite her recent history of falls and documented fall risk, was left unattended and had an unwitnessed fall. The fall resulted in fracture to Resident #46's cervical spine requiring hospitalization and surgery from 05/07/26 to 05/18/26.The facility further failed to mitigate the risk for falls and accidents when they failed to revise her care plan with post-surgical instructions upon her re-admission to the facility.An Immediate Jeopardy (IJ) situation was identified on 05/28/2026. While the IJ was removed on 05/29/2026, the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems.This deficient practice could place residents at risk of harm due to not providing needed interventions to prevent falls that lead to sustaining injuries.Findings Included:Record review of Resident #46 face sheet indicated she is [AGE] year-old female. She was admitted into the facility on [DATE] and readmitted on [DATE]. Her diagnosis are cerebral infraction (A thrombotic stroke occurs when a blood clot forms in an artery in the brain disrupting blood flow and leading to brain cell death); muscle wasting and atrophy (partial or complete wasting away of a part of the body); muscle weakness; and cognitive communication deficit (communication is impaired due to underlying cognitive difficulties rather than a primary language or speech problem).Record review of Resident #46 MDS dated [DATE] has section cognitive patterns blank and did not report a BIMS summary score. Resident #46 was rated as having poor decisions and supervision required under cognitive skills for daily decision making. Resident #46 was scored a 0 under section of rejection of care. Resident #46 was reviewed for functional abilities chair- to- chair transfer indicated she needed supervision or touching assist. Under walk 10 feet resident score stated the facility did not attempt due to illness, exacerbation, or injury.Record review of Resident #46's care plan revealed: Focus - Resident #46 is a high-risk or falls as evidenced by history of falls dated: actual fall with no injury on dates 2/1/26, 2/15/26,2/23/26, 3/10/26, 5/07/26. The care plan revealed Resident #46 had a history of 5 falls with no injury. Care planned interventions for Resident #46's prior to her fall on 05/07/26 besides the wheelchair positioning listed the following; Remind Resident #46 to lock her wheelchair before rising from chair 02/01/26; Standard of Care in place unless otherwise noted: Bed in low and locked, position, call light within reach, personal items and fluids close at hand, clear clean pathways and uncluttered surroundings, nightlights on/adequate lighting 02/15/26, secure wheelchair cushion to wheelchair 02/23/26; Evaluate for injury and neurological changes, Safety education provided regarding keeping on shoes during all transfers, Environmental check for additional hazards 03/10/26; Ensure and encourage resident to maintain proper footwear prior to transfers and mobilizing in wheelchair. Encourage resident to call for assistance when needed 03/17/26, EDUCATED AND ENCURAGED TO CALL FOR STAFF ASSISTANCE TO GO TO RESTROOM. 11/13/24, EDUCATED (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Houston	6534 Stuebner Airline Road Houston, TX 77091

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RESIDENT NOT TO PUT BELONGINGS IN WC 11/24/24. An intervention initiated on 06/16/24 revealed, Do not leave resident in wheelchair next to the bed. The care plan did not include any updated interventions since the resident's fall on 5/7/2026. Resident #46's care plan was not revised upon her return from the hospital on [DATE] and lacked individualized fall prevention interventions, supervision requirements, post- operative cervical spine precautions, positioning requirements, transfer assistance, and monitoring needs.Record review of Incident and Accidents date range from 12/28/25- 5/28/26 states Resident #46 had a witnessed fall on 03/10/26 and unwitnessed fall on 5/7/26.Record review of the facility investigation report on 5/26/26 indicated the witness statement did not include the assigned charge nurse or CNA.Record review of LVN C statement for incident on 05/07/26 states she observed resident on the floor in the room in front of her wheelchair. Patient was assessed for injuries and vitals obtained. Patient was assisted back into her wheelchair. Orders were sent to transfer out to the emergency room. Change of condition and risk management completed.Record review of progress notes recorded on 5/07/26 at 12:00pm by attending RN states Patient is wheelchair dependent. Continue fall precautions due to mobility limitations and hemiparesis (partial weakness or reduced strength on one side of the body).Incident note on progress note dated 05/07/2026 at 1:46pm The nurse was notified by the CNA that pt was on the floor in her room in front of her wheelchair. When asked by the nurse what happened, the patient is unable to give details of the incident.Record review on 05/26/2026 of witness statement from CNA C dated on 05/07/2026 Resident #46 agreed when asked if she attempted transfer without assistance resulting in a fall.Record review of Resident #46 discharge plan from the hospital dated 05/07/2026- 05/18/2026 at 11:19am states the resident chief complaint as patient presents with fall from wheelchair on date 5/2-5/6/2026 and continues after discharge to SNF, patient had an unwitnessed fall from wheelchair. On 05/09/2026 spine surgery for cervical spinal fracture on C6- C7 facet. History of present illness reported Discharge recommendations include supervision recommendations one to one. Occupation Therapist evaluation completed on 05/12/2026 reported on assessment results Activities of Daily Living status impaired, impaired endurance, and impaired functional mobility.An observation on 5/26/26 at 10:25am, Resident #46 was lying the bed with rails up. Resident #46 was observed wearing a hard cervical collar. An attempt to conduct an interview with Resident #46 was made, she was unable to answer questions and made gurgling sounds.Phone interview on 5/26/26 at 1:25pm, Family Member A stated he learned about Resident #46's incident through a staff member. He stated he went to the facility