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	11/13/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49415 Based on interview and record review, the facility failed to immediately notify the resident's representative, consistent with his or her authority, when there was a significant change in the resident's physical, mental, or psychosocial status for 1 (Resident #1) of 3 residents reviewed for notification of changes in condition. The facility failed to ensure Resident #1's resident representative was immediately notified when the resident had a change in condition that required Resident #1 to be transported via ambulance to the hospital due to him being unresponsive. This failure could result in resident representatives not being able to make important medical decisions regarding their family member. Findings included: Record Review of Resident #1's face sheet, dated 11/1/24, revealed the resident was a [AGE] year-old male and was admitted to the facility on [DATE] from an acute care hospital. Diagnoses included: Cerebral Infarction due to Embolism of Cerebral Artery (refers to a stroke where a blood clot (embolus) travels from another part of the body and blocks a blood vessel in the brain, causing a localized area of brain tissue to die off due to lack of oxygen supply (infarction), Metabolic Encephalopathy (a brain disorder that occurs when an underlying condition causes a chemical imbalance in the blood that affects the brain), Primary Hypertension (a condition in which the force of the blood against the artery walls is too high), Monoplegia (causes paralysis or weakness in a single limb) of Upper Limb Affecting Right Dominant Side, Post Traumatic Seizures (seizures that occur after a traumatic brain injury), Diabetes Mellitus Due to Underlying Condition with Hypoglycemia without Coma (occurs when someone with diabetes does not have enough sugar in his/her blood), Expressive Language Disorder (a condition where people can understand what others are saying but have a hard time expressing their own ideas when they speak), Chronic Obstructive Pulmonary Disease/COPD (a group of lung diseases that block airflow and make it difficult to breathe), Chronic Kidney Disease Stage 3 (when kidneys are mildly to moderately damaged, making it harder for them to filter waste from the blood), Altered Mental Status (a general term for a change in how well the brain is working). (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #1's admissions MDS assessment dated [DATE] revealed a BIMS score of 00 which indicated severe cognitive impairment. The MDS showed it was very important for Resident #1 to have family or a close friend involved in discussions about his care. Also, Resident #1 was unable to respond to most questions on the MDS. Furthermore, he used a wheelchair and was dependent for all ADLs and he coughed or choked during meals. Record Review of Resident #1's Care Plan dated 11/1/24 showed resident had a pressure ulcer or potential for a pressure ulcer development. Also, Resident #1 required antidepressant medication and had a communication problem. Furthermore, Resident #1 had an ADL Self Care Performance Deficit. Record Review of Resident #1's Nursing Progress Notes revealed RN-A documented on 11/8/24 at 5:13 p. m. that on 11/8/24 at 4:55 p.m. she Noted resident somulent [sic], not arousing to voice and minimally responsive to tactile stimuli . Phone call to Dr [physician's name] who agrees to 911 to hospital for evaluation of change of condition. Verbal report given to 911 paramedics at 1705 [5:05 p.m.]. Interview on 11/13/24 at 12:17 p.m. with Resident #1's RR, she stated she was not informed by the facility Resident #1 went to the hospital until Monday, 11/11/24 by email. RR stated the hospital had contacted her and let her know Resident #1 was in the hospital. She stated Resident #1 was still in the hospital and was not doing well. She said her father was put on a ventilator, his sodium and blood sugar levels were off and he had an elevated white blood count. The RR stated the hospital asked her to sign a Do Not Resuscitate Order because they did not feel Resident #1 would make it. Interview on 11/13/24 at 2:41 p.m. with RN-A stated Resident #1 was somnolent (drowsy or inclined to sleep), had a lack of response on 11/8/24. She assessed Resident #1 by checking his vital signs and she called the doctor. She stated the doctor agreed to call 911. RN-A stated Resident #1 had lunch with his needed assistance due to cognitive problems and a risk of aspiration. She stated a CNA had fed Resident #1 lunch. RN-A said Resident #1 was his usual self-prior to her finding him somnolent. RN-A stated she was responsible for notifying the family. She did usually contact the family to let them know a resident had been sent out. She would call the family by phone and leave a voice mail asking for a call back if they did not answer. However, she stated she did not contact the family regarding Resident #1 being sent out to the hospital. RN-A it was the end of her shift on a Friday, she was tired, hungry, needed to go to the bathroom and just simply forgot to notify the family. She was off Saturday and Sunday but returned on Monday and found out someone had emailed the family. RN-A said they do abuse/neglect training at least once a month. Interview on 11/13/24 at 2:52 p.m. with CNA-B stated they did abuse/neglect training once a month. She stated if a resident had a change of condition, she would report it to the charge nurse right away. Interview on 11/13/24 at 2:56 p.m. with CNA-C stated they did abuse/neglect training at least once a month or more. She would report to the head nurse if a resident had a change in condition. Interview on 11/13/24 at 4:26 p.m. with ADON-D stated Resident #1 was discharged to the hospital on 11/8/24. Resident #1 was somnolent, had respiratory issues and was admitted to the hospital. The family was not notified by the facility, but they should have been that day. The hospital notified RR that Resident #1 was admitted to the hospital. ADON-D said the facility normally notified family if a resident went to the hospital. ADON stated the resident could have passed without the family knowing due the facility not notifying the family he was sent to the hospital non-responsive. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of the facility's Abuse/Neglect Policy, undated stated The facility will provide and ensure the promotion and protection of resident rights. Record Review of the facility's Family Notification Policy under Social Services Manual dated 2003, revealed: Objectives: 1. To keep families informed. Procedures: 1. The family will be notified of any resident change, i.e., . 2.Health problem . 2. Each resident, and/or family representative is asked to give a list of family members who can be contacted in a case of emergency or urgency. 3. Notification will occur in a timely manner 4. All current family names, telephone numbers, and locations for notification purposes will be kept in the residents' chart. Record Review of the facility's Resident Rights Policy, undated, under Planning and implementing care revealed The resident has the right to be informed of, and participate in, his or her treatment, including .The right to be informed, in advance, of changes to the plan of care. Also, under Information and Communication Notification of changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative (s), when there is- .A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment);. Record Review of the facility's Nursing Policy & Procedure Manual effective 12/2017 revised 4/10/2024, under Discharge or Transfer to another Facility and under subtitle Emergency Transfer revealed When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer will be provided to the resident and the resident representative as soon as practicable. Record Review of the facility's SBAR (Situation, Background, Assessment and Recommendation) Policy, undated revealed the facility is to Notify the family of all new orders and changes in condition and document notification.