STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675691	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntsville Health Care Center	2628 Milam 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report an allegation of neglect to HHSC for 1 of 5 residents reviewed for neglect. The facility did not report when CNA A did not have another staff member to provided care to Resident #1, left Resident #1 to obtain more supplies for care, and the resident rolled off of the bed. Resident #1 sustained a fracture of the left thigh bone near the knee.This failure could place residents at risk of harm due to delays in reporting neglect. Findings included:Record review of a face sheet dated 10/29/25 indicated Resident #1 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included hemiplegia (severe or complete loss of strength leading to paralysis on one side of the body and is usually the result of brain damage)/hemiparesis (one-sided muscle weakness) due to cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off) affecting left side, pain, peripheral vascular disease (a blood circulation disorder that causes the blood vessels outside of the heart and brain to narrow, block, or spasm), and hypertension (condition in which the force of the blood against the artery walls is too high).Record review of the state optional MDS dated [DATE] indicated Resident #1 required extensive assistance of 2 persons for bed mobility. Record review of a Fall Risk Screener dated 09/05/25 indicated Resident #1 was low risk for falls with a score of 9 out of 31 (0-9-low risk; 10-31-high risk).Record review of the quarterly MDS dated [DATE] indicated Resident #1 was dependent for toileting hygiene and required substantial-maximum assistance for roll left-to-right. Record review of an incident report dated 10/22/25 indicated Resident #1 while receiving peri-care from CNA A at 03:20 a.m., resident was rolled onto her side to provide care after an incontinent episode. While the resident was on her side, she suddenly had a large bowel movement in the middle of care. CNA A turned to get some more supplies from the cart he had in the doorway. During that time, the resident attempted to reach for something on her bedside table and rolled off the bed. Nurse was notified and upon arrival, performed a head to toe assessment. No injuries nor bruising noted on assessment. Vitals are normal, respiration was even and unlabored. Resident was assisted back to bed with the help of 2 staff. Resident #1 indicated she hurt all over and PRN pain medication was given as previously ordered by the physician. Record review of Progress Notes indicated a nurse note entry dated 10/22/25 at 03:44 a.m. resident slipped and fell as aid was performing peri care. No injuries nor bruising noted on assessment. Vitals are normal, resp is even and unlabored. Resident is assisted back to bed, pain medication given. Resident is stable condition.Record review of a Post Fall Review dated 10/23/25 at 08:00 a.m. indicated Resident #1 was awake, alert, and oriented to person, place, and time. Her vital signs and neuro checks were normal for the resident with no abnormal findings. Record review of neuro check monitoring documentation from 10/22/25 at 04:00 a.m. through 10/23/25 at 11:00 a.m. indicated no abnormal findings. Record review of Progress Notes with a nurse note entry dated 10/23/25 at 11:18 a.m. indicated Note Text : This nurse presented to patient's room during rounds, patient observed to be lethargic and responsive to painful stimuli only. Vitals were checks - BP: 145/84 HR:125 O2:88MD [name] contacted, verbal orders for ER send out for evaluation and treatment received along with 2L O2 via nasal canula.[Name] EMS contacted 1110[Name] EMS arrival 1120RP - [Name] notified 1118Report called in to ER nurse 1121Patient left facility via stretcher at 1128. During an interview on 10/29/25 at 10:25 a.m. the DON said Resident #1 did not have a fall. He said she was part way out of the bed. He said she was assisted back into bed with no complaints of pain or discomfort. He said the next day she started showing altered mental status, so they sent her to the hospital, and she had a UTI. He said nothing was said about her having a fracture until several days after she was admitted to the hospital. He said the x-ray report he received did not indicate the age of the fracture but did indicate she was osteopenic. He said he was trying to get a determinate of age of the fracture to know if it happened at the facility or at the hospital since he was told she possibly had a fall at the hospital.Record review of a hospital Imaging Report dated 10/23/25 provided by the DON via email on 10/29/25 at 12:37 p.m. indicated Resident #1 had a 2 view x-ray of the left femur at 06:34 p.m. with clinical history of fall injury. Findings were the femur was osteopenic (condition where the bone lacks enough minerals to be strong) and there was a fracture of the femoral (thigh bone) shift near the knee.During a phone interview on 10/29/25 at 01:33 p.m. CNA A said he was making his last 2 hour round on his residents. He said he knew Resident#1 required 2 staff for care. He said when he went to clean Resident #1 he was not able to find any other staff to assist because they were in other rooms. He said he went to clean her up and she had a large bowel movement which he

