STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455573	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Texoma Healthcare Center	1000 Hwy 82 E Sherman, TX 75090

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for two of seven residents (Residents #2 and Resident #3) reviewed for ADL care. The facility failed to ensure staff provided consistent showers/baths for Resident #2 and Resident #3. This failure could place residents at risk of not receiving needed hygiene care which could cause skin breakdown, a loss of dignity and self-worth. Findings include: 1. Record review of Resident #2's Quarterly MDS assessment, dated 07/29/24, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. She had a BIMS score of 12, which indicated she was moderately cognitively impaired. She had not rejected care and required substantial to maximum assistance with showers and baths. Her active diagnoses included a cerebral vascular accident (stroke) and aftercare following joint replacement surgery. Record review of Resident #2's care plan, reviewed on 03/22/24, reflected, .The resident has an ADL Self Care performance deficit due to weakness, debility related to right hip arthroplasty (hip replacement) . Interventions . Bathing: requires staff x 1 for assistance . Record review of hall D's shower schedule, updated on 07/04/24, reflected Resident #2 was scheduled for a shower on Tuesday's, Thursday's, and Saturdays on the 2 p.m. to 10 p.m. shift. Record review of Resident #2's ADL documentation survey report for July 2024 reflected no showers on scheduled days for 07/02/24, 07/04/24, 07/09/24, 07/11/24, 07/13/24, 07/16/24, 07/18/24, 07/23/24,07/25/24, 07/27/24 and 07/30/24. In an interview with Resident #2 on 07/30/24 at 2:15 p.m. she stated she had gone over 2 weeks without getting a shower. She stated the aides will tell you they do not have enough towels or wash cloths or will tell you they will have to get to you later. She stated she started keeping some extra linen in her room so she could take a spit bath. She stated she did get a shower last weekend (07/27/24). She stated she had never been offered a shower three times a week since she had been here and would like to have her showers as scheduled. (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: 455573	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Texoma Healthcare Center	1000 Hwy 82 E Sherman, TX 75090

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow up interview with Resident #2 on 08/01/24 at 08:30 a.m. she stated she was not provided nor offered a shower on 07/30/24, her scheduled shower day. She stated she just sponged off the best she could. In an interview with NA H on 08/01/24 at 11:15 a.m. revealed she was assigned to Resident #2 on 07/30/24. She first stated Resident #2 had refused her shower, but then stated she was told by NA I she had refused her shower. She stated she had not asked or offered Resident #2 a shower. She stated she had not informed the Charge Nurse that Resident #2 had not received her shower. She stated they were supposed to document showers given and or refused in the electronic record and stated she thought she had documented in the resident's record. 2. Record review of Resident #3's Annual MDS assessment, dated 05/07/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. He had a BIMS score of 7, which indicated he was severely cognitively impaired. He had not rejected care and required substantial to maximum assistance with showers and baths. His active diagnoses included dementia and urgency of urination. Record review of Resident #3's care plan, reviewed on 04/15/24, reflected, .The resident has an ADL Self Care performance deficit due to weakness, debility and cognitive decline related to dementia and chronic kidney disease .Interventions . Bathing: requires staff x 1 for assistance . Record review of hall A's shower schedule, updated on 07/04/24, reflected Resident #3 was scheduled for a shower on Monday, Wednesday, and Friday on the 6 a.m. to 2 p.m. shift. Record review of Resident #3's ADL documentation survey report for July 2024 reflected no showers on scheduled days for 07/01/24, 07/03/24, 07/05/24, 07/08/24, 07/10/24, 07/12/24, 07/15/24, 07/17/24, 07/19/24, 07/22/24, 07/26/24, 07/29/24 and 07/31/24. He had received one bed bath on 07/24/24 according to the record. In an interview with Resident #3 on 07/30/24 at 02:20 p.m. he stated he was not getting his showers. He stated the last time he got a shower was last Wednesday (07/24/24). He stated he was supposed to get his showers on Monday, Wednesday, and Fridays. He stated he would like to have his showers as scheduled. In an observation and interview with Resident #3 on 07/31/24 at 02:45 p.m. resident was sitting in his wheelchair in the dining room eating popcorn. He stated he had not received his shower today on the day shift. He stated he was not sure if he was going to get a shower this evening or not. In an observation and interview with Resident #3 on 08/01/24 at 08:15 a.m. resident was observed in his room in bed. Resident was wearing the same shirt he was observed in on 07/31/24. Resident #3 stated he did not get his shower yesterday (07/31/24), but stated his roommate got his. He stated he did not know why they did not give him his shower. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Texoma Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Hwy 82 E Sherman, TX 75090	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with NA F on 08/01/24 at 9:20 a.m. revealed she and NA G were assigned to Hall A on 07/31/24. She stated they had split the showers that were scheduled, and NA G was supposed to shower Resident #3. She stated they were supposed to let the charge nurse know if someone refused a shower or if they did not give a shower. She stated they had missed some showers in the past when they were short of linens but stated it did not happen very often. She stated if she did not get to a shower then she would let the oncoming aide know so they could try and give the shower. She stated she was not sure why Resident #3 did not get his shower. In an interview with NA G on 08/01/24 at 9:36 a.m. she stated she was assigned to Hall A on 07/31/24 but was working the opposite side and assumed NA F was giving Resident #3's shower. She stated she was not aware there had been a problem with him getting his showers. She stated she had given him showers in the past but admitted she had not documented them. She stated she could not recall when the last time she had given Resident #3 a shower. In an interview with LVN E on 08/01/24 at 11:30 a.m., she stated they were responsible for ensuring the resident's showers and ADL care were performed. She stated the CNAs were supposed to let them know if a resident refused ADL care or if they were unable to give the scheduled shower or bath. She stated she had not been notified by any of the CNAs that Resident #3 refused any of his showers or that any had been missed. In an interview with the DON on 08/01/24 at 11:40 a.m. she stated Residents were supposed to get showers according to the scheduled shower days and documented in the record, and it was the responsibility of the CNAs and the Charge nurse to make sure residents got their showers. She stated if a resident refused to take a shower it should be documented in the electronic record and should include the attempt by the staff member to find out why the resident refused a shower, and what was done about it. The DON stated the risk to Residents not getting their showers were skin issues, hygiene, and loss of dignity. Record review of the facility's undated policy titled, Bath, Tub/shower, reflected, .The frequency and type of bathing depends on resident preference, skin condition, tolerance, and energy level. Although a daily bath or shower is preferred and necessary for some, the aging skin can be maintained by bathing every two day or with partial bathing as needed .Goal .The resident will experience improved comfort and cleanliness by bathing .The resident will maintain intact skin integrity .The resident will be free from soil, odor, dryness, and purities following bathing .

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NAME OF PROVIDER OR SUPPLIER Texoma Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Hwy 82 E Sherman, TX 75090	

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one of three (Resident #1) residents reviewed for pharmacy services. The Facility failed to ensure Facility staff ordered medications in a timely manner for Resident #1 upon his admission on 07/23/24 which resulted in missed doses of Anastrozole 1 mg, Liothyronine Sodium 5 mg, Bupriopion HCL ER 150 mg, Cefadroxil 500 mg and Propranolol HCL 20 mg on 07/24/24. This failure placed the residents at risk of not receiving medications as ordered by the physician and a delay in treatment and worsening of their condition. Findings included: Review of Resident #1's Face Sheet dated 07/31/2024 reflected a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included hypertension (high blood pressure) hypothyroidism (deficiency of the thyroid gland), methicillin susceptible staphylococcus aures infection (bacterial infection), and post-traumatic stress disorder(anxiety disorder that can come from a traumatic event). Review of Resident #1's 5-day MDS assessment dated [DATE] reflected Resident #1 had BIMS score of 04 which indicated he was severely cognitively impaired. The 5-day assessment reflected the resident had a personal history of malignant neoplasm. Review of Resident #1's Comprehensive Care Plan dated 04/20/2024 reflected Resident #1 had hypertension, required antidepressant medication, had