

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Focused Care at Huntsville		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 Nottingham St Huntsville, TX 77340	
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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, 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 3 of 6 staff (CNA C, MA D, and RN A) reviewed for infection control.1.The facility failed to ensure CNA C followed infection control measures during dining service on 7/13/2026.2. The facility failed to ensure MA D followed infection control measures during medication administration on 7/14/2026.3. The facility failed to ensure RN A wore the appropriate PPE when wound care was provided to Resident #3 on 7/14/2026.These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings included:1.During an observation on 7/13/2026 at 12:13 PM, CNA C applied gloves without sanitizing or handwashing and entered room [ROOM NUMBER] and set up his tray and removed her gloves then left the room without hand hygiene. She then applied gloves and passed a meal tray to room [ROOM NUMBER]. She removed her gloves, left room [ROOM NUMBER], and returned to the dining cart without hand hygiene.During an observation on 7/13/2026 at 12:18 PM, CNA C applied gloves without sanitizing or handwashing and entered room [ROOM NUMBER] and set up his tray and removed her gloves, then left the room without hand hygiene. She then applied gloves and passed a meal tray to room [ROOM NUMBER]. She removed her gloves, left room [ROOM NUMBER], and returned to the dining cart without hand hygiene. During an interview on 7/13/2026 at 12:20 PM, CNA C said she had been trained on infection control measures. She said she realized she had not sanitized between glove changes after she noticed she was being watched. CNA C said she should have sanitized after her glove changes. CNA C said she just forgot to perform hand hygiene between glove changes. She said that poor hand hygiene could cause infections to spread. 2. During an observation on 7/14/2026 at 08:18 AM, MA D prepared medications and entered room [ROOM NUMBER], handed him water, and administered medications. MA D returned to her cart, and prepared medications from the cart without hand hygiene. MA D then entered room [ROOM NUMBER], handed her water, and administered medications without performing hand hygiene. She returned to her cart and then sanitized her hands.During an interview on 07/14/2026 08:25 AM, MA D said she had been trained on infection control measures. MA D said she thought she was required to sanitize between every two residents. She said not washing her hands or using alcohol-based sanitizer between each resident encounter, could spread infections.During an interview on 07/14/2026 at 10:53 AM, the DON stated she expected all staff to follow the CDC's recommendations for hand hygiene during care. She said the risk for the residents were infections if hand hygiene was not performed between each resident encounter. She said she would provide the facility's policy for hand hygiene for review.During an interview on 7/14/2026 at 1:45 PM, the Administrator said all staff was provided with education on infection control policies including handwashing. She stated staff should utilize (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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Focused Care at Huntsville		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 Nottingham St Huntsville, TX 77340	
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 - Some	hand hygiene while passing trays to residents, which included sanitizing or washing hands after each tray was passed. She said gloves did not take the place of sanitizing hands, and should not be utilized to pass out meal trays. She said when medications were administered, staff should wash or sanitize their hands after medication administration, and prior to accessing the medication cart and entering another resident's room. She stated, moving forward, she expected all staff to follow the facility's infection control policy, and practice proper hand hygiene.3. Record review of an admission Record dated 7/14/2026 for Resident #3 indicated he admitted to the facility on [DATE] and he was [AGE] years old with diagnoses of hemiplegia following cerebral infarction (paralyzed on one side of the body following a stroke), and pressure ulcer of sacral region and other site (bed sore caused from pressure to the tailbone and right hip). Record review of a Quarterly MDS Assessment for Resident #3 dated 6/18/2026 indicated he had severe impairment in thinking with a BIMS score of 0. He was dependent on staff for all ADLs. He had an unhealed pressure ulcer/injury that were stage 3 wounds (full thickness tissue loss) that were present on admission. Record review of a care plan for Resident #3 dated 4/16/2026 indicated he had a foley catheter and was at risk for increased urinary tract infections. He had a stage 3 pressure injury to his sacrum. Interventions included administer treatments as ordered. There was no care plan for EBP. Record review of active physician orders for Resident #3 dated 7/14/2026 indicated he had orders