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	06/18/2025

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 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the right to a dignified existence and self-determination facility for 1 of 9 (Resident #1) residents reviewed for resident rights. The facility failed to ensure Resident #1 was treated with respect and dignity when she refused a shower on 05/21/25 around 9:30 PM and was showered despite her refusals by CNA A. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth, psychosocial harm and distrust with staff. The noncompliance was identified as Immediate Jeopardy Past Noncompliance (PNC). The Immediate Jeopardy began on 05/21/25 at 9:30 PM and ended on 05/28/25. The facility had taken actions noted in the findings that corrected the noncompliance before the incident investigation began on 06/17/25. Findings included: Review of Resident #1's Quarterly MDS, dated [DATE], reflected she was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. She had the diagnoses of Chronic Obstructive Pulmonary Disease (COPD) with acute exacerbation (a lung disease with a sudden worsening symptoms including breathlessness, mucus, and cough), Alzheimer's disease (loss of cognition), chronic pain syndrome, and anxiety disorder (excessive or persistent worry or fear). Her BIMS score was a 5 (severely impaired cognition). Further review of Section GG-Functional Abilities reflected she usually required substantial/maximal assistance for bed to chair transfers. Record review of Resident #1's care plan reflected the resident had an activity of daily living (ADL) performance deficit and required one staff to assist with bathing and bed mobility, dated initiated 02/13/25. Further review reflected a focus area, dated initiated 05/23/25, The resident has a history of trauma that may have a negative impact. The trauma is [due to]: Feeling angry [due to] shower being done after she refused. Interventions included: .If resident refuses her shower stop immediately . If the resident has escalated, if at all possible do not touch the resident unless absolutely necessary for resident's or others safety ., dated initiated 05/23/25. Record review of Resident #2's Quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. She had the diagnoses of cancer, heart failure, stroke with paralysis on her left non-dominant side, and major depression disorder (persistent feelings of sadness). Her BIMS score was a 7 (severely impaired cognition). (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 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #2's care plan reflected the resident had impaired cognitive function/dementia or impaired thought processes; interventions included .Use residents preferred name . face the resident when speaking .Provide the resident with necessary cues- stop and return if agitated ., dated initiated 10/07/24. Record review of the Provider Investigation Report (PIR) (Form 3613-A of Texas Health and Human Services) reflected an incident date and time of 05/21/25 at 9:30 PM, dated reported 05/22/25 at 10:15 AM and signed by the Administrator on 05/28/25. Further review revealed on 05/21/25 around 8:40 AM, Resident #1 told her nurse that she needed to talk to someone in charge because she was upset about her care last night. Further review revealed on 05/21/25 around 9:30 PM Resident #1 told CNA A several times she did not want a shower and without Resident #1's consent, CNA A physically lifted Resident #1 from the armpits from the bed into the shower chair and Resident #1 was given a shower by CNA A and CNA B. Resident #1 did not have a history of similar allegations and was interviewable and had the capacity to make informed decisions. Resident #1 had a head-to-toe assessment on 05/22/25 at 10 AM and had no injuries. The facility immediately suspended CNA A and CNA B and obtained interviews from both CNA's and Resident #1, completed resident safe surveys on 05/22/25 with no other concerns, and started staff monitoring for 4 weeks (05/22/25-06/18/25). Staff were in-serviced on resident rights, including a resident's right to refuse a shower, and trauma informed care on 05/22/25. Record review of Resident #1's verbal statement written by the Administrator, undated, reflected that two CNA's came to her room to take her to the shower and she told them she did not want a shower and she was cold: Two aides came into my room to take me to the shower . I told them that I am cold and don't want a shower. [CNA A] said you are getting a shower tonight. I was begging to not get a shower and told her to stop and go away. They grabbed me by my wrist and pulled me up to put me in the chair. The first shower was cold and then she put me in the other shower[,] it was fine [the shower water temperature] but I kept saying I did not want a shower. [They] put me in the shower and started washing me. Barely gave me a towel to dry off and put me in a gown took me back to my room and put me to bed. I just did not like it. Record review of CNA A's verbal statement, undated, written by the Administrator reflected the following: .(Resident #1) was like do I even have to have a shower and I said yes you will feel better. She was being like her energy was she did not want a shower . Did she have an attitude? Yes, but she got a shower and will feel better. I picked her up under her armpits slid back in chair and took her to the shower room. When asked how many times did (Resident #1) say she did not want a shower? Her response was twice and I told her she would feel better after her shower . Do you know that [residents] have the right to refuse a shower? Yes, knows about the papers and getting a nurse to assist with refusal of showers. Record review of resident safe surveys, dated 05/22/25 reflected Resident #1 safe survey: 1. Do you feel safe at this facility: 'Yes and No' (continued on next page)

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F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nursing progress note dated 05/22/25 at 11:18 AM written by ADON D reflected Resident #1's physician was notified about the bruising to the resident's abdomen at 11 AM and the resident was their own responsible party, and there were no new orders and the resident was encouraged to avoid grabbing or pushing on her abdomen when coughing and reminded to call nursing if she had any pain or increased coughing so that PRN medications would be given. A nursing progress note dated 05/22/25 at 12:33 PM written by ADON D reflected a title of Event-Other reflected Resident #1's vitals were checked with no concerns and her cognition was oriented/no problem, she had no pain or injury and included the following Resident reported to Charge Nurse an incident that happened last night. Resident stated that 2 CNA Staff grabbed her by the wrist, put her on the shower chair and took her to the shower room even though [resident] told the CNAs that she is not feeling well multiple times .Resident Statement: Last night 2 ladies came to my room, one of them is big, the other is tiny. They asked me to shower but I refused. They grabbed me by my wrist, put me on the chair then took me to the shower room . ADON D notified Resident #1's physician on 05/22/25 at 9 AM, and there were no new orders. Resident #1 was their own representative with a date and time of notification as 05/22/25 at 8:45 AM, and the Administrator was notified. A social services progress note, dated 05/22/25 at 3:56 PM, written by the Social Worker: This [Social Worker] met w/ resident Re: complaint of two female staff that reportedly made resident participate in a shower when she verbally declined. Resident requested that these two female staff not be assigned to her again. [The Administrator] informed this [Social Worker] that both female staff have been removed from this facility permanently. This [Social Worker] assured resident that she would not encounter these two female staff in this facility again. This [Social Worker] also reached out to [the Psychologist] to request a post trauma follow up visit with resident as soon as possible. A nursing progress note dated 05/23/25 at 11:32 AM, written by the Social Worker, reflected she assisted Resident #1 with a post trauma therapeutic call with resident and [the Psychologist]. A general progress note dated 05/23/25 at 5:23 PM written by the Psychologist: (Resident #1) is a participant in a telehealth appointment per administrator request in regard to an incident that occurred Thursday (05/22/25). This patient is consulted with via phone assisted by the facility social worker. (Resident #1) is AOx4 [alert and oriented to person, place, time, and event] and able to articulate said needs. patient reported to me that yesterday she was feeling ill and had been in pain due to her couching and COPD symptomology. she reported that two aids came in to give her a shower and she requested to be left alone today, that she did not feel up to taking shower. she proceeded to explain to me one aid grabbed my right arm, and one grabbed my left arm and pulled me out of bed and into a shower chair. I said to them, I'm hurting and do not want a shower. they said to me you will be getting one regardless. the administrator was alerted promptly that patient requested to meet with who was in charge of facility. the administrator suspended both employees immediately pending further investigation. Patient was very happy and appeased to hear employees were suspended and said she does feel safe in building. she admits the incident was very upsetting to her when it occurred. she said when she returned to her room, she was not assisted by the two employees . (continued on next page)

