STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675964	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mrc Creekside	1433 Veterans Memorial Parkway 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 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 interviews and record reviews, the facility failed to develop a person-centered comprehensive care for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet the resident's needs for 1 of 6 residents (Residents #48) reviewed for comprehensive care plans.The facility failed to ensure Resident #48's comprehensive care plan was revised to reflect the resident requiring a wound vacuum for wound treatments.This failure could place residents at risk of inadequate monitoring of equipment.Findings included:Record review of an admission Record for Resident #48 dated 5/6/2026 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of type 2 diabetes, Parkinson's disease (movement disorder of the nervous system that worsens over time), and neuromuscular dysfunction of bladder (nerve damage or injuries that causes loss of control of the bladder).Record review of active physician orders for Resident #48 dated 5/5/2026 indicated an order for NPWT to sacral wound (wound on the tailbone) at 125 mmhg every day shift for wound care that started on 3/30/2026.Record review of an Annual MDS Assessment for Resident #48 dated 3/6/2026 indicated she did not have any impairment in cognition with a BIMS score of 13. She had an indwelling catheter (tube placed in the bladder to drain the bladder) and an ostomy (an opening in the abdomen that allows waste to exit the body). She had a surgical wound.Record review of a care plan for Resident #48 dated 4/22/2026 indicated she had the potential/actual impairment to skin integrity due to surgical wound to sacrum. There was not a care plan for the wound vac or interventions. During an interview on 5/6/2026 at 9:43 am, an interim MDS Coordinator said she was filling in for the MDS Coordinator at the facility. She said the facility MDS Coordinator was out on leave. She said care plans should be revised and updated with new orders or changes. She said she missed updating the care plan for Resident #48 and the wound vac should have been on her care plan. She said she would update it. She said updating the care plans was to ensure the staff were aware of what was happening with the residents. She said she worked remotely for the facility and was not in attendance at the morning meetings. She said the facility did contact her about 2-3 times a week for updates.Attempted an interview on 5/6/2026 with the DON, but she was out on leave.During an interview on 5/6/2026 at 10:52 am, the Administrator said members of the IDT team were responsible for updating and revising the care plans. He said the care plans should be updated with changes. He said the purpose of the care plans was to keep everyone updated. He said he expected the staff to update the care plans as needed.Record review of a facility policy titled Care Plan, Comprehensive Person-Centered dated 2001 indicated, . A comprehensive, person-centered care plan that includes measurable objective and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 7. The comprehensive, person-centered care plan; b. described the services that are to be furnished to attain or maintain the resident's highest practicable physical, and mental, and psychosocial well-being .

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 3 (treatment cart) carts reviewed.The Treatment Nurse failed to ensure the medication cart for treatments was locked and secured on 5/4/2026.This deficient practice could place residents at risk for adverse reactions to medications and misappropriation of medications.Findings included:During an observation on 5/04/2026 3:04 pm, the Treatment Nurse and MA A were in the room of Resident #48 to provide wound care. The Treatment Nurse sanitized her hands and donned (put on) a gown and cleaned an overbed table and placed wax paper down. The Treatment Nurse placed wound care supplies on an overbed table that was in the doorway of Resident #48's room. The Treatment Nurse entered the room and left the cart in the hallway unlocked with the keys in the lock and closed the door to Resident #48's room. The Treatment Nurse performed wound care on Resident #48 and when the care was completed, she exited the room and said she was not supposed to leave the keys in the cart.During an interview on 5/04/2026 at 3:28 pm, the Treatment Nurse said when she gathered her supplies, she should have taken the keys and locked the cart. She said her cart had different types of dressings and ointments that residents should not have access to. She said the cart should not be left unattended or unlocked unless they were in front of it. She said residents could get in the cart if left unlocked and unattended.Attempted an interview on 5/6/2026 with the DON, but she was out of the facility.During an interview on 5/6/2026 at 9:30 am, the ADON said she had been employed at the facility since December 2025. She said nurse medication/treatment carts should always be locked. She said the person responsible for the cart should have the keys in their possession and never leave the carts unattended. She said residents could get access to all the things in the carts if they were left unlocked and unattended.During an interview on 5/6/2026 at 10:52 am, the Administrator said carts should always be locked and not left unattended due to safety issues. He said he expected the staff to follow policy.Record review of a facility policy titled Medication Labeling and Storage revised February 2023 indicated, .The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys .

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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 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 2 of 5 staff (Treatment Nurse and LVN B) reviewed for infection control.The facility failed to ensure the Treatment Nurse did not touch clean items with dirty gloves when wound care was provided to Resident #48 on 5/4/2026.The facility failed to ensure LVN B wore a gown during high-contact resident care activities for Resident #48 on 5/5/2026.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 #48 dated 5/6/2026 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of type 2 diabetes, Parkinson's disease (movement disorder of the nervous system that worsens over time), and neuromuscular dysfunction of bladder (nerve damage or injuries that causes loss of control of the bladder).Record review of active physician orders for Resident #48 dated 5/5/2026 indicated an order for NPWT to sacral wound (wound on the tailbone) at 125 mmhg every day shift for wound care that started on 3/30/2026.Record review of an Annual MDS Assessment for Resident #48 dated 3/6/2026 indicated she did not have any impairment in cognition with a BIMS score of 13. She had an indwelling catheter (tube placed in the bladder to drain the bladder) and an ostomy (an opening in the abdomen that allows waste to exit the body). She had a surgical wound.Record review of a care plan for Resident #48 dated 4/22/2026 indicated she had the potential/actual impairment to skin integrity due to surgical wound to sacrum. There was not a care plan for the wound vac or interventions. During an observation on 5/4/2026 at 3:04 pm, the Treatment Nurse and MA A were in the room of Resident #48 to provide wound care. The Treatment Nurse sanitized her hands and donned (put on) a gown and cleaned an overbed table and placed wax paper down. The Treatment Nurse placed the wound supplies on the overbed table and entered the room. MA A washed her hands in the room and donned a gown and put on gloves. MA A assisted Resident #48 on her right side. The Treatment Nurse removed the dressing that was noted to Resident #48's sacrum and placed it in the trash with her gloves. The Treatment Nurse sanitized her hands and put on clean gloves. The Treatment Nurse cleaned the wound with normal saline and 4x4 gauze and placed the gauze in the trash. The Treatment Nurse patted the wound dry with 4x4 gauze and removed her gloves and placed them in the trash. The Treatment Nurse washed her hands in the bathroom and put on clean gloves. The Treatment Nurse applied skin prep to peri wound (area around the wound). The Treatment Nurse applied a foam dressing in the wound bed and placed a strip of foam as a bridge to Resident #48's hip area. The Treatment Nurse removed her gloves and placed them in the trash and sanitized her hands. The Treatment Nurse put on clean gloves and placed a dressing on the wound for vacuum suction. The Treatment Nurse removed the brief from underneath Resident #48's buttocks and placed it in the trash. The Treatment Nurse touched a clean brief and placed it underneath Resident #48's buttocks. The Treatment Nurse picked up the wound vac that was in a chair in the room and attached a cannister to the wound vac and turned it on. Resident #48 was repositioned in bed. The Treatment Nurse doffed (took off) her gown and gloves and placed them in the trash and removed the trash from the room. MA A doffed her gown and gloves and washed her hands. The Treatment Nurse exited the room and placed the trash in the soiled linen utility room. The Treatment Nurse reentered Resident #48's room and washed her hands in the bathroom.During an interview on 5/4/2026 at 3:28 pm, the Treatment Nurse said during the wound care that was provided to Resident #48, she should have changed her gloves and sanitized her hands before she touched the wound vac. She said there was a risk of spreading infections if she touched clean items with dirty gloves. She said she should not have touched the clean brief with dirty gloves. During an observation on 5/5/26 at 8:00 am LVN B was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed administering an IV antibiotic, which included flushing a PICC line for Resident #44. An enhanced barrier precautions sign was observed posted inside Resident #44's room. LVN B did not wear a gown for enhanced barrier precautions while flushing the PICC line or connecting the tubing for the IV antibiotic.During an interview on 5/5/26 at 8:20 am LVN B said she forgot to put the gown on. She said she knew the resident was on enhanced barrier precautions because she had a foley catheter, an open wound, and a PICC line. She said it was an infection control issue.During an interview on 5/6/2026 at 9:30 am, the ADON said she had been employed at the facility since December 2025. She said she was the IP for the facility. She said she trained staff monthly on infection control that included hand washing. She said she monitored the staff daily to ensure they were following infection control measures. She said the staff were trained on hire, annually and as needed. She said hand hygiene should be done before and after care, and when hands were visibly soiled. She said staff should never touch clean items with dirty gloves or clean equipment. She said she expected her staff to follow protocols for infection control including enhanced barrier precautions. She said she will be providing more education and in-services going forward to ensure staff were compliant. She said there was a risk for infections.Attempted an interview on 5/6/2026 with the DON, she was out of the facility.During an interview on 5/6/2026 at 10:52 am, the Administrator said staff should perform hand hygiene before and after care. He said he expected his staff to follow proper protocols related to infection control and enhanced barrier precautions. He said he would be providing further education for staff going forward to ensure compliance. He said residents could be at risk of cross contamination and if enhanced barrier precautions were not followed.Record review of a facility policy titled Enhanced Barrier Precautions dated December 2024 read: .Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities . and .Enhanced barrier precautions apply when .b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions or excretions that are unable to be covered or contained . and .Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheostomies. Peripheral IV catheters are not considered an indwelling medical device for purposes of EBPs . and .EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply . and .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: .i. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.) .Record review of a facility policy titled Handwashing/Hand Hygiene revised October 2023 indicated, .This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Indications for hand hygiene: c. After contact with blood, body fluids, or contamination surfaces; f. before moving from work on a soiled body site to a clean body site on the same resident .