and arrived before the ambulance. Family Member A stated the staff informed him Resident #46 was taken out of her bed and put in her wheelchair, then the nurse assigned to her had left her unattended which resulted in a fall. He stated a second nurse saw Resident #46 on the floor, and the facility called the ambulance, and she was taken to the hospital. He stated once she got to the hospital, he found out Resident #46 had sustained a fracture to her neck and needed to have two major surgeries. He stated, I feel the nursing home is not giving her the best care.Interview on 5/26/26 at 3:37pm, LVN A stated he was the charge nurse who completed Resident #46 re-admission. LVN A stated the facility did training on falls through routine in-service. LVN A stated the policy on falls and his duty was to ensure the residents were assessed. LVN A reported Resident #46 is high risk for falls and on the Falling Star Program. LVN A reported Resident #46 was on regular supervision but need full assistance to complete her ADL's. LVN A stated he completed Resident #46 re-admission orders from the hospital. LVN A stated high fall risk residents shouldn't be left alone, he personally checks on them every 15 minutes. He did not indicate Resident #46 was on increased supervision. He stated he was verbally telling the aids, there was no formal documentation. He stated Resident #46 was already on the Falling Star Program for high-risk falls.Interview on 5/26/26 at 4:43pm, CNA A she has worked with Resident #46 this past week and in the past. CNA A stated Resident #46 required full assistance including feeding and changing her. CNA A stated the facility policy on falls was if anyone witnessed a fall they would complete a visual check first and look for blood, severe visible wounds, and retrieve the nurse to do an assessment. CNA A Resident #46 cannot (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Houston	6534 Stuebner Airline Road Houston, TX 77091

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hold a conversation and needs full assistance. Prior to her fall, CNA A stated before she fell she was able to pick herself up and needed regular supervision. CNA A stated she did not know when she reviewed Resident #46's care plan. CNA A stated she did not know about the Falling Star program, but resident identified as high risk wore a red arm band with the words Risk Fall. CNA A stated all the residents who were high for falls had fall mats and their beds were lowered. CNA A stated before she fell she was able to pick herself up and needed regular supervision.An interview was conducted on 5/26/26 at 5:12pm, CNA B stated she had worked with the facility for one year. CNA B stated Resident #46 was total care and the staff helped her do everything. CNA B stated her charge nurse LVN A had informed her prior to the shift starting that Resident #46 was total care. Staff stated it was related to a fall Resident #46 had that led to the increased care when she returned to the facility. CNA B stated her charge nurse would let her know who was on the Falling Star Program. Staff stated the program was for residents who were high risk for falls. CNA B stated the charge nurse informed the aides verbally it was not written anywhere. CNA B stated the facility was always providing ongoing training on falls. CNA B stated she doesn't know about a care plan or how to review their interventions on one. CNA B responded she has been assigned to Resident #46 yesterday and today, and a few times last week. CNA B stated she was total care since she returned from the hospital the first time. She knows because she was told by the charge nurse. CNA B learned of the fall or Resident #46 from her change nurse (LVN A) by verbally informing her prior to her shift. CNA B stated the nurse verbally will let her know who is on the falling star program by name.On 5/26/26 an interview with LVN B was held at 5:41pm. LVN B stated she is wearing a cervical collar from a recent fall. This Surveyor asked LVN B who is responsible for submitting orders when a resident returns from the hospital. LVN B reported the admitting nurse is the one who writes in the orders. LVN B added the resident with for high fall risk should be care planned and they have a sign on the door. LVN B stated she had not worked with Resident #46 since last month and was told Resident #46 was wearing a neck brace from a fall. LVN B stated if there no order writing and or a change of status since her return.On 5/27/26 at 10:17am an interview CNA C reported she worked the day of the incident and completed witness statement on the incident report, but was not assigned to Resident #46 on fall dated 05/07/2026. CNA C stated she assisted the assigned staff (CNA D) who had called out to her. CNA C stated she saw Resident #46 was on the floor with her back on the floor. On the day of the incident CNA C stated Resident #46 was unstable and was witnessed sliding down her wheelchair. CNA C stated that she transferred Resident #46 back into her bed to prevent a fall. CNA C stated, resident did not have mobility on her rights side. Staff stated Resident #46 is on the list as high risk for falls. CNA C stated Resident #46 is nonverbal. CNA C Resident #46 had regular supervision with assisted transfers. CNA C reported she read the care plans on the resident to identify any new changes before her shift. Resident #46 is a two person assist and was told verbally by her charge nurse. CNA C stated Resident #46 normally had her wheelchair close to her bedside which is where a majority of her falls would occur.An interview on 5/27/2026 at 10:47am LVN C stated she worked with Resident #46. LVN C mentioned that Resident #46 had a stroke and then had fallen right after she had to return from the hospital. LVN C stated she noticed the resident wearing a c-collar that she kept on at all times. LVN C stated she completed the incident report dated 5/7/2026 for the fall but she was not present at the time of the fall. She stated when the incident occurred, she went to assess the resident and saw her on the floor in front of the wheelchair lying face up. Staff stated Resident #46 was unable to respond to what happened as she had just returned from the hospital less than 24 hours from having a stroke. Resident #46 was mumbling but could make out what she was saying. LVN C stated the CNA called her and informed her a resident had fallen. LVN C stated she was not the assigned charge nurse that day, but the nurse was new and stepped away to go on break. LVN C stated she did read the resident's care plan, and it explains to the staff what type of care services the resident should be receiving. Each day she reviewed electronic medical record to check what the previous aid charted and discusses this during clinical in the morning. Per LVN C she stated on the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Houston	6534 Stuebner Airline Road Houston, TX 77091