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F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an observation and interview on 06/17/25 at 11:55 AM with Resident #1's roommate, Resident # 2, she was lying in bed and stated that about a month ago, she heard a female staff member come into their room, the privacy curtain was closed so she did not see who the staff member was and could hear the exchange. Resident #2 stated the staff member told Resident #1 it was time for her shower and Resident #1 responded that she did not want to take a shower- she did not feel good and had pain, and the staff member told Resident #1 that she was getting up for a shower. She stated it was exactly as Resident #1 described it, that was what she heard. She stated she did not think it was right that Resident #1 was made to get up and shower and no one had forced Resident #2 to take a shower or forced her to get up. She stated there are shower sheets residents sign when residents refused to take a shower. She stated she felt safe at the facility and understood her rights including her right to refuse a shower. In an interview on 06/17/25 at 12:10 PM with LVN C she stated that she was a charge nurse for Resident #1's hall. She stated she was in-serviced on the types of abuse and neglect including who to report to and resident rights including the resident's right to refuse a shower on 05/22/25 and did not work with Resident #1 until a day or two after the incident and when she saw Resident #1 next, her hair was knotted, and she was upset. She said Resident #1 told her that she was made to take a shower by staff when she did not want to take a shower. She stated that Resident #1 commonly refused showers and she offered to brush out her hair and Resident #1 let her brush her hair. She stated resident's had the right to refuse a shower and physically picking up a resident and showering them despite their refusals a violation of the resident's rights. In an interview on 06/17/25 at 12:45 PM with ADON D she stated she received a phone call from staff who relayed what Resident #1 had said about being forced to take a shower and she instructed staff to also contact the Administrator immediately. ADON D stated that she completed a head-to-toe assessment of Resident #1 on 05/22/25 and there were no bruises on her wrist, a small bruise on her forearm, and she had an unrelated bruise to the side of her abdomen. ADON D stated Resident #1 told her the bruise was on her abdomen was due to Resident #1 pushing on her side while coughing and she was sent out the same day due to an increase in COPD symptoms. ADON D stated she completed a trauma assessment and Resident #1 expressed she was still very angry about the incident, and she was referred to counseling services. She stated that in a conference call with one of the CNA's and the Administrator CNA A or CNA B said something like she needed a shower anyway. ADON D stated she considered the incident to be a violation of the resident's rights because residents had the right to refuse a shower and it could have caused physical or mental harm to the resident. Attempts to interview CNA A via phone on 06/17/25 at 1:44 PM and on 06/18/25 at 12:46 PM were unsuccessful with a disconnected dial tone. In an interview on 06/17/25 at 2:10 PM with the Social Worker she stated she spoke with Resident #1 with the Administrator on 05/22/25 and told them that there were aides that got her ready for a shower despite her telling them she did not want a shower. The Social Worker stated Resident #1 was very distraught when talking about the incident and she told Resident #1 that a psychologist was going to come in and meet with her. She stated that the Administrator had said in a morning meeting that the employees were not going to come back to the facility. She stated that she considered the incident Resident #1 described as a violation of the resident's rights and residents had the right to refuse a shower. She stated that Resident #1 seemed to be fine now and she met with her about a week after on 05/30/25 and she did not indicate she was still upset about the shower. (continued on next page)

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F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/17/25 at 3:49 PM with CNA B she stated that on the evening of 05/21/25 CNA A flagged her down and asked for help with showering Resident #1. She stated did not assist CNA A in getting the resident out of bed was they were already in the shower room at the time she was asked to be a witness. CNA B states when she entered the shower room Resident #1 was in the shower room and said multiple times she was going to call her lawyers, CNA A told CNA B that Resident #1 had been saying that since CNA A had gotten her up. CNA B stated she took the residents hair out of a ponytail and washed and conditioned her hair- she had a big knot in her hair and refused CNA B to brush it and said she was going to do it herself. CNA B stated she assisted with washing Resident #1 and dried her off and CNA A took her to her room. CNA B stated she had not worked with Resident #1 before and thought she was demented. When given a scenario of a resident who did not want to get up for a shower and was showered despite their refusals, CNA A stated that would be a violation of the resident right's. She stated she would have intervened and told her nurse and the Abuse Coordinator who was the Administrator immediately. She stated residents had the right to refuse a shower. She stated she was called by the Administrator on 05/22/25, was informed she was suspended pending the investigation and gave her statement, she no longer worked at the facility. In an interview on 06/17/25 at 4:10 PM with a family member of Resident #1, she stated Resident #1 called her the day the incident happened and told her she was forced to take a shower and sounded very angry. She stated that Resident #1 is her own representative and she had not spoken with the administrator or Resident #1 about the incident since it occurred. In an interview on 06/17/25 at 4:41 PM with the Psychologist she stated she received a phone call from the Administrator last month around 05/22/25 and was told an incident had occurred and was asked to come see the resident because it seemed very important. The Psychologist stated the Social Worker assisted in a telehealth visit via phone because she was out of town an unable to visit in person. She stated Resident #1 seemed very with it, sounded alert and oriented, and told her that aides had pulled her by the wrist from her bed and one aide told her you're going to get a shower today no matter what despite her telling them that she was hurting and did not want the aides back. The Psychologist stated that their call was cut short because Resident #1 was going to the hospital related to their COPD and increased coughing and she followed up with Resident #1 the following week and Resident #1 had concerns of the aides not coming back to the facility. The Psychologist stated she reassured Resident #1 that the aides were not coming back and she felt better. She stated that a resident being showered despite their refusals was a violation of their rights because they had the right to refuse a shower. (continued on next page)

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F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/17/25 at 6:10 PM with LVN F he stated he was the charge nurse for Resident #1's hall on the evening shift (6 PM-6 AM) 05/21/25. He stated he was familiar with Resident #1 and had worked with her when she was on the rehabilitation side of the facility. He stated that Resident #1 used to be a nurse and she did not want to be a bother to anyone and was particular about her care. He stated that at the beginning of the shift on 05/21/25, he was passing medications to residents and did not hear anything at the time but did notice she was not in her room and was pleasantly surprised that she had gotten up to take a shower because she typically did not want to get out of bed- she had a cough for a while and was not feeling well. He stated that he saw her later and her hair was still a little wet and she complained that they gave her a shower and left her hair damp. He stated that Resident #1 and seemed focused on her hair and he wanted to make her comfortable so he offered to look for a hair dryer to dry her hair. He stated that CNA A only told him that she got her to take a shower. He stated Resident #1 did not disclose to him anything about what had happened and neither CNA told him anything other than she CNA A said she got a shower, and he found out the following day and was in-serviced on 05/22/25 on resident rights including the right to refuse showers, and trauma informed care. He stated that if he had known what had happened he would have immediately ensured the resident felt safe, ensured the CNA did not provide her any care, and would have contacted the Administrator who was the abuse coordinator. He stated that giving a resident a shower despite their refusals could have caused physical or mental harm to the resident. LVN F stated that residents had the right to refuse showers. He stated the facility was the residents home, and if they are home they might not want anyone to get them up or to take a shower. In an interview on 06/18/25 at 9:28 AM with the Regional Compliance Nurse, she stated that she was contacted by the Administrator on 05/22/25 regarding an allegation of abuse. She stated that she assisted the Administrator via phone to ensure they followed their abuse and neglect policy. She stated that the Administrator suspended the two employees (CNA A & CNA B) pending the investigation and she updated Resident #1's care plan due to her anger at being made to shower despite her refusals. She stated that the facility's policy was to update the resident's care plan to indicate a traumatic event occurred and did not think Resident #1 had lasting trauma due to the incident and it was care planned as a trauma event due to the resident's expression of anger and to ensure staff were aware how to care for the resident and to stop immediately if the resident refused a shower. She stated showering a resident despite their refusals was a violation of the resident rights and could have caused physical and psychosocial harm to the resident. In an interview on 06/18/25 at 11:28 AM with LVN I revealed Resident #1 typically stayed in her bed and sometimes would ask to get up. She stated on 05/22/25 during her rounds, Resident #1 appeared furious told her that the previous night (05/21/25), two girls came into Resident #1's room and told her it was her shower day, she refused, and they picked her up anyway and took her to the shower room and washed her, and said she was going to sue the aides. LVN I stated Resident #1 stated that the aides picked her up by the wrists and looked at her wrists and saw no marks or bruising, made sure she was okay, and told the resident she was going to get someone to talk to her and immediately went to get the Administrator and the Administrator and Social Worker went to talk with Resident #1. She stated that she considered it was a violation of the resident's rights and a resident could be physically or mentally harmed by being showered despite her refusals. She stated that when resident's refused a shower CNA's were supposed to let the nurse know and talk to the resident to see if they might change their mind and if the resident still refused then they have a shower refusal sheet they had them sign. (continued on next page)