for wound care that started on 6/30/2026 for his right hip. and wound care orders for his sacrum dated 6/30/2026. An order for catheter care every shift started on 4/16/2026. During an observation on 7/14/2026 at 11:18 am, CNA B was in the room of Resident #3 to assist with wound care and was wearing a gown and gloves. RN A washed her hands in the bathroom and applied gloves. RN A cleaned the overbed table with a micro kill wipe allowed to dry and placed wax paper on overbed table with the wound care supplies on top. RN A removed her gloves and placed them in the trash. RN A sanitized her hands and applied gloves. RN A did not put on a gown. There was a sign above the bed of Resident #3 for EBP that indicated what PPE needed to be worn when high contact care was provided that included a gown and gloves. CNA B assisted with holding Resident #3. RN A removed the dressing that was on Resident #3's sacrum and placed it in the trash along with her gloves. RN A sanitized her hands and applied gloves. RN A cleaned the wound with normal saline and 4x4 gauze in a circular motion. RN A placed the gauze in the trash along with her gloves. RN A sanitized her hands and applied gloves. RN A cut a piece of hydrofera blue dressing (used to kill bacteria) to fit the wound bed, moistened it with normal saline, and placed it in the wound bed and covered with a dressing. RN A dated the dressing 7/14 along with her initials. RN A removed her gloves, placed them in the trash, and sanitized her hands. RN A placed gloves on her hands and removed a dressing from his right hip and placed the dressing and gloves in the trash. RN A sanitized her hands and donned (put on) gloves. RN A cleaned the wound to his right hip with normal saline and 4x4 gauze and placed the gauze in the trash along with her gloves and sanitized her hands. RN A donned gloves and patted the right hip wound dry with a 4x4 gauze and placed the gauze in the trash along with her gloves. RN A sanitized her hands and donned gloves. RN A sanitized her hands and applied gloves. RN A cut a piece of hydrofera blue to fit the wound bed and moistened it with normal saline and placed it in the wound. RN A removed her gloves and placed them in the trash; sanitized her hands; donned gloves and placed a dressing over the wound. RN A removed her gloves and placed them in the trash and exited the room with the trash. RN A re-entered the room and washed her hands in the bathroom. CNA B removed her gown and gloves, placed them in the trash, and washed her hands. During an interview on 7/14/2026 at 12:00 pm, RN A said she did not wear a gown when she provided wound care to Resident #3. She said the resident was on EBP for a wound and had a catheter, and she should have worn a gown. She said she forgot and usually wore (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Focused Care at Huntsville		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 Nottingham St Huntsville, TX 77340	
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 - Some	one when care was provided to him. She said if staff did not follow EBP and wear the appropriate PPE, they could spread infections or germs to residents. During an interview on 7/15/2026 at 11:28 am, the ADON said she was the IP for the facility. She said, monthly, she trained the staff on EBP, PPE, and handwashing. She said residents who required EBP included residents who had foley catheters, open wounds, IVs, tracheostomies (opening in the neck for breathing) and enteral feedings (feeding tubes). She said Resident #3 was on EBP for wounds and he had a foley catheter. She said staff should wear gowns and gloves when direct care was provided to him or other residents who were on EBP. She said she was made aware of RN A not wearing the appropriate PPE when she performed wound care on yesterday 7/14/2026 with Resident #3. She said they had PPE in the rooms and signs above the beds, so the staff were made aware of what residents required EBP. She said there was a risk of infections to residents, if staff did not follow the appropriate measures with EBP. During an interview on 7/15/2026 at 11:31 am, the DON said the ADON was the IP for the facility, and trained staff on infection control. She said staff were trained on EBP quarterly with check offs. She said residents who had IVs, gastrostomy tube (feeding tubes in the stomach), catheters, and open wounds would require EBP. She said Resident #3 was on EBP. She said they had signs in the rooms above the bed and PPE was in the rooms also so staff would know who required EBP. She said there was a risk of transferring contaminants to other residents if they did not wear the appropriate PPE. During an interview on 7/15/2026 at 11:58 am, the Administrator said the IP for the facility was the ADON. She said they conducted in-services on infection control and EBP often. She said residents who required EBP had signage in the rooms above their beds and PPE was available in the rooms. She said staff should wear gowns and gloves when care was provided to residents on EBP. She said there was a risk of contaminating and spreading infections to other residents. She said they planned to continue education with staff and make sure staff followed protocols and policies. Record review of the facility's policy titled Infection Control; Enhanced Barrier Precautions dated 4/1/2024 indicated, .Enhanced barrier precautions (EBP) are CDC guidance to reduce the transmission of multi-drug-resistant organisms (MDRO) in health care settings, including nursing home. EBP require team members to wear gowns and gloves while performing high-contact care activities with residents who are infected or colonized with a targeted MDRO, or who have open wound or indwelling medical device. 