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	day of incident, 5/07/2026, the new nurse was assigned to Resident #46 care. LVN C stated she heard the nurse left the resident in the wheelchair and left to go to lunch. After the medication aide went into the room and saw the resident. LVN C reported assigned nurse left to lunch and was notified but she never returned to the facility to complete the assessment. In the past LVN C stated Resident #46 would try to get in her chair if resident was placed near which led to many of her falls and was in her care plan was updated not to leave her unattended with the wheelchair.An interview was held on 5/27/26 at 11:42am with the Administrator reported she completed her internal investigation for Resident #46 fall on 05/07/2026. The Administrator responded it was unsubstantiated because she could not determine what caused the fall. Her investigation reflected Resident #46 was fed, changed, dry, and at the time of the incident she did not need assistance to transfer herself. The Administrator reported Resident #46 was on regular supervision, she had 2 hours checks as the other residents. Administrator reported the RN A was assigned to Resident #46 on 05/07/26. The Administrator stated the fall on 5/7/26 led to a fracture. Administrator reported Resident #46 did not show signs of pain or discomfort at the time of the fall when the nurse assessed. Resident #46 was sent to the hospital just in case as the assessment did not indicate any signs or symptoms of injury. The Administrator stated they were unaware of the injury until the day she was discharged from the hospital. The Administrator reported they did a training covering falls, strokes and they have one training scheduled for next month. The Administrator reported a care plan provides a multitude of things such as interventions, prevention practices, and steps for staff to follow for the resident.Interview held 5/27/26 at 12:32pm with the ADON stated she was at the facility on 5/7/2026 when Resident #46 fell. ADON stated the fall was unwitnessed. ADON stated she was out so she had not had time to review Resident #46. ADON stated she trains the nurses for increased care on Resident #46. ADON stated nurses who assess the resident will make the changes to the resident care plan and determine the level of supervision and other intrinsic factors on the incident report. ADON stated it had not been 14 days therefore the MDS assessment had not been revised. ADON stated the nurses are responsible for updating the fall list and deeming the resident high risk for falls.Interview on 05/29/26 at 12:22 pm with the Administrator stated all safe were educated and have a tasks list to complete which includes a review of the care plan. Administrator the charge nurses will ensure the resident safety by providing coverage and ensuring resident safety prior to going on break which includes not leaving Resident #46 unattended. Administrator has updated the residents daily charting to ensure documentation is maintained for residents. Care plan interventions were updated and included the injury along with interventions. All staff were provided with in-services before their shift to ensure compliance.On 5/29/26 at 10:11am an interview was held with the Corporate MDS Nurse who stated her title is Director of Regional Reimbursement. The MDS Nurse reported she has been assigned to this role with the facility since April 20,2026. The MDS Nurse stated she knows Resident #46. MDS Nurse reported anyone who has access to the system can update the care plan. She stated she encourages the an IDT approach at the facility level to make changes on the care plan as they are still not fully staffed. The MDS Nurse stated that she Resident #46 fell on 5/7/26 and returned to the facility on 5/18/26 the MDS assessment was not reviewed, the facility has 14 days to make significant changes. Once the review is completed it will then trigger the cause identified which will led to the IDT meeting. The MDS Nurse stated that she does not attend IDT meeting but if the facility invited her she would attend the resident review. The MDS Nurse stated the ADON, nurses, and the DON are responsible for updating the care plan at this time. The MDS Nurse reported the time frame is 14 days to initiate change and 28 days to complete the total changes on the care plan. The MDS Nurse reported they did not know Resident #46 was injured therefore the care plan was not revised sooner. The MDS Nurse stated they needed to gather data, that is the purpose of the MDS to help with the residents' care, therefore the plan could not be updated sooner. At facility level, the staff responsibilities are after the resident's problem is triggered not before.On 5/29/26 at 12:18pm in a follow-up interview with the ADON was asked about the RN who was assigned to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Houston	6534 Stuebner Airline Road Houston, TX 77091