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F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/18/25 at 1:45 PM with the Administrator she stated a nurse came to her at the end of morning meeting and told her she needed to speak with Resident #1. The Administrator stated she immediately spoke with Resident #1 who told her, the night before (05/21/25), she was in her bed and it was her shower day, she didn't really want to take a shower, aides grabbed her by the wrists and put her in her chair and made her take a shower even though she didn't want to. She stated that Resident #1 told the Administrator that she did not want the aides to take care of her again and the Administrator assured her that they would not take care of her anymore. The Administrator stated she interviewed Resident #1's roommate, Resident #2, and she told the Administrator that everything Resident #1 told her happened- was what Resident #2 heard happen, and the privacy curtain was closed so she did not visually see the incident. The Administrator stated that Resident #1 provided a description that fit with two aides (CNA A & B) that worked on 05/21/25 6 PM- 6 AM shift, CNA A was assigned to Resident #3's hall. She stated she called and suspended both CNA A and CNA B pending the investigation on 05/22/25, they had not come back to the facility, and she interviewed them regarding the incident. She stated that CNA A told her that she had showered Resident #1 the evening of 05/21/25 and asked CNA B to help because Resident #1 was being difficult. She stated CNA A told her that Resident #1 said several times that she did not want a shower and CNA A told Resident #1 that she had to take a shower because she would feel better and CNA A physically picked her up under her armpits, slid her back into her chair and took her to the shower room. CNA A told the Administrator that she knew that resident's had the right to refuse a shower and knew about the refusal papers and they were to involve the nurse, but the resident got a shower and would feel better. The Administrator stated when she interviewed CNA B she told the Administrator that she heard the resident did say she didn't want a shower and CNA A told Resident #1 that she would feel better after a shower. CNA A told the Administrator Resident #1 kept saying she was going to call her lawyers. CNA A told the Administrator she had not worked with Resident #1 and thought she had dementia so she did not think much of what Resident #1 said and residents needed to take showers. The Administrator stated that resident's had a right to refuse a shower. She stated she expected when resident's refused showers for CNA's to wait a little while and try again later or get someone else to ask the resident, and then informed the charge nurse so they could attempt and document it with a refusal sheet. She stated that she in-serviced all staff on trauma informed care and that resident's had a right to refuse showers. Resident #1's physician was notified. She stated she attended an AD Hoc QAPI meeting on 05/22/25 with the Regional Compliance Nurse, Regional Director of Operations, the Medical Director, regarding the incident and what the Administrator needed to do. She stated that she had psychological services speak with Resident #1 and her care plan was updated. The Administrator stated the social worker completed safe surveys of residents with no other concerns. In an interview on 06/18/25 at 6:25 PM with CNA K she stated that she worked the evening shifts on Resident #1's hall and worked the evening after the incident on 05/22/25. CNA K stated Resident #1 was able to voice her needs and had never seen her out of bed in the year she had worked at the facility. She stated she had asked Resident #1 if she wanted a shower in the past and Resident #1 would reply no I'm not taking a shower and she had the resident sign a refusal form, informed the charge nurse who also signed the sheet, and there was a box they put it in at near the ADON's office. When provided the scenario of an aide giving a resident a shower despite their refusals, she stated it was a violation of the resident's rights and the resident could have been harmed physically and mentally. She stated she would have intervened immediately and ensured the resident felt safe and report to the Abuse Coordinator who was the Administrator. She stated that resident's have rights, the facility was the residents home and what they say goes. (continued on next page)

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	06/18/2025

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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F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on 06/17/25 (12:10 PM) and 06/18/25 across both shifts (6 AM- 6 PM & 6 PM-6 AM) with various staff members (ADON D, CNA E, CNA G, CNA H, CNA J, CNA K, LVN C, LVN F, LVN I, LVN L, LVN M, LVN P, MA N, and Social Worker) revealed staff had been in-serviced on resident rights on 05/22/25. When provided a scenario where a resident refused a shower and a CNA transferred them by their wrists or under their armpits and gave a resident a shower despite the resident's refusals- all stated it was a violation of the resident's right to refuse a shower and would have intervened and ensured the resident was safe and immediately report it to the Abuse Coordinator. They staff were aware of the shower refusal process of having the resident and the nurse and aide signed the refusal sheet and they were turned into a box near the ADON D's office. Record review of facility's resident rights policy titled Resident Rights, undated, reflected: The resident has a right to a dignified existence, self-determination .A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident . Exercise of Rights - The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. 1. The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. 2. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Respect and dignity - The resident has a right to be treated with respect and dignity . Self-determination - The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice. 1.The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provisions of this part. 2.The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident . Record review of the facility's Bathing/Shower Policy titled Bath, Tub/Shower, undated, 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 days or with partial bathing as needed . Procedure 1. The resident will receive assistance with bathing according to their resident centered plan of care. (continued on next page)

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F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Become familiar with type and pattern of bathing, assistance or aids needed, skin condition, presence of dressing or casts . Record review of CNA A's personnel file reflected she was hired on 05/01/25 with a last worked date of 05/21/25 and was terminated from employment on 05/23/25. The facility had conducted Texas Department of Public Safety Criminal History verification and Employee Misconduct Registry Employability status check without any concerns. Record review of CNA B's personnel file reflected she was hired on 04/18/25 with a last worked date of 05/21/25 and was terminated from employ[TRUNCATED]