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(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 - Some Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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(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 - Some Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 10 residents (Resident #1, Resident #2, and Resident #3) reviewed for care plans.The facility failed to ensure that Resident #1's, #2's and #3's care plans were initiated and included appropriate interventions for ADL Care.This failure could place residents who required assistance with care at risk of serious harm and injury. Findings included:1. Record review of a face sheet dated 10/29/25 indicated Resident #1 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included hemiplegia (severe or complete loss of strength leading to paralysis on one side of the body and is usually the result of brain damage)/hemiparesis (one-sided muscle weakness) due to cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off) affecting left side, pain, peripheral vascular disease (a blood circulation disorder that causes the blood vessels outside of the heart and brain to narrow, block, or spasm), and hypertension (condition in which the force of the blood against the artery walls is too high). Record review of the care plan initiated on 05/21/25 for Resident #1 did not address her ADL assistance requirements. Record review of the state optional MDS dated [DATE] indicated Resident #1 required extensive assistance of 2 persons for bed mobility. Record review of the quarterly MDS dated [DATE] indicated Resident #1 was dependent for toileting hygiene and required substantial-maximum assistance for roll left-to-right. Record review of an incident report dated 10/22/25 indicated Resident #1 while receiving peri-care from CNA A at 03:20 a.m., resident was rolled onto her side to provide care after an incontinent episode. While the resident was on her side, she suddenly had a large bowel movement in the middle of care. CNA A turned to get some more supplies from the cart he had in the doorway. During that time, the resident attempted to reach for something on her bedside table and rolled off the bed. Nurse was notified and upon arrival, performed a head to toe assessment. No injuries nor bruising noted on assessment. Vitals are normal, respiration was even and unlabored. Resident was assisted back to bed with the help of 2 staff. Resident #1 indicated she hurt all over and PRN pain medication was given as previously ordered by the physician. Record review of Progress Notes indicated a nurse note entry dated 10/22/25 at 03:44 a.m. resident slipped and fell as aid was performing peri care. No injuries nor bruising noted on assessment. Vitals are normal, resp is even and unlabored. Resident is assisted back to bed, pain medication given. Resident is stable condition.Record review of a Post Fall Review dated 10/23/25 at 08:00 a.m. indicated Resident #1 was awake, alert, and oriented to person, place, and time. Her vital signs and neuro checks were normal for the resident with no abnormal findings. Record review of neuro check monitoring documentation from 10/22/25 at 04:00 a.m. through 10/23/25 at 11:00 a.m. indicated no abnormal findings. Record review of Progress Notes with a nurse note entry dated 10/23/25 at 11:18 a.m. indicated Note Text : This nurse presented to patient's room during rounds, patient observed to be lethargic and responsive to painful stimuli only. Vitals were checks - BP: 145/84 HR:125 O2:88MD [name] contacted, verbal orders for ER send out for evaluation and treatment received along with 2L O2 via nasal canula.[Name] EMS contacted 1110[Name] EMS arrival 1120RP - [Name] notified 1118Report called in to ER nurse 1121Patient left facility via stretcher at 1128. During an interview on 10/29/25 at 10:25 a.m. the DON said Resident #1 did not have a fall. He said she was part way out of the bed. He said she was assisted back into bed with no complaints of pain or discomfort. He said the next day she started showing altered mental status, so they sent her to the hospital, and she had a UTI. He said nothing was said about her having a fracture until several days after she was admitted to the hospital. He said the x-ray report he received did not indicate the age of the fracture but did indicate she was osteopenic. He said he was trying to get a determinate of age of the fracture to know if it happened at the facility or at the hospital since he was told she possibly had a fall at the hospital.Record review of a hospital Imaging Report dated 10/23/25 provided by the DON via email on 10/29/25 at 12:37 p.m. indicated Resident #1 had a 2 view x-ray of the left femur at 06:34 p.m. with clinical history of fall injury. Findings were the femur was osteopenic (condition where the bone lacks enough minerals to be strong) and there was a fracture of the femoral (thigh bone) shift near the knee.During a phone interview on 10/29/25 at 01:33 p.m. CNA A said he was making his last 2 hour