4. High contact resident care activities: wound care; any skin opening requiring a dressing .Record review of the facility's policy titled Hand Hygiene revised October 2022 indicated, .Hand hygiene is used to prevent the spread of pathogens in healthcare settings. Hand hygiene is a general term that describes hand washing using soap and water or the use of an alcohol-based hand rub to destroy harmful pathogens, such as bacteria or viruses, on the hands .1. You should always perform hand hygiene .before applying and after removing personal protective equipment, (gloves, gown, mask, face shield/goggles) .after contact with intact skin .after contact with medical equipment or other environmental surfaces that may be contaminated.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Focused Care at Huntsville		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 Nottingham St Huntsville, TX 77340	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure an accurate MDS reflected the resident's status for 1 of 6 residents (Resident #6) reviewed for resident assessments. The facility incorrectly coded the MDS Assessments for Resident #6 to indicate the use of an anticoagulant (blood thinner); not an antiplatelet (prevents platelets from sticking together). This failure could place residents at risk of not receiving the appropriate care and services to maintain the highest level of well-being. Findings included: Record review of an admission Record for Resident #6 dated 7/14/2026 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of cerebral infarction (stroke), hypertensive heart disease (elevated blood pressure in the heart), heart failure (heart's inability to pump effectively) and dementia (a progressive condition that affects memory, thinking, reasoning and the ability to perform everyday activities.) Record review of an Annual MDS Assessment for Resident #6 dated 4/22/2026 indicated she did not have any impairment in thinking with a BIMS score of 15. Medication review indicated she received an anticoagulant during the 7-day look back period. Record review of a care plan for Resident #6 dated 4/23/2026 indicated he was on an antiplatelet. Interventions included administering anticoagulants and antiplatelet medications as ordered by the physician. Record review of active physician orders for Resident #6 dated 7/14/2026 indicated an order for clopidogrel (antiplatelet) 75 mg one time a day that started on 2/4/2026. There was no order for an anticoagulant. During an interview on 7/14/2026 at 3:12 pm, the MDS Coordinator said she had been the coordinator for 2 years in the facility. She said Resident #6 was prescribed clopidogrel 75 mg daily that started on 2/5/2026. She said the resident was not prescribed an anticoagulant. She said she modified the MDS assessments that day to remove Resident #6 taking an anticoagulant. She said anticoagulants were blood thinners and clopidogrel was an antiplatelet. She said she was responsible for completing the MDS assessments for the facility. She said the Regional Consultant conducted MDS assessment audits from time to time. She said there could be a risk of adverse reactions if the residents were given the wrong medicine. She said the MDS assessments provide information that was needed for the care plan and used for reimbursement purposes. She said she thought it was a typo and the assessment had been corrected. During a phone interview on 7/15/2026 at 10:44 am, the Regional Reimbursement Coordinator for the facility said he visited the facility a few times each month. He said he reviewed transmissions daily and other things once a month for accuracy. He said the MDS Coordinator for the facility did reach out to him on yesterday 7/14/2026 to inform him that Resident #6 had been coded as taking an anticoagulant. He said the MDS Coordinator went by what was put in PCC (charting system) and what the order had was how they coded the medications. He said clopidogrel was an antiplatelet, and was not an anticoagulant. He said MDS assessments painted a picture of what care the resident should receive and what was going on. He said he planned to audit, correct the MDS assessments, and in-service staff to make sure assessments were specific to each medication. During an interview on 7/15/2026 at 11:31 am, the DON said the MDS Coordinator was responsible for completing the assessments in the facility for the residents and signed them to indicate they were accurate and complete. She said clopidogrel was an antiplatelet and not an anticoagulant. She said there was a list in PCC that would tell them the drug classes to make it easier to see how to classify drugs when completing MDS Assessments. She said if the assessments were not coded accurately, it could affect the outcome scores for the facility or payment reimbursements. She said the facility did not have a policy related to MDS Assessments; they followed the RAI manual. During an interview on (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Focused Care at Huntsville		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 Nottingham St Huntsville, TX 77340	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/15/2026 at 11:58 am, the Administrator said the MDS Coordinator was responsible for completing the assessments for the facility. She said the Regional Reimbursement Coordinator monitored the assessments, and visited the facility quarterly with in person education. She said clopidogrel was an antiplatelet and not an anticoagulant. She said there could be a risk if taking other medications that were contraindicated, and if not coded correctly, could cause an adverse reaction. She said going forward, they would add to their PIPs, and continue to monitor and conduct chart audits. She said the facility did not have a policy on MDS Assessment and they followed the RAI manual. A copy of a facility policy for Accuracy of Assessments was requested, none was provided. The facility said they used the RAI manual for guidance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Focused Care at Huntsville		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 Nottingham St Huntsville, TX 77340	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in 1 of 1 kitchen reviewed for food and nutrition services. The facility failed to ensure the Dietary Manager maintained sanitary conditions while preparing trays during meal service on 07/13/2026. This failure could place residents at risk of foodborne illness and food contamination. Findings include: During an observation on 07/13/2026 at 11:40 AM, the dietary manger was preparing meal trays for lunch. Prior to placing resident tray card on the tray, the dietary manager was observed putting the fingers of her right hand to her mouth and touching her tongue before picking up the tray card and placing it on the tray. The dietary manager then placed the plate warmer, plate, utensils, condiments, and drinks on the tray before passing the tray to the cook. The dietary manager moved on to prepare the next tray and was observed putting the fingers of her right hand to her mouth and touching her tongue before picking up the meal card and placing it on the tray. The dietary manager was approached about her hand touching her tongue prior to preparing the trays. The dietary manger stated, The papers are sticking together. The dietary manager then stopped preparing trays. She washed her hands and instructed the cook to wash her hands also. Serving utensils were replaced with clean utensils, and the work area was cleaned. Observation continued with no other incidents of dietary manager touching her mouth while preparing resident trays. During an interview on 7/13/2026 at 12:30 PM with the dietary manager, she stated she did not normally prepare trays during meal service. She stated dietary aides were responsible for preparing the tray. She stated she was preparing trays during lunch due the scheduled dietary aide not reporting to work related to a personal matter. She stated the tray cards were sticking to one another, she was trying to keep everything moving, and did not think about her fingers touching her mouth. She said she understands that it should not have happened and that it could cause an increased risk of illness or infection by touching the items after touching her mouth. The dietary manager stated the facility hand washing and infection control policy was followed by dietary staff. She stated there was not a policy specific to dietary department. She stated all staff are in-serviced on the infection control policy and handwashing at least annually. She stated she participated in the in-services provided by the facility. During an interview on 7/13/2026 at 1:45 PM with the Administrator, she stated the dietary manger was responsible for making sure dietary staff followed all infection control policies, including handwashing. She stated staff should wash their hands after touching their face and prior to touching any plates, utensils or trays. She stated a possible risk of dietary staff touching their face or mouth and then touching the tray and objects on the tray was risk of infection and contamination of items. She stated moving forward she expected all dietary staff to follow the facilities infection control policy and practice proper hand hygiene. She stated she would be providing education to the dietary department and monitor for any infection control concerns. Record review of the facility's policy titled Hand Hygiene, revised 10/24/2022, indicated .1. You should always perform hand hygiene: before touching your mouth, nose or eyes. 2. You must perform hand hygiene (hand washing or the use of an ABHR (alcohol based hand rub)) after contact with bodily fluids, such as urine or blood, mucous membranes, such as the mouth or nose, and non-contact skin.		