hypothyroidism, had a cellulitis infection of the left knee, and took oral chemotherapy medication. The interventions all included administer medications as per MD orders. Review of Resident #1's Physician Order recap report dated 07/31/24 reflected, .Anastrozole 1mg (Hormone based chemotherapy) 1 tablet by mouth one time a day .Liothyronine sodium 5 mg (thyroid hormone) one table by mouth, Bupriopion HCL ER 150 mg (antidepressant) one tablet two times a day, Cefadroxil 500 mg (antibiotic) 1 tablet twice a day and Propranolol HCL 20 mg (antihypertensive) 1 tablet two times a day . all with a start date of 07/24/24. Record review of Resident #1's MAR for July 2024 reflected on 07/25/24 the AM administration for Anastrozole 1mg, Liothyronine sodium 5 mg, Bupriopion HCL ER 150 mg, Cefadroxil 500 mg, and Propranolol HCL 20 mg were all coded as 9 (which indicated not available) by RN B. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with RN B on 07/30/24 at 12:00 p.m. stated Resident #1 admitted to the facility on [DATE] around 07:00 p.m. She stated the pharmacy closed at 05:00 p.m. so any admission after 5 p.m. they must use medications out of the E-Kit. She stated when she went to pass Resident #1's a.m. medication on 07/25/24, none of his medications had arrived at the facility. She stated she checked the E-Kit and retrieved the medication she could, but Anastrozole 1mg, Liothyronine sodium 5 mg, Bupriopion HCL ER 150 mg, Cefadroxil 500 mg, and Propranolol HCL 20 mg were not available not in the E-Kit. She stated she coded those medications as 9 on the MAR to reflect the medication was not available to be administered. She stated she contacted the pharmacy to ensure the medication had been ordered. She stated the pharmacy indicated they would be sent out later that day. She stated the medications did not come in before her shift ended at 06:00 p.m. on 07/24/24. She stated the Nurse Practitioner saw Resident #1 on 07/24/24 and she had informed her of the missed medications. In an interview with the Facility's contracted pharmacy on 07/31/24 at 8:45 a.m. it was revealed the facility had faxed orders to the pharmacy on 07/23/24 but had not called. The pharmacy representative stated the procedure for any order for new medications that was submitted after 05:00 p.m. the facility had to fax the orders as well as call to make sure the medications were filled timely. She stated they had some medications in the E-kit the facility can utilize if a medication is needed before they can get it to the facility, but stated there were a limited number of medications available through the E-Kit. She stated they also had contracted pharmacy that they can reach out to so the facility could go locally and pick up a medication. She stated if they call after hours, they can sometimes get the medication to the facility on the late evening delivery. She stated if the facility does not call then the orders were processed as a routine order and not a stat order. In an interview with RN D on 07/31/24 at 9:35 a.m. she stated on all new admission they call the MD and review the discharge orders from the hospital and verify the medications. She stated once the medications were verified by the physician, they send the orders to the pharmacy. She stated if it was after hours, she also calls the pharmacy. She stated if a resident needed a medication before the pharmacy delivered the medication, she would get it out the E-Kit if available and if it was not, she would contact the physician for further instructions. In an interview with the DON on 07/31/24 at 10:45 a.m., the DON stated the facility had recently changed pharmacy's and were still getting used to the process. She stated the pharmacy procedure for any new medication ordered after the pharmacy had closed, the staff was to fax over the orders and then call the on-call pharmacist to ensure the medication was filled timely. The DON further added if the resident did not have their medications as ordered, their condition could get worse. She stated the pharmacy procedure was posted at each of the nurse's stations and it outlines the ordering protocol. Record review of the facility's undated policy, Ordering Medications, reflected, Medications and related products are received from the pharmacy supplier on a timely basis .Medication orders are phoned or faxed to the pharmacy and written on a mediation order form provided by the pharmacy for that purpose of the physicism order form .New Medications .If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform pharmacy of the need for prompt delivery and request delivery. Use the emergency kit when the resident needs a medication prior to pharmacy delivery. If not in the emergency kit, contact the pharmacy for possible local pharmacy to fill enough of the medication until the next scheduled delivery .