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure residents were free from abuse for two (Resident #1 and Resident # 2) of 9 residents reviewed for abuse. The facility failed to protect Resident #1, who was on mental health services, from mental anguish on 05/21/25 at 9:30 PM when, when despite her refusals, she was physically lifted, under her armpits, by CNA A from her bed to the shower chair was given a shower by despite her refusals. As a result, Resident #1 experienced mental anguish and anger. Resident #2 who was on mental health services experienced mental anguish/being upset after hearing her roommate being forced to shower by facility aides. This failure could place residents at risk for not having measures in place to protect them from serious harm, mental anguish, abuse, or neglect. The noncompliance was identified as Immediate Jeopardy Past Noncompliance (PNC). The Immediate Jeopardy began on 05/21/25 at 9:30 PM and ended on 05/28/25. The facility had taken actions noted in the findings that corrected the noncompliance before the incident investigation began on 06/17/25. Findings included: Review of Resident #1's Quarterly MDS, dated [DATE], reflected she was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. She had the diagnoses of Chronic Obstructive Pulmonary Disease (COPD) with acute exacerbation (a lung disease with a sudden worsening symptoms including breathlessness, mucus, and cough), Alzheimer's disease (loss of cognition), chronic pain syndrome, and anxiety disorder (excessive or persistent worry or fear). Her BIMS score was a 5 (severely impaired cognition). Further review of Section GG-Functional Abilities reflected she usually required substantial/maximal assistance for bed to chair transfers. Record review of Resident #1's care plan reflected the resident had an activity of daily living (ADL) performance deficit and required one staff to assist with bathing and bed mobility, dated initiated 02/13/25. Further review reflected a focus area, dated initiated 05/23/25, The resident has a history of trauma that may have a negative impact. The trauma is [due to]: Feeling angry [due to] shower being done after she refused. Interventions included: .If resident refuses her shower stop immediately . If the resident has escalated, if at all possible do not touch the resident unless absolutely necessary for resident's or others safety ., dated initiated 05/23/25. Record review of Resident #2's Quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. She had the diagnoses of cancer, heart failure, stroke with paralysis on her left non-dominant side, and major depression disorder (persistent feelings of sadness). Her BIMS score was a 7 (severely impaired cognition). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #2's care plan reflected the resident had impaired cognitive function/dementia or impaired thought processes; interventions included .Use residents preferred name . face the resident when speaking .Provide the resident with necessary cues- stop and return if agitated ., dated initiated 10/07/24. Record review of the Provider Investigation Report (PIR) (Form 3613-A of Texas Health and Human Services) reflected an incident date and time of 05/21/25 at 9:30 PM, dated reported 05/22/25 at 10:15 AM and signed by the Administrator on 05/28/25. Further review revealed on 05/21/25 around 8:40 AM, Resident #1 told her nurse that she needed to talk to someone in charge because she was upset about her care last night. Further review revealed on 05/21/25 around 9:30 PM Resident #1 told CNA A several times she did not want a shower and without Resident #1's consent, CNA A physically lifted Resident #1 from the armpits from the bed into the shower chair and Resident #1 was given a shower by CNA A with assistance in the shower room by CNA B. Resident #1 did not have a history of similar allegations and was interviewable and had the capacity to make informed decisions. Resident #1 had a head-to-toe assessment on 05/22/25 at 10 AM and had no injuries. The facility immediately suspended CNA A and CNA B and obtained interviews from both CNA's and Resident #1, completed resident safe surveys on 05/22/25 with no other concerns, and started staff monitoring for 4 weeks (05/22/25-06/18/25). Staff were in-serviced on abuse and neglect and resident rights, including a resident's right to refuse a shower, and trauma informed care on 05/22/25. Record review of Resident #1's verbal statement written by the Administrator, undated, reflected that two CNA's came to her room to take her to the shower and she told them she did not want a shower and she was cold: Two aides came into my room to take me to the shower . I told them that I am cold and don't want a shower. [CNA A] said you are getting a shower tonight. I was begging to not get a shower and told her to stop and go away. They grabbed me by my wrist and pulled me up to put me in the chair. The first shower was cold and then she put me in the other shower[,] it was fine [the shower water temperature] but I kept saying I did not want a shower. [They] put me in the shower and started washing me. Barely gave me a towel to dry off and put me in a gown took me back to my room and put me to bed. I just did not like it. Record review of CNA A's verbal statement, undated, written by the Administrator reflected the following: .(Resident #1) was like do I even have to have a shower and I said yes you will feel better. She was being like her energy was she did not want a shower . Did she have an attitude? Yes, but she got a shower and will feel better. I picked her up under her armpits slid back in chair and took her to the shower room. When asked how many times did (Resident #1) say she did not want a shower? Her response was twice and I told her she would feel better after her shower . Do you know that [residents] have the right to refuse a shower? Yes, knows about the papers and getting a nurse to assist with refusal of showers. Record review of resident safe surveys, dated 05/22/25 reflected Resident #1 safe survey: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Do you feel safe at this facility: 'Yes and No' 2. Has anyone mistreated you or anyone in this facility: 'Yes last night' 3. If you have been mistreated or witnessed mistreatment, would you report it to someone: 'Yes I did' 4. Who did you report it to? 'My attorney and the police' . Further review of resident safe surveys with 17 residents revealed no concerns regarding abuse, they felt safe at the facility, and knew how to report mistreatment. In an interview and observation on 06/17/25 at 11:38 AM, Resident #1 was in bed and dressed wearing a nasal cannula, she was a poor historian. She stated there was an incident about a month ago, a staff member told her she had to get up out of bed and Resident #1 did not want to get up, she had pain and was not feeling good. She stated that the staff member told her she was getting up even though she kept saying no. She stated the staff member grabbed her by the wrists and put her in her wheelchair and was not sure was else happened. She stated she felt very angry, was swinging her hands around and tried to swat at and hit the staff member away and repeated she did not want to get up and said no but they got her up anyway. She stated she told her nurse. She stated she was not able to recall anything about a shower except for a time that her hair was left wet. She stated that she did not like to get up out of bed because she had pain and declined health and preferred bed baths. She stated she was an [AGE] year-old woman in her dying days and wanted to stay in bed. She stated she felt safe at the facility knowing the staff member was not there because someone from the facility told her they were not working for the facility anymore. Record review of Resident #1's progress notes from 05/01/25-06/17/25, reflected the following: A nursing progress note dated 05/22/25 at 8:45 AM written by ADON D: Resident reported to Charge Nurse an incident that happened last night. Resident stated that 2 CNA Staff grabbed her by the wrist, put her on the shower chair and took her to the shower room even though res. told the CNAs that she is not feeling well multiple times. Administrator and MD notified. A nursing progress note dated 05/22/25 at 9 AM with the note text of Trauma Informed Assessment written by the ADON D reflected Resident #1 had no previous trauma or diagnosis of PTSD and reported she had not experienced or witnessed a situation that was extremely frightening, and she had felt angry: has felt angry. Description: Yes what happened last night still make me angry. A nursing progress note dated 05/22/25 at 10:42 AM, written by ADON D, reflected Resident #1 had a head-to-toe skin assessment and resident had bruising to her right forearm 3 x 2.5 cm and on the right lateral side of her abdomen. Resident #1 was asked about how they obtained bruising and stated the bruise on her abdomen was from her applying pressure to the area when she coughed and was not sure how she obtained the bruise on her forearm. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nursing progress note dated 05/22/25 at 11:18 AM written by ADON D reflected Resident #1's physician was notified about the bruising to the resident's abdomen at 11 AM and the resident was their own responsible party, and there were no new orders and the resident was encouraged to avoid grabbing or pushing on her abdomen when coughing and reminded to call nursing if she had any pain or increased coughing so that PRN medications would be given. A nursing progress note dated 05/22/25 at 12:33 PM written by ADON D reflected a title of Event-Other reflected Resident #1's vitals were checked with no concerns and her cognition was oriented/no problem, she had no pain or injury and included the following Resident reported to Charge Nurse an incident that happened last night. Resident stated that 2 CNA Staff grabbed her by the wrist, put her on the shower chair and took her to the shower room even though [resident] told the CNAs that she is not feeling well multiple times .Resident Statement: Last night 2 ladies came to my room, one of them is big, the other is tiny. They asked me to shower but I refused. They grabbed me by my wrist, put me on the chair then took me to the shower room . ADON D notified Resident #1's physician on 05/22/25 at 9 AM, and there were no new orders. Resident #1 was their own representative with a date and time of notification as 05/22/25 at 8:45 AM, and the Administrator was notified. A social services progress note, dated 05/22/25 at 3:56 PM, written by the Social Worker: This [Social Worker] met w/ resident Re: complaint of two female staff that reportedly made resident participate in a shower when she verbally declined. Resident requested that these two female staff not be assigned to her again. [The Administrator] informed this [Social Worker] that both female staff have been removed from this facility permanently. This [Social Worker] assured resident that she would not encounter these two female staff in this facility again. This [Social Worker] also reached out to [the Psychologist] to request a post trauma follow up visit with resident as soon as possible. A nursing progress note dated 05/23/25 at 11:32 AM, written by the Social Worker, reflected she assisted Resident #1 with a post trauma therapeutic call with resident and [the Psychologist]. A general progress note dated 05/23/25 at 5:23 PM written by the Psychologist: (Resident #1) is a participant in a telehealth appointment per administrator request in regard to an incident that occurred Thursday (05/22/25). This patient is consulted with via phone assisted by the facility social worker. (Resident #1) is AOx4 [alert and oriented to person, place, time, and event] and able to articulate said needs. patient reported to me that yesterday she was feeling ill and had been in pain due to her couching and COPD symptomology. she reported that two aids came in to give her a shower and she requested to be left alone today, that she did not feel up to taking shower. she proceeded to explain to me one aid grabbed my right arm, and one grabbed my left arm and pulled me out of bed and into a shower chair. I said to them, I'm hurting and do not want a shower. they said to me you will be getting one regardless. the administrator was alerted promptly that patient requested to meet with who was in charge of facility. the administrator suspended both employees immediately pending further investigation. Patient was very happy and appeased to hear employees were suspended and said she does feel safe in building. she admits the incident was very upsetting to her when it occurred. she said when she returned to her room, she was not assisted by the two employees . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an observation and interview on 06/17/25 at 11:55 AM with Resident #1's roommate, Resident # 2, she was lying in bed and stated that about a month ago, she heard a female staff member come into their room, the privacy curtain was closed so she did not see who the staff member was and could hear the exchange. Resident #2 stated the staff member told Resident #1 it was time for her shower and Resident #1 responded that she did not want to take a shower- she did not feel good and had pain, and the staff member told Resident #1 that she was getting up for a shower. She stated it was exactly as Resident #1 described it, that was what she heard. She stated she did not think it was right that Resident #1 was made to get up and take a shower and no one had forced Resident #2 to take a shower or forced her to get up. She stated there are shower sheets residents sign when residents refused to take a shower. She stated she felt safe at the facility. Record review of Resident #2 progress notes from 05/01/25 to 06/18/25 reflected the following: A general note written by the Psychologist, dated 05/23/25 at 6:36 PM, (Resident #2) is seen while maintaining routine rounds at facility. (Resident #2) is on mental health services as advised by care plan team for adjustment and optimal well-being while residing in long term care. (Resident #2) was assisted with phone consult due to an incident that occurred the evening prior. (Resident #2) said she was upset because her roommate was being forced to take a shower, and she did not want to. (Resident #2) said they were rough with her which upset her even though she says she feels safe in the building. (Resident #2) gets very emotional due to her diagnosis and emotional instability . Record review of Resident #2's progress notes reflected a late entry general note written by the Psychologist, dated 05/28/25 at 3 PM, reflected: (Resident #2) is seen while maintaining routine rounds at facility. (Resident #2) is on mental health services as advised by care plan team for adjustment and optimal well-being while residing in long term care. Resident #2 was doing well, expressed no new concerns . In an interview on 06/17/25 at 12:10 PM with LVN C she stated that she was a charge nurse for Resident #1's hall. She stated she was in-serviced on the types of abuse and neglect including who to report to and resident rights including the resident's right to refuse a shower on 05/22/25 and did not work with Resident #1 until a day or two after the incident and when she saw Resident #1 next, her hair was knotted, and she was upset. She said Resident #1 told her that she was made to take a shower by staff when she did not want to take a shower. She stated that Resident #1 commonly refused showers and she offered to brush out her hair and Resident #1 let her brush her hair. She stated resident's had the right to refuse a shower and physically picking up a resident from under their armpits or wrists and showering them despite their refusals was abuse and could have caused physical harm or mental harm to the resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/17/25 at 12:45 PM with ADON D she stated she received a phone call from staff who relayed what Resident #1 had said about being forced to take a shower and she instructed staff to also contact the Administrator immediately. ADON D stated that she completed a head-to-toe assessment of Resident #1 on 05/22/25 and there were no bruises on her wrist, a small bruise on her forearm, and she had an unrelated bruise to the side of her abdomen. ADON D stated Resident #1 told her the bruise was on her abdomen was due to Resident #1 pushing on her side while coughing and she was sent out the same day due to an increase in COPD symptoms. ADON D stated she completed a trauma assessment and Resident #1 expressed she was still very angry about the incident and she was referred to counseling services. She stated that in a conference call with one of the CNA's and the Administrator CNA A or CNA B said something like she needed a shower anyway. ADON D stated she considered the incident to be abuse. She stated that physically moving a resident by lifting under their armpits, despite their refusals, from the bed to a shower chair and showering them could have resulted in physical harm or mental distress. Attempts to interview CNA A via phone on 06/17/25 at 1:44 PM and on 06/18/25 at 12:46 PM were unsuccessful with a disconnected tone. In an interview on 06/17/25 at 2:10 PM with the Social Worker she stated she spoke with Resident #1 with the Administrator on 05/22/25 and she told them that there were aides that got her ready for a shower despite her telling them she did not want a shower. The Social Worker stated Resident #1 was very distraught when talking about the incident and she told Resident #1 that a psychologist was going to come in and meet with her. She stated that the Administrator had said in a morning meeting that the employees were not going to come back to the facility. She stated they are in-serviced regularly on abuse and neglect and was able to name the types and reporting requirements. She stated that she considered the incident Resident #1 described as abuse. She stated that Resident #1 seemed to be fine now and she met with her about a week after on 05/30/25 and she did not indicate she was still upset about the shower. In an interview on 06/17/25 at 3:49 PM with CNA B she stated that on the evening of 05/21/25 CNA A flagged her down and asked for help with showering Resident #1. She stated did not assist CNA A in getting the resident out of bed, they were already in the shower room at the time she was asked to be a witness. CNA B stated when she entered the shower room Resident #1 was in the shower room and said multiple times she was going to call her lawyers, CNA B told CNA A that Resident #1 had been saying that since CNA A had gotten her up. CNA B stated she took the residents hair out of a ponytail and washed and conditioned her hair- she had a big knot in her hair and refused CNA B to brush it and said she was going to do it herself. CNA B stated she assisted with washing Resident #1 and dried her off and CNA A took her to her room. CNA B stated that she was not concerned about abuse because she had not worked with Resident #1 before and thought she was demented. When given a scenario of a resident who did not want to get up for a shower and was physically picked up by their armpits and taken to be showered despite their refusals, CNA B stated that would be abuse and the resident could have been physically harmed. She stated she would have intervened and told her nurse and the Abuse Coordinator who was the Administrator immediately. She stated she was called by the Administrator on 05/22/25, was informed she was suspended pending the investigation and gave her statement, she no longer worked at the facility. (continued on next page)