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #46 on 5/7/2026. ADON stated she was in training and was still under review. The ADON stated she had seen RN prior to her break and informed her she was going to complete a checkoff and medication review. The ADON stated she provided the RN with a three-day orientation and an electronic medical record overview of the residents. The ADON stated when the RN left, she had attempted to get hold of RN but there was no response.Record review revealed the facility policy on fall prevention dated 5/08/2026 revealed in part under high-risk protocols c. Provide intervention that address unique risk factors measured by the risk assessment tool: Medications, psychological, cognitive state, or recent change in functional status.Number 7 states in policy Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care.a. Interventions will be monitored for effectiveness.b. The plan of care will be revised as needed.An Immediate Jeopardy (IJ) was identified on 05/28/26 at 1:18PM. The Administrator was notified. The Administrator was provided with the IJ template on 05/28/26 at 2:06PM. While the immediacy was removed on 05/29/26 at 3:20 PM, the facility remained out of compliance at a scope of isolated with serious injury from a fall resulting from inadequate supervision and failure to implement care plan or follow physicians orders.The following Plan of Removal submitted by the facility was accepted on 05/29/2026 at 8:07 AMn the morning.The facility implemented the following corrective measures to remove the deficient practice:ADON and designees reviewed Resident #46 medical record, fall interventions, supervision needs, transfer status, and post- surgical precautions were immediately reviewed by the interdisciplinary team.ADON and designees reviewed residents care plan and updated to include the individualized fall prevention interventions, supervision requirements, post- operative cervical spine precautions, positioning requirements, transfer assistance, and monitoring needs. Completion date was 5/28/26ADON and designees In-serviced direct care clinical staff on Falling Star & Fall Prevention Program which included falling star identification system, fall risk assessment process, intervention for yellow star residents, post- fall protocol, quality assurance and performance improvement, staff education, regulations and guidelines, fall prevention best practices, documentation requirements. Completion date was 05/28/26 and 5/29/2026ADON and designees reviewed all other resident with potential to be affected with immediate audit who have fallen in the last 30 days which included fall risk assessments were current, residents had appropriate interventions in place, care plans reflected the resident needs, ensured safety devices and supervision interventions were implemented, staff aware of resident-specific fall prevention interventions. Completion date was 05/28/26ADON and designees held in-service education for licensed nurses, CNA's, restorative staff, and direct care staff which included accident prevention and supervision requirements, compliance with resident specific care plans, high risk fall protocol, proper supervision of resident seated in wheelchairs, frequent rounding expectations, immediate reporting and assessment of falls, post- fall procedures and documentation requirements, resident safety responsibilities during staff breaks and shift transitions. Completed on 05/28/26ADON and designees instructed all direct care staff to review high- risk fall residents at the beginning of each shift to verify interventions, safety devices, supervision measures, and care plan compliance. Education is expected to be completed prior to the next working shift. Completed on 05/28/26ADON and designees reviewed the Fall Prevention program and High- Risk Fall Protocol policy, no changes were made. Completed 05/28/26ADON and designees Adhoc QAPI was help with the IDT and Medical Director to inform them of the Immediate Jeopardy. Completed on 05/28/26PRN Nurse involved in incident on 05/7/26 was terminated on 05/07/26.Monitoring of the POR included the following:On 05/29/2026 observations were made, records were reviewed, and direct care nursing staff were interviewed.Record review of MDS resident matrix, fall prevention policy, QAPI adhoc, review of in-services fall prevention, management and use of safety devices dates completed on 5/28/26 & 5/29/26, Ensuring all care plan interventions are followed by all shifts dated 05/28/26 with signature sheet. Resident #46 care plan revision with focus problem had actual fall with major injury on 5/7/26- interventions included adding resident the Dozzie system (alerts when resident is (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Houston	6534 Stuebner Airline Road Houston, TX 77091

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	off the bed), encourage resident to follow IDT recommendations to reduce fall risk injuries, facility fall prevention program, and PT consult for strength and mobility; completed on 05/28/26. Follow up with additional residents who are high for fall risk (5 residents reviewed). Significant change assessment completed and revised for mobility as needs total assistance, mental stability disorientated. Significant change assessment completed for 5 additional residents on 05/28/2026. Incident and accident form updated for fall on 05/07/2 and deemed under un-witnessed fall incidents dated 05/28/26.Interview with the Administrator on 5/29/26 at 12:22 pm a plan of review interview was conducted with this Surveyor. This Surveyor asked administrator was the facility's proper supervision definition means and how it will be monitored. Administrator stated she is going to ensure all the staff are educated by incorporating a task list and ensure they have read the care plan. This Surveyor requested more clarification on resident safety responsibilities during staff breaks. The Administrator stated that when staff go on breaks they are ensuring residents safety is covered and provide the additional oversite while on break. She reported the care plan was revised to include injury's to align with the interventions and updated accordingly.A second interview with LVN C on 5/29/26 at 12:56pm was conducted in person on 6am - 2pm shift. This Surveyor asked LVN C what new changes were implemented for Resident #46. LVN C reported that she is aware resident is a high fall risk, the list was updated and placed in the nurses station. Resident #46 now has the Dozzie Program installed so when the resident moves or gets off the bed it sends alerts to the staff. LVN C reported that under no circumstances should Resident #46 be left unattended when out of bed. If a staff is going on break makes the CNA's know to have coverage and check on the resident. Every time she comes in for shift report she will discuss changes of condition. Staff reported she will continue to notify the doctor and family while completing her assessment duties.Interview with CNA D on 5/29/26 at 1:11pm. CNA D stated she was educated on Resident #46 being included in the falling start program. The facility updated the list is now available at the nurse station. She stated the care plan for residents was updated and reviewed. CNA D stated she knows Resident #46 should not be left in her wheelchair unattended, if she did see the resident, she would help transfer her and report to the nurse.Interview with LVN A on 5/29/26 at 1:37pm. He reported the facility provided him with in-services. LVN A stated he was made aware of the changes on the falling star program. When him or his staff are going on break, they are to notify the nurse and let them know where he will be and how long. LVN A stated Resident #46 should not be left alone in her wheelchair unattended as she is a fall risk. If witnessed her in her wheelchair unattended he would document, call on the assigned staff, and report it to the doctor and ADON.A follow up interview was completed with CNA E on 5/29/26 at 1:58pm. CNA E stated she did training and was provided with in-services that required a quiz at the end. She stated the resident was added to the falling star list and now when she documents and alert comes out resident is a fall risk. She is going to review Resident #46 and complete her documentation on her shift of status and ensure she not left unattended. Staff stated if she did see the resident left unattended, she would notify the charge nurse.An interview with LVN D on 5/29/26 at 2:16pm stated he was trained over four areas which included falls. He stated Resident #46 should not be out of bed unattended. Staff are to be reporting if any concerns arise. If he saw resident unattended, he would relocate her to the nurses station to monitor and report on her discovery to her supervisor.On 5/29/26 at 2:22pm a phone interview was conducted with RN. RN stated he was trained on reporting and falls.Interview with CNA F on 5/29/26 at 2:27pm stated she was trained by the facility on a few policies. CNA F stated she was trained on falls. Staff said she is aware Resident #46 is not supposed to be left sitting her wheelchair unattended. Resident is to be transferred back into bed. If she saw resident left in wheelchair unattended, she would bring resident up to the nurses station and have someone watch her. Then she would notify the charge nurse and follow the chain of commands ADON and Administrator.Observation on 05/29/26 of the facility indicated residents all had their star placed visibly on the doorway. List of high risk residents was available at the nurses station and on the cart.Record review of facilities fall audit and assessment for 5 residents who met high fall risk were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Houston	6534 Stuebner Airline Road Houston, TX 77091

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	completed on 05/28/26 by the physician.Record review of facilities incidents and accidents date range from 04/28/26- 05/28/26 was completed on 05/28/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Houston	6534 Stuebner Airline Road Houston, TX 77091

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview, and record review the facility failed to designate a registered nurse to serve as the director of nursing on a full-time basis at least 8 consecutive hours a day, 7 days a week for 2 of 60 (05/18/2026 and 05/25/2026) days reviewed.The facility failed to provide RN coverage for 05/18/2026 and 05/25/2026 to meet the requirements of an RN working a full 8 hours a day.These failures could result in periods without required RN oversight and placed residents at risk for unmet care needs, delayed assessments, and inadequate supervision of licenses and unlicensed staff. Findings include:Record review of the facilities PBJ data for fiscal year 1 2026 revealed the results as ?Not Triggered' for no RN hours.Record review of the facilities RN Coverage Timesheets revealed no RN worked for 05/18/2026 and 05/25/2026.During an interview on 05/28/2026 at 3:44pm with the Administrator she stated the facility has been without a DON for approximately 30 days. She stated that when a DON was not present, the facility typically assigned other RNs to cover DON responsibilities; however, they have recently experienced staffing shortage. The Administrator reported she has posted the DON position on Indeed and anticipates a new DON start at the beginning of next month. She stated the primary risk of not having an RN in the building would be the inability to provide certain treatments, such as initiating an IV. She stated she could not identify any services a resident would be unable to receive in the absence of an RN and stated there had not been a lapse in care when an RN was not present.Record review of the facilities policy for Nursing Services-Registered Nurse (RN) revised on 05/30/2025 read.Policy: It is the intent of the facility to comply with Registered Nurse staffing requirements as per Social Security Act S1919 and S1819. Full-time is defined as working 40 or more hours a week.The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week. (The requirement for 8 consecutive hours of RN services can be met by any RN or multiples of RNs. The facility will designate a Registered Nurse to serve as the Director of Nursing on a full-time basis.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Houston	6534 Stuebner Airline Road Houston, TX 77091