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(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 Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(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 Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents for 1 of 5 residents reviewed for accidents and supervision. (Resident #1)The facility failed to provide adequate supervision for Resident #1 who was assessed for 2 staff members for care. CNA A did not have another staff member to provided care to Resident #1, left Resident #1 to obtain more supplies for care, and the resident rolled off of the bed. Resident #1 sustained a fracture of the left thigh bone near the knee. An IJ was identified on 10/29/25. The Administrator was notified and the IJ template was provided to the facility on [DATE] at 04:40 p.m. While the IJ was removed on 10/30/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm due to the facility's needed to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place residents at risk of not receiving the amount of supervision or assistance required to prevent serious injury and/or actual harm. Findings included:Record review of a face sheet dated 10/29/25 indicated Resident #1 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included hemiplegia (severe or complete loss of strength leading to paralysis on one side of the body and is usually the result of brain damage)/hemiparesis (one-sided muscle weakness) due to cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off) affecting left side, pain, peripheral vascular disease (a blood circulation disorder that causes the blood vessels outside of the heart and brain to narrow, block, or spasm), and hypertension (condition in which the force of the blood against the artery walls is too high).Record review of the state optional MDS dated [DATE] indicated Resident #1 required extensive assistance of 2 persons for bed mobility. Record review of a Fall Risk Screener dated 09/05/25 indicated Resident #1 was low risk for falls with a score of 9 out of 31 (0-9-low risk; 10-31-high risk).Record review of the quarterly MDS dated [DATE] indicated Resident #1 was dependent for toileting hygiene and required substantial-maximum assistance for roll left-to-right. Record review of an incident report dated 10/22/25 indicated Resident #1 while receiving peri-care from CNA A at 03:20 a.m., resident was rolled onto her side to provide care after an incontinent episode. While the resident was on her side, she suddenly had a large bowel movement in the middle of care. CNA A turned to get some more supplies from the cart he had in the doorway. During that time, the resident attempted to reach for something on her bedside table and rolled off the bed. Nurse was notified and upon arrival, performed a head to toe assessment. No injuries nor bruising noted on assessment. Vitals are normal, respiration was even and unlabored. Resident was assisted back to bed with the help of 2 staff. Resident #1 indicated she hurt all over and PRN pain medication was given as previously ordered by the physician. Record review of Progress Notes indicated a nurse note entry dated 10/22/25 at 03:44 a.m. resident slipped and fell as aid was performing peri care. No injuries nor bruising noted on assessment. Vitals are normal, resp is even and unlabored. Resident is assisted back to bed, pain medication given. Resident is stable condition.Record review of a Post Fall Review dated 10/23/25 at 08:00 a.m. indicated Resident #1 was awake, alert, and oriented to person, place, and time. Her vital signs and neuro checks were normal for the resident with no abnormal findings. Record review of neuro check monitoring documentation from 10/22/25 at 04:00 a.m. through 10/23/25 at 11:00 a.m. indicated no abnormal findings. Record review of Progress Notes with a nurse note entry dated 10/23/25 at 11:18 a.m. indicated Note Text : This nurse presented to patient's room during rounds, patient observed to be lethargic and responsive to painful stimuli only. Vitals were checks - BP: 145/84 HR:125 O2:88MD [name] contacted, verbal orders for ER send out for evaluation and treatment received along with 2L O2 via nasal canula. [Name] EMS contacted 1110[Name] EMS arrival 1120RP - [Name] notified 1118Report called in to ER nurse 1121Patient left facility via stretcher at 1128. During an interview on 10/29/25 at 10:25 a.m. the DON said Resident #1 did not have a fall. He said she was part way out of the bed. He said she was assisted back into bed with no complaints of pain or discomfort. He said the next day she started showing altered mental status, so they sent her to the hospital, and she had a UTI. He said nothing was said about her having a fracture until several days after she was admitted to the hospital. He said the x-ray report he received did not indicate the age of the fracture but did indicate she was osteopenic. He said he was trying to get a determinate of age of the fracture to know if it happened at the facility or at the hospital since he was told she possibly had a fall at the hospital.Record review of a hospital Imaging Report dated 10/23/25 provided by the DON via email on