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	455573	A. Building B. Wing	06/18/2025

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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/17/25 at 4:10 PM with a family member of Resident #1, she stated Resident #1 called her the day the incident happened and told her she was forced to take a shower and sounded very angry. She stated that Resident #1 is her own representative and she had not spoken with the administrator or Resident #1 about the incident since it occurred. In an interview on 06/17/25 at 4:41 PM with the Psychologist she stated she received a phone call from the Administrator last month around 05/22/25 and was told an incident had occurred and was asked to come see the resident because it seemed very important. The Psychologist stated the Social Worker assisted in a telehealth visit via phone because she was out of town an unable to visit in person. She stated Resident #1 seemed very with it, sounded alert and oriented, and told her that aides had pulled her by the wrist from her bed and one aide told her you're going to get a shower today no matter what despite her telling them that she was hurting and did not want the aides back. The Psychologist stated that their call was cut short because Resident #1 was going to the hospital related to their COPD and increased coughing. She stated she followed up with Resident #1 the following week (05/28/25) and Resident #1 had concerns of the aides not coming back to the facility. The Psychologist stated she reassured Resident #1 that the aides were not coming back and she felt better. She stated she also saw Resident #1 on 04/02/25 and she was focused on discharging from the facility which was unrealistic due to her being non-ambulatory and increased COPD symptoms. She stated she was following up with the resident today on 06/17/25. In an interview on 06/17/25 at 6:10 PM with LVN F he stated he was the charge nurse for Resident #1's hall on the evening shift (6 PM-6 AM) 05/21/25. He stated he was familiar with Resident #1 and had worked with her when she was on the rehabilitation side of the facility. He stated that Resident #1 used to be a nurse and she did not want to be a bother to anyone and was particular about her care. He stated that at the beginning of the shift on 05/21/25, he was passing medications to residents and did not hear anything at the time but did notice she was not in her room and was pleasantly surprised that she had gotten up to take a shower because she typically did not want to get out of bed- she had a cough for a while and was not feeling well. He stated that he saw her later and her hair was still a little wet and she complained that they gave her a shower and left her hair damp. He stated that Resident #1 and seemed focused on her hair and he wanted to make her comfortable, so he offered to look for a hair dryer to dry her hair. He stated that CNA A only told him that she got her to take a shower. He stated Resident #1 did not disclose to him anything about what had happened and neither CNA told him anything other than she got a shower, and he found out the following day and was in-serviced on 05/22/25 on identifying and reporting abuse and neglect, resident rights including the right to refuse showers, and trauma informed care. He stated that if he had known what had happened, he would have immediately ensured the resident felt safe, ensured the CNA did not provide her any care, and would have contacted the Administrator who was the abuse coordinator. He stated that physically transferring a resident, under their armpits, and giving them a shower despite their refusals, was abuse and could have caused physical and mental harm to the resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/18/25 at 9:28 AM with the Regional Compliance Nurse, she stated that she was contacted by the Administrator on 05/22/25 regarding an allegation of abuse. She stated that she assisted the Administrator via phone to ensure they followed their abuse and neglect policy. She stated that the Administrator suspended the two employees (CNA A & CNA B) pending the investigation and she updated Resident #1's care plan due to her anger at being made to shower despite her refusals. She stated that the facility's policy was to update the resident's care plan to indicate a traumatic event occurred and did not think Resident #1 had lasting trauma due to the incident and it was care planned as a trauma event due to the resident's expression of anger and to ensure staff were aware how to care for the resident and to stop immediately if the resident refused a shower. She stated physically moving a resident from under her armpits or wrists and showering them despite their refusals was abuse and could have caused physical and psychosocial harm to the resident. In an interview on 06/18/25 at 11:28 AM with LVN I revealed Resident #1 typically stayed in her bed and sometimes would ask to get up. She stated on 05/22/25 during her rounds, Resident #1 appeared furious told her that the previous night (05/21/25), two girls came into Resident #1's room and told her it was her shower day, she refused, and they picked her up anyway and took her to the shower room and washed her, and said she was going to sue the aides. LVN I stated Resident #1 stated that the aides picked her up by the wrists and looked at her wrists and saw no marks or bruising, made sure she was okay, and told the resident she was going to get someone to talk to her and immediately went to get the Administrator and the Administrator and Social Worker went to talk with Resident #1. She stated that she considered it to be abuse. She stated that a resident could be harmed by being picked up from her bed under her armpits or by her wrists and made to take a shower despite their refusals both psychologically and physically. She stated that when resident's refused a shower CNA's were supposed to let the nurse know and talked to the resident to see if they might change their mind and if the resident still refused then they have a shower refusal sheet they had them sign. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/18/25 at 1:45 PM with the Administrator she stated a nurse came to her at the end of morning meeting and told her she needed to speak with Resident #1. The Administrator stated she immediately spoke with Resident #1 who told her, the night before (05/21/25), she was in her bed and it was her shower day, she didn't really want to take a shower, aides grabbed her by the wrists and put her in her chair and made her take a shower even though she didn't want to. She stated that Resident #1 told the Administrator that she did not want the aides to take care of her again and the Administrator assured her that they would not take care of her anymore. The Administrator stated she interviewed Resident #1's roommate, Resident #2, and she told the Administrator that everything Resident #1 told her happened- was what Resident #2 heard happen, and the privacy curtain was closed so she did not visually see the incident. The Administrator stated that Resident #1 provided a description that fit with two aides (CNA A & CNA B) that worked on 05/21/25 6 PM- 6 AM shift, CNA A was assigned to Resident #3's hall. She stated she called and suspended both CNA A and CNA B pending the investigation on 05/22/25, they had not come back to the facility, and she interviewed them regarding the incident. She stated that CNA A told her that she had showered Resident #1 the evening of 05/21/25 and asked CNA B to help because Resident #1 was being difficult. She stated CNA A told her that Resident #1 said several times that she did not want a shower. CNA A told the Administrator Resident #1 kept saying she was going to call her lawyers and she had not worked with Resident #1 and thought she had dementia so she did not think much of it. The Administrator stated that resident's had a right to refuse a shower and physically moving a resident, under their armpits, to a shower chair and showering them despite their refusals could be considered abuse and could physically or psychologically harm the resident. She stated she expected when resident's refused showers for CNA's to wait a little while and try again later or get someone else to ask the resident, and then inform the charge nurse so they could attempt and document it with a refusal sheet. She stated that she in-serviced all staff on abuse and neglect including recognizing abuse and reporting to her immediately, and on trauma informed care. Resident #1's physician was notified. She stated she attended an AD Hoc QAPI meeting on 05/22/25 with corporate involvement and the Medical Director, regarding the incident and what the Administrator needed to do. In an interview on 06/18/25 at 6:25 PM with CNA K she stated that she worked the evening shifts on Resident #1's hall and worked the evening after the incident on 05/22/25. CNA K stated Resident #1 was able to voice her needs and had never seen her out of bed in the year she had worked at the facility. She stated she had asked Resident #1 if she wanted a shower in the past and Resident #1 would reply no I'm not taking a shower. She stated when resident's refused showers she had the resident sign a refusal form, informed the charge nurse who also signed the sheet, and there was a box they put it in at near the ADON's office. She was able to name types of abuse including reporting to the Abuse Coordinator. When provided the scenario of an aide physically transferring a resident by lifting under their armpits and giving them a shower despite their refusals, she stated it was abuse and the resident could have experienced physical harm. She stated she would have intervened immediately and ensured the resident felt safe and report to the Abuse Coordinator who was the Administrator. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In interviews on 06/17/25 and 06/18/25 across both shifts (6 AM- 6 PM & 6 PM-6 AM) with various staff members (ADON D, CNA E, CNA G, CNA H, CNA J, CNA K, LVN C, LVN F, LVN I, LVN L, LVN M, LVN P, MA N, and Social Worker) revealed staff had been in-serviced on abuse and neglect, resident rights (including residents had a right to refuse showers), and trauma informed care on 05/22/25. The above-mentioned staff members were able to verbalize abuse and different forms of abuse and neglect including reporting to the Administrator who was the facility's abuse coordinator. The above mentioned staff members stated they had received in-services on resident rights and trauma informed care and when a resident declined showers that meant no and they did not force resident's to do something they did not want to do. When provided a scenario where a resident refused a shower and a CNA transferred them by their wrists or under their armpits and gave a resident a shower despite the resident's refusals- all stated they considered it to be abuse and would ensure the resident was safe and immediately report it to the Abuse Coordinator. They stated physically transferring a resident under the armpits from the bed to shower chair and showering the resident despite refusals could result in physical and mental harm to the resident. Record review of the facility's AD Hoc QAPI (an unscheduled, as needed meeting for a Quality Assurance and Performance Improvement (QAPI) program) meeting, dated 05/22/25, attended by the Administrator, Medical Director, Regional Compliance Nurse regarding the incident and what steps they needed to take next. Record review of CNA A's personnel file reflected she was hired on 05/01/25 with a last worked date of 05/21/25 and was terminated from employment on 05/23/25. The facility had conducted Texas Department of Public Safety Criminal History verification and Employee Misconduct Registry Employability status check without any concerns. Record review of CNA B's personnel file reflected she was hired on 04/18/25 with a last worked date of 05/21/25 and was terminated from employment on 06/05/25. The facility had conducted Texas Department of Public Safety Criminal History verification and Employee Misconduct Registry Employability status check without any concerns. Record review of abuse and neglect in-services conducted by the facility on 05/22/25 reflected the facility staff were trained on abuse and neglect, types of abuse, who was the abuse coordinator and when abuse should be reported. Reco[TRUNCATED]