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan that included services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #46) reviewed for care plans.The facility failed to review and revise Resident #46 care plan despite her history of four recent falls (2/1/26, 2/15/26, 2/23/26, and 3/10/26) before she had a major fall on 05/07/26 and when she was re-admitted to the facility on [DATE] with a neck fracture and with post-surgical needs.This deficient practice could place residents at risk of harm as qualified staff responsible for carrying out interventions were not notified of their roles and responsibilities of the specific are and services implemented for the resident.Findings include: Record review of Resident #46 face sheet indicated she is [AGE] year-old female. Her admitting date is recorded as 7/23/21 and readmitted on [DATE] with diagnosis of cerebral infraction (A thrombotic stroke occurs when a blood clot forms in an artery in the brain disrupting blood flow and leading to brain cell death); muscle wasting and atrophy (partial or complete wasting away of a part of the body); muscle weakness; and cognitive communication deficit (communication is impaired due to underlying cognitive difficulties rather than a primary language or speech problem).Record review of Resident #46 MDS dated [DATE] has section cognitive patterns blank and did not report a BIMS summary score. Resident #46 was rated as having poor decisions and supervision required under cognitive skills for daily decision making. Resident #46 was scored a 0 under section of rejection of care. Resident #46 was reviewed for functional abilities chair- to- chair transfer indicated she needed supervision or touching assist. Under walk 10 feet resident score stated the facility did not attempt due to illness, exacerbation, or injury.Record review of Resident #46's care plan revealed: Focus - Resident #1 is a high-risk or falls as evidenced by history of falls dated: actual fall with no injury on dates 2/1/26, 2/15/26,2/23/26, 3/10/26, 5/07/,26. The care plan revealed Resident #46 had a history of 5 falls with no injury. An intervention backdated 6/16/24 and revealed in part, Do not leave resident in wheelchair next to the bed. The care plan did not have any updated interventions since the resident's fall on 5/7/2026. Care plan did not include any updates on focused care for the cervical collar or interventions outlined for staff.Record review of Resident #46 discharge plan from the hospital dated 05/18/2026 at 11:19am states the resident chief complaint as patient presents with fall from wheelchair on date 5/2-5/6/26 and continues after discharge to SNF, patient had an unwitnessed fall from wheelchair. History of present illness reported Discharge recommendations include supervision recommendations one to one. Physicians' postoperative treatment plan stated client is to continue to wear Maimi J collar, may stand as tolerated with no bending, lifting, twisting for 2 -3 months. Occupation Therapist evaluation completed on 05/12/2026 reported on assessment results Activities of Daily Living status impaired, impaired endurance, and impaired functional mobility.A record review on 5/26/26 of Resident #46 care plan has an intervention backdated 6/16/24 and reads in part, Do not leave resident in wheelchair next to the bed. Care plan did not have any updated interventions since residents fall on 5/7/2026. Care plan revealed Resident #46 has a history of 5 falls with no injury. Care plan did not include any updates on injury from fall on 5/7/2026 to include cervical collar care.Record review of re-admission orders were not completed and dated 5/26/2026. Order submitted by LVN A stated, Resident must have cervical collar on at all times until return appointment with the sx (surgeon).An observation on 5/26/26 at 10:25am, Resident #46 was lying the bed with rails up. Resident #46 was observed wearing a hard cervical collar. The room was free from obstruction and organized but did not include a fall mat on either side of the bed. An attempt to conduct an interview with Resident #46 was made, she was unable to answer questions and made gurgling sounds.Phone interview on 5/26/26 at 1:25pm, Family Member A stated he learned about (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Houston	6534 Stuebner Airline Road Houston, TX 77091

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #46's incident through a staff member. He stated he went to the facility and arrived before the ambulance. Family Member A stated the staff informed him Resident #46 was taken out of her bed and put in her wheelchair, then the nurse assigned to her had left her unattended which resulted in a fall. He stated a second nurse saw Resident #46 on the floor, and the facility called the ambulance, and she was taken to the hospital. He stated once she got to the hospital, he found out Resident #46 had sustained a fracture to her neck and needed to have two major surgeries. Family Member A stated he attempted to move Resident #46 to another facility but did not have power of attorney. He stated, I feel the nursing home is not giving her the best care. Family Member A stated Resident #46 was non-verbal now and before she could make sentences and now she could not.On 5/26/26 at 2:32pm observation of Resident #46 in her room call light within reach of the resident. No staff were in the room or in the hallway. Resident was lying bed without her cervical collar. C-Collar was placed on the bedside table, out of reach from resident.Interview on 5/26/26 at 3:37pm, LVN A stated he was the charge nurse who completed Resident #46 re-admission. LVN A stated the resident's comprehensive care plan identifies what is going on with the resident. He stated he reviews it daily in the resident's electronic chart. LVN A stated he verbally updates his staff during report at the beginning of each shift. LVN A stated if he were to witness a staff member not following the care plan he would address them then go check on the resident to verify if the interventions were being followed. LVN A stated the manager or the ADON are normally responsible for the updates in the care plans. LVN A stated he was assigned to Resident #46 this week and last week.Interview on 5/26/26 at 4:43pm, CNA A stated it had been a long time since she reviewed are care plan and she couldn't name a date the last time she reviewed Resident #46care plan. Staff did say she recalls seeing updates on Resident #46, she had alerts pop up on her electronic chart. CNA A [NAME] her delegated charge nurse is LVN A.An interview was conducted on 5/26/26 at 