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	12/15/2025

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 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)

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 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 she did not see the sign on the door that indicated the resident was on EBP. She said residents were 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