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that each resident who experiences a significant change in status is comprehensively assessed within 14 days for 1 of 9 residents (Residents #4) reviewed for significant change. The facility failed to ensure Resident # 4 had a Significant Change Assessment completed after she had a change in vision needs. This failure could place residents at risk of not having assessments completed when there has been a significant change in their condition and could lead to failure to not provide necessary care. Findings included: Record review of Resident #4's face sheet, dated [DATE], reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), Hypertension (a condition in which the force of the blood against the artery walls it's too high), and Cognitive Communication Deficit (refers to difficulties with communication that arise from impairment in cognitive processes). Record review of Resident #4's physician progress note dated [DATE] reflected .Assessments: 1. Cataract, unspecified cataract type, unspecified laterality .Discussion: Patient was seen and examined. She has cataracts. Patient to FU with RGB for surgery . Record review of Resident #4's Quarterly Review MDS assessment, dated [DATE], reflected she had a BIMS score of 10, indicating she was moderately cognitively impaired. Section B1000 reflected she had adequate ability to see in adequate light and did not use corrective lenses. Record review of Resident #4's Care Plan Review dated [DATE] reflected no mention of vision issues, need for eye care or eye surgery. Record review of Resident #4's physical order summary dated [DATE] reflected an order on [DATE] May have Ophthalmologist Care. Order dated [DATE] reflected S.S. to make appt for patient cataract (a clouding or opacification of the normally clear lens of the eye that obscures the passage of light through the lens to the retina of the eye) surgery. Interview and observation of Resident #4 on [DATE] at 11:24am revealed she needed eyeglasses. She was observed wearing the eyeglasses while she was looking at her tablet. She stated she needed to go to the eye doctor because she cannot see from her left eye and had floaters in her right eye. She stated it was urgent she got to the eye doctor due to her declining vision. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Social Worker on [DATE] at 2:16pm revealed she had made several attempts to get Resident #4 to the eye doctor for a new eye exam because her previous eye exam was expired. She had an appointment for surgery on [DATE] but they had not accepted her due to her needing a new vision exam. They then scheduled her new vision exam on [DATE] but the facility was unsuccessful in transporting her to the exam due to an incident in which she fell during transport. She had continued to try and look for options to get the eye evaluation done, to include finding a provider that could do the exam at the facility or finding a provider that would accept Resident #4 on a stretcher. Resident #4 needed special transportation due to her large frame and girth. The only way to safely transport her would be by stretcher. The current provided, RGC, stated they would not accept her on stretcher. The Social Worker stated she did not have a written record of her attempts to get Resident #4 to her eye exam. Interview with MDS Nurse O on [DATE] at 3:12pm revealed quarterly MDS assessments were completed based on the resident's electronic file that included diagnoses, physician orders and physician progress notes. She stated she was responsible for updating Resident #4's MDS. She stated she did not see anything from the eye doctor that said she had cataracts and therefore did not believe it needed to be noted in the MDS . She stated Resident #4's file did not have a diagnosis of any vision impairment or cataract in her MDS or Face Sheet and the only thing they had that mentioned it was the Nurse Practitioners note on [DATE]. She stated they would typically need something from the eye doctor with the diagnosis of Cataracts to include it in the MDS. Interview with ADON Q on [DATE] at 3:31pm revealed she was aware of Resident #4's vision problem and the struggle they were having to get her to her eye evaluation. She stated she was not familiar with the expectation on what should be on MDS because she did not complete the MDS. She was aware of the resident wearing corrective lenses but did not know the resident was having vision decline. She did not know what the risk was of not having vision issues noted in the MDS because they took care of all of Resident #4's needs and the vision impairment would be knowledge passed down by word of mouth and through staff completing rounds with their residents. She noted if Resident #4's vision was improved it would improve her quality of life. Interview with the Administrator on [DATE] at 4:37pm revealed she did not know whether a vision impairment would go on an MDS. She stated cataracts did not automatically mean a vision impairment but stated it was a vision issue. She stated there would be a risk to a resident not having an up to date and accurate MDS because staff would not know exactly how to care for that resident. Interview with the DON on [DATE] at 5:25pm revealed vision impairment should be noted on a MDS assessment. The risk of not having a vision impairment on the MDS would be the resident might not have gotten the treatment she needed for her eyes. Interview with Administrator on [DATE] at 9:05 AM revealed the facility did not have a policy for MDS. The facility follows the RAI Manual . (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CMS's RAI Version 3.0 Manual effective [DATE] reflected .B1000 .A person's reading vision often diminishes over time. If uncorrected, vision impairment can limit the enjoyment of everyday activities such as reading newspapers, books or correspondence, and maintaining and enjoying hobbies and other activities. It also limits the ability to manage personal business, such as reading and signing consent forms. Moderate, high or severe impairment can contribute to sensory deprivation, social isolation, and depressed mood. Planning for Care Reversible causes of vision impairment should be sought. Consider whether simple environmental changes such as better lighting or magnifiers would improve ability to see. Consider large print reading materials for persons with impaired vision. For residents with moderate, high, or severe impairment, consider alternative ways of providing access to content of desired reading materials or hobbies. Steps for Assessment 1. Ask family, caregivers, and/or direct care staff over all shifts, if possible, about the resident's usual vision patterns during the 7-day look-back period (e.g., is the resident able to see newsprint, menus, greeting cards?). 2. Then ask the resident about their visual abilities. 3. Test the accuracy of your findings: o Ensure that the resident's customary visual appliance for close vision is in place (e.g., eyeglasses, magnifying glass). o Ensure adequate lighting. o Ask the resident to look at regular-size print in a book or newspaper. Then ask the resident to read aloud, starting with larger headlines and ending with the finest, smallest print. If the resident is unable to read a newspaper, provide material with larger print, such as a flyer or large textbook. o When the resident is unable to read out loud (e.g. due to aphasia, illiteracy), you should test this by another means such as, but not limited to: - Substituting numbers or pictures for words that are displayed in the appropriate print size (regular-size print in a book or newspaper) . B1200: Corrective Lenses Health-related Quality of Life o Decreased ability to see can limit the enjoyment of everyday activities and can contribute to social isolation and mood and behavior disorders. o Many residents who do not have corrective lenses could benefit from them, and others have corrective lenses that are not sufficient. o Many persons who benefit from and own visual aids do not have them on arrival at the nursing home. Planning for Care o Knowing if corrective lenses were used when determining ability to see allows better identification of evaluation and management needs. o Residents with eyeglasses or other visual appliances should be assisted in accessing them. Use and maintenance should be included in care planning. o Residents who do not have adequate vision without eyeglasses or other visual appliances should be asked about history of corrective lens use. o Residents who do not have adequate vision, despite using a visual appliance, might benefit from a re-evaluation of the appliance or assessment for new causes of vision impairment. Steps for Assessment 1. Prior to beginning the assessment, ask the resident whether they use eyeglasses or other vision aids and whether the eyeglasses or vision aids are at the nursing home. Visual aids do not include surgical lens implants. 2. If the resident cannot respond, check with family and care staff about the resident's use of vision aids during the 7-day look-back period. 3. Observe whether the resident used eyeglasses or other vision aids during reading vision test (B1000). 4. Check the medical record for evidence that the resident used corrective lenses when ability to see was recorded. 5. Ask staff and significant others whether the resident was using corrective lenses when they observed the resident's ability to see. CMS's RAI Version 3.0 Manual CH 3: MDS Items [B] [DATE] Page B-14 B1200: Corrective Lenses (cont.) Coding Instructions o Code 0, no: if the resident did not use eyeglasses or other vision aid during the B1000, Vision assessment. o Code 1, yes: if corrective lenses or other visual aids were used when visual ability was assessed in completing B1000, Vision