5:12pm with CNA B who stated she is familiar with Resident #46. CNA B stated Resident #46 is a total care resident which means the staff have to help her do everything. CNA B stated she had to change her brief, clean, and dry her, feed her, and put clothes on her. CNA B reported that her charge nurse (LVN A) informed her prior to the shift starting what care Resident #46 needed. CNA B stated the charge nurse informs the aids verbally as it is not written anywhere. Staff stated there are no orders or plan that are provided other than being verbally told by charge nurse on the resident's level of care. CNA B stated an intervention is used to help solve a problem. CNA B stated she did not know about care plans or how to review interventions on one. CNA B stated she has been assigned to Resident #46 yesterday and today, and last week.Interview on 05/26/26 with LVN B held at 5:41pm. LVN B stated she was familiar with Resident #46 although she has not worked with her in a while. LVN B stated the care plan notifies the CNA's of the interventions on the care plan. LVN B stated the care plan was a plan of care for the resident, a guideline for the residents and their specific needs. LVN B stated the charge nurses normally did the initial assessments and then they are discussed amongst the departments. LVN B stated the MDS Nurse updated the care plans and nurses could do baseline care plan changes.On 5/27/26 at 10:17am an interview was held with CNA C indicated interventions are in place to help care for the patient. She reported that PCC also provide alerts to help notify them if anything needs reviewing or monitoring. CNA C attends shift report at every shift report about the resident, what happened at each round, how long ago each task was conducted (feeding, changing), anything significant if they been up or asleep. CNA C stated Resident #46 care includes full assistance with a two person assist. CNA C stated she know because the charge nurse verbally told her prior to the shift but did not receive any other training or updates.An interview on 5/27/26 at 11:42am the Administrator stated The Administrator stated she was unsure if Resident #46 care plan and has not learned every resident's care plan. The Administrator stated it is normally assigned to the MDS nurse, but the facility has not held one for some time. Administrator reported a corporate MDS nurse is doing this job remotely. The Administrator stated they did train covering falls and signs of strokes after Resident #46 fell and they have one training course scheduled for next month. The Administrator (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Houston	6534 Stuebner Airline Road Houston, TX 77091

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated a care plan provides a multitude of things such as interventions, prevention practices, and steps for staff to follow for the resident. She said the steps are specific to the care the resident needs. The Administrator stated the nursing staff should review the care plan daily and review any changes that have occurred. The Administrator stated it was important to follow the care plan, if the care plan was not followed there could be a gap in care services or delay in care The Administrator stated it is important to check the residents baseline, see any changes, review level of care, and communicate to the reset of the team.An interview on 5/27/26 at 12:32pm, the ADON stated she was at the facility on 5/7/2026 when Resident #46 fell. The ADON stated when reviewing a fall the nurse should complete the assessment and notify the doctor about the assessment findings. She said the nurse should place any orders, complete the risk management, assess for pain, fall type, and if unwitnessed they should complete one more task which is check for neuros. ADON reported she was out on leave therefore she had no time to review Resident #46. ADON stated that since Resident #46 return there had been a change in resident's ADL care. The ADON stated she made a request to MDS Nurse on 5/27/26 to check if Resident #46 qualified for significant change assessment on her MDS, since resident has not met her 14-day time frame. ADON stated she and the corporate nurses trained the nurses and CNA's on providing care to Resident #46. ADON stated she provided the facility staff with in-service training the day of the incident. ADON stated the staff are aware of the Falling Star Program because it will comes up on the electronic charting and the resident's care plan.A record review on comprehensive care plan policy on 5/27/26 reads in part, 1. The care planning process will include an assessment of the resident's strengths and needs. All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality, and incorporate culturally competent and trauma-informed care as indicated. 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.Record review on 5/29/26 revealed facility trained on topic Ensuring All Care Plan Interventions are followed by all shifts dated 5/28/26.Record review on 05/29/26 facility Fall Prevention Program states in part, The assessment indicates the resident's fall risk score and the nurse will initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. Each resident's risk factors and environment hazards will be evaluated when developing the resident's comprehensive plan of care. Interventions will be monitored for effectiveness; the plan of care will be revised as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Houston	6534 Stuebner Airline Road Houston, TX 77091