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(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. (continued on next page)

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #1) and 2 of 4 staff (CNA A and CNA B) reviewed for infection control. 1.The facility failed to ensure CNA A and CNA B followed EBP for Resident #1 when providing care on 12/15/2025. 2. The facility failed to ensure CNA A and CNA B changed gloves and washed or sanitized their hands when providing care to Resident #1 on 12/15/2025.These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices.Findings included: Record review of an admission Record for Resident #1, dated 12/15/2025, indicated he admitted on [DATE] and was [AGE] years old with diagnoses of cerebral infarction (stroke), hemiplegia affecting right dominant side (paralyzed on right side of the body), and type 2 diabetes. Record review of active physician orders for Resident #1 dated 12/15/2025 indicated he had an order for EBP enhanced barrier precautions due to wound: ulcer to left foot that started on 11/11/2025.Record review of a Quarterly MDS Assessment for Resident #1, dated 11/21/2025, indicated he had moderate impairment in thinking with a BIMS score of 11. He was totally dependent on staff for toileting hygiene. He was always incontinent of urine and bowel. Record review of a care plan for Resident #1, dated 11/19/2025, indicated he was on enhanced barrier precautions related to a diabetic ulcer of his left foot. Interventions included enhanced barrier precautions: PPE for EBP was necessary when performing high-contact care activities that included providing hygiene and changing briefs. Staff were to utilize PPE appropriate for EBP: gown and gloves.During an observation on 12/15/2025 at 10:19 a.m., Resident #1 had a sign on his door for EBP. CNA A and CNA B were in the hallway gathering supplies to provide incontinent care for Resident #1. CNA A sanitized her hands and placed gloves on both hands and entered the room. CNA B donned (put on) gloves on both hands and did not sanitize her hands before they were applied and entered the room. On the wall in the room by the door were gloves and gowns. CNA B aided with turning and repositioning. CNA B opened the brief and pulled it down between his thighs. CNA B removed wipes from the package and wiped down both of his inner thighs and placed the dirty wipe in the trash. CNA B removed more clean wipes and wiped Resident #1's penis in a circular motion and placed the dirty wipe in the trash. Resident #1 was rolled onto his left side and assisted by CNA A. Resident #1 had a large bowel movement and CNA B removed multiple clean wipes from the package and cleaned Resident #1's buttocks and rectal area. CNA B rolled the brief underneath his buttocks and removed it and placed it in the trash. CNA B placed a clean brief with the same dirty gloves under the resident's buttocks. Resident #1 was rolled onto his back and the brief was secured. Resident #1 was repositioned in bed by both staff. CNA B touched his pillows and fluffed them under his head and placed his cap on his head and pulled the linens back over the resident. CNA A removed her gloves and placed them in the trash and washed her hands. CNA B gathered the trash, removed her gloves, placed them in the trash and washed her hands.During an interview on 12/15/2025 at 10:31 a.m., CNA A said Resident #1 was on EBP and she should have worn a gown during the care provided. She said she did not wear a gown because she forgot. She said there was a risk of spreading infections if staff did not follow EBP. She said she was trained on EBP and Resident #1 had a wound that required the staff to wear a gown and gloves when care was provided.Record review of a skills checklist for CNA A, dated 4/30/2025, indicated she was satisfactory with personal hygiene.During an interview on 12/15/2025 at 10:33 a.m., CNA B said she worked for an agency and was assigned this facility from time to time. She said hand hygiene should be performed before and after care was completed, which included hand washing or using hand sanitizer. She said she did not perform hand hygiene before she donned gloves to provide care to Resident #1. She said she forgot to sanitize her hands. She said when she changed tasks after cleaning and removing the dirty brief before she touched clean items, she should have changed her gloves and washed her hands. She said she kept the same gloves on during care and forgot about changing them. She said Resident #1 was on EBP and she should have worn a gown. She said usually PPE was in a container in the hallway and did not see the sign on the door for EBP. She said residents were e at risk for infections and cross contamination if staff did not follow infection control practices.During an interview on 12/15/2025 at 2:17 p.m., the ADON said staff received competency checks on hire and yearly thereafter. She said the DON and the IP conducted training on infection control with the staff. She said she conducted training on 12/15/2025 for hand hygiene and EBP