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to ensure the comprehensive care plan described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 (Residents #1, #2, #3, and #9) of 9 residents reviewed for comprehensive care plans. 1. The facility failed to create a care plan that reflected Resident #1's preference for bed baths and shower refusals. 2. The facility failed to create a care plan that reflected Resident #2's shower refusals. 3. The facility failed to create a care plan that reflected Resident #3's shower refusals. 4. The facility failed to create a care plan that reflected Resident #9's vision needs. This failure puts residents at risk of not being provided personalized care and negatively impact their quality of life. Findings included: 1. Review of Resident #1's Quarterly MDS, dated [DATE], reflected she was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. She had the diagnoses of Chronic Obstructive Pulmonary Disease (COPD) (a sudden worsening of COPD including breathlessness, mucus, and cough), Alzheimer's disease (loss of cognition), chronic pain syndrome, and anxiety disorder (excessive or persistent worry or fear). Her BIMS score was a 5 (severely impaired cognition). Further review of Section GG-Functional Abilities reflected she required substantial/maximal assistance for bed to chair transfers and showers. In an interview on [DATE] at 11:38 AM with Resident #1 she stated that she did not like to get up out of bed because she had pain and declined health and stated she would be open to bed baths. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 6:10 PM with LVN F he stated that Resident #1 commonly refused showers and typically did not get out of bed. He stated when a resident refused a shower the aide was supposed get someone else to try or try at another time and then inform the charge nurse. He stated there were shower sheets that were signed by the nurse and the aide when residents still chose to refuse showers. In an interview on [DATE] at 6:25 PM with CNA K she stated Resident #1 was able to voice her needs and she had never seen Resident #1 out of bed in the year she had worked at the facility. She stated she had asked Resident #1 if she wanted a shower in the past and Resident #1 would reply no I'm not taking a shower and she had the resident sign a refusal form, informed the charge nurse who also signed the sheet, and there was a box they put it in at near the ADON's office. Record review of Resident #1's care plan reflected the resident had an activity of daily living (ADL) performance deficit and required one staff to assist with bathing and bed mobility, dated initiated [DATE]. Further review reflected a focus area, dated initiated [DATE], The resident has a history of trauma that may have a negative impact. The trauma is [due to]: Feeling angry [due to] shower being done after she refused. Interventions included: .If resident refuses her shower stop immediately . If the resident has escalated, if at all possible do not touch the resident unless absolutely necessary for resident's or others safety ., dated initiated [DATE]. Resident #1's care plan did not address she commonly refused showers. Record review of Resident #1's medical record reflected there were no shower refusal sheets. Record review of Resident #1's point of care task for bathing for the month of [DATE] ([DATE]-[DATE]) reflected she bathed on [DATE], [DATE], [DATE], and [DATE]. 2. Record review of Resident #2's Quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. She had the diagnoses of cancer, heart failure, stroke with paralysis on her left non-dominant side, and major depression disorder (persistent feelings of sadness). Her BIMS score was a 7 (severely impaired cognition). Further review of Section GG-Functional Abilities reflected she required substantial/maximal assistance for bed to chair transfers and showers. In an interview on [DATE] at 4:24 PM with Resident #2 she stated that she did refuse showers and had never been forced to get up and the facility had her sign shower refusal sheets. She stated she did not like to sign the shower refusal sheets because the wording said something about it being bad for her health. She stated she had never been forced to take a shower by staff. Record review of Resident #2's care plan reflected the resident had impaired cognitive function/dementia or impaired thought processes; interventions included .Use residents preferred name . face the resident when speaking .Provide the resident with necessary cues- stop and return if agitated ., dated initiated [DATE]. The care plan did not reflect Resident #2 refused showers and did not like to sign the shower sheets. (continued on next page)

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	06/18/2025

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's point of care scheduled tasks for bathing for the month of [DATE] ([DATE]-[DATE]) reflected she bathed on Tuesdays, Thursdays, and Saturdays and had bathed on [DATE], [DATE], [DATE]. Record review of Resident #2's medical record revealed a shower refusal sheet signed by Resident # 2 dated on [DATE]. In an interview on [DATE] at 12:10 PM with LVN C, she stated Resident #1 and Resident #2 commonly refused showers. She stated that if a resident refused a shower, then aides were supposed to try to ask the resident either at a different time, or get someone else to ask the resident and the resident still refused there was a shower refusal form that residents signed. In an interview on [DATE] at 11:41 AM with CNA J, she stated that she provided showers or bed bath for Resident #1, and Resident #2. She stated that Resident #1 and Resident #2 did not like to get up out of bed and commonly refused showers. She stated that when resident's refused showers there were shower refusal sheets they signed. 3. Record review of Resident #3's Quarterly MDS, dated [DATE], reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. He had the diagnoses of heart failure, respiratory failure, and anxiety disorder (persistent feelings of worry) and depression disorder (persistent feelings of sadness or loss of interest) and a BIMS score of 7 (severely impaired cognition). Further review of Section GG-Functional Abilities reflected he required substantial/maximal assistance for bed to chair transfers and showers. In an observation and interview on [DATE] at 2:40 PM with Resident #3 revealed he was seated at the edge of his bed wearing oxygen via nasal cannula. He stated that he did refuse showers at times and staff respected his refusal. He stated that he signed refusal sheets when he did not want to take a shower. Record review of Resident #3's undated care plan did not reflect Resident #3 refused showers. Record review of Resident #3's point of care flow sheet for the month of June ([DATE]-[DATE]) reflected he showered on [DATE], [DATE], [DATE], and [DATE]. Record review of Resident #3's medical record revealed shower refusal sheets signed by Resident #3 dated on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. In an interview on [DATE] at 12:45 PM with ADON D, she stated that Residents #1, #2, and #3 commonly refused showers and was not sure if it was care planned. She stated that the MDS Nurse was responsible for care plans. She stated shower refusal sheets were turned in and uploaded into the resident's record and was not sure why Resident #1 had no shower refusal sheets and Resident #2's record appeared to be missing some shower refusal sheets as well. She stated they might not be scanned into the system yet. She stated that sometimes Resident #2 would ask for some rags to wipe herself off instead of showering. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 11:28 AM with LVN I, she stated that Residents #1, #2, and #3 commonly refused showers. In an interview on [DATE] at 4:57 PM with MDS Nurse O, she stated the care plans were updated by nursing if it were something acute and she was responsible for quarterly and annual care planning with the IDT. She stated a resident's bathing preference such as bed baths and shower refusals would be typically covered on the annual and quarterly care plan meetings with the IDT. She reviewed Residents #1, #2, and #3's care plans and stated that Resident #1's shower refusals and preference for bed baths, Resident #