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 did not maintain an infection prevention program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents (Resident #7) reviewed for infection control.- CNA X failed to change gloves, wash, or sanitize hands after cleaning Resident #7's buttocks, and before handling the clean brief and bed linens.CNA Y failed to change gloves, wash, or sanitize hands after cleaning Resident #7's peri-area during incontinent care and before handling the clean brief, bed linens, and touching Resident #7's face.These failures could place residents who required assistance with toileting needs at risk for cross contamination and infection.Record review of Resident # 7's face sheet revealed a [AGE] year-old admitted to the facility on [DATE], initially admitted on [DATE] and originally admitted on [DATE]. Resident #7's diagnoses included Quadriplegia (condition characterized by partial or complete paralysis of all four limbs and torso), disorder of the brain, Aphasia (language disorder caused by damage in a specific area of the brain), diseases of the upper respiratory tract, urinary tract infection, Neuromuscular function of the bladder (nerve damage to the bladder), gastrostomy status (a surgically created opening in the abdomen directly into the stomach with a feeding tube) and colostomy status (a surgical created opening in the abdomen to allow stool to exit, that connects the large intestine to the outside of the body, and pouch worn on the outside) and Dysphagia (swallowing disorder).Record review of the quarterly Minimum Data Set (MDS) resident assessment dated [DATE] revealed Resident # 7 had short term and long-term memory problems. Resident #7 had moderately impaired cognitive skills for daily decision making. Resident #7 required staff assistance for bed mobility, transfers, dressing, toilet use and personal hygiene.Record review of Resident # 7's undated care plan revealed in part; Problems: Resident #7 required enhanced based precautions due to colostomy and G-tube with immunosuppressive disease processes. Interventions included: Enhanced Barrier precautions - Gown and gloves required when providing direct care and if anticipating coming into contact with surfaces and materials potentially contaminated by the resident. Problem: Resident #7 had an ADL self-care performance deficit r/t TBI(traumatic brain injury). Interventions included: Toilet hygiene - moderate to max assist, dressing - total assist, mobility assistance when rolling left to right - max assist. Problem: Resident #7 had functional bladder incontinence r/t impaired mobility, inability to communicate needs and physical limitations. Interventions included: the resident uses disposable briefs. Change frequently and PRN.Observation and interview on 5/28/26 at 4:30PM, Resident #7 was alert and in bed with the head of bed raised. A sign for Enhanced barrier precautions instructions was on the door to the room. Isolation personal protective equipment was in the small cart just outside the door to the room. The door was closed. Isolation trash and linen containers were in the resident's bathroom. CNA X and CNA Y gathered supplies then washed their hands in the bathroom then put on clean gowns and clean gloves. Both CNAs unfasted Resident #7's brief, rolled the brief down between Resident #7's thighs. The CNAs rolled the resident to his left side and CNA Y tucked the tabs of the brief under Resident #7's left hip, rolled the resident to his right side and CNA X removed the soiled brief with urine. Using disposable wipes CNA X cleansed Resident #7's lower abdomen and right groin. CNA 2 cleansed Resident #7's left groin CNA X cleansed the tip of the penis and the urethral meatus using clean wipes and a separate clean wipe to cleanse the scrotum. CNA X cleansed Resident #7's buttocks with a clean wipe and cleansed the anal area with a clean wipe. CNA X positioned the clean brief beneath the resident's buttocks and fastened the tab to Resident #7's right side and CNA Y fastened the tab to the left side of the resident. CNA X and CNA Y touched the resident's gown and covered his body and touched the bedding to pull the covers over the resident. CNA Y touched Resident #7's head and face then wiped his mouth with a moistened washcloth. CNA X and CNA Y did not: remove used gloves, perform hand hygiene, put on clean gloves after cleaning the resident and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Houston	6534 Stuebner Airline Road Houston, TX 77091

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	before touching the clean brief, bedding, and the resident's face/head. In an interview on 5/28/26 at 4:30PM, CNA X and CNA Y both stated they were nervous because they were being observed and knew they should have: changed gloves, performed hand hygiene, and put on clean gloves after the dirty part of the peri care. CNA X and CNA Y both stated it was cross-comminating to touch clean items with dirty, used gloves and should have changed gloves before touching the clean items. CNA Y stated she should not have touched Resident #7 on the face with gloves used for incontinent care because the gloves were not clean and she didn't realize she did this. In an interview on 5/29/26 at 12:30 PM, the ADON stated the CNAs were responsible for providing peri care. The ADON stated hands should be washed and gloves changed to prevent infection. The ADON stated that once done with the cleaning portion of the procedure, the gloves are to be removed, hand hygiene performed and clean gloves put on because after cleaning the resident during peri care, the gloves would be dirty and should no longer touch anything like linen and clean briefs or the resident's skin. The ADON stated it was the facility policy to perform hand hygiene between glove changes. The ADON stated she was responsible for oversights and training regarding infection control, peri care, and hand hygiene. The ADON stated since the DON left on 5/5/26 she had been conducting staff training, including peri care, infection control, and hand hygiene.Record review of the facility policy for Perineal Care revised on date 5/1/25 read in part: Policy: It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown.12. Males.h. cleanse the scrotum using.new disposable wipe with each stroke.k. Clean and dry the bottom of the scrotum and the anal area.15. Reposition as desired and cover resident. 16. Remove gloves and discard. Perform hand hygiene.Record review of the facility policy for Hand Hygiene revised on date 4/10/25 read in part: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. 7. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.Record review of the facility policy for Infection Prevention and Control Program revised on date 4/2/25 read in part: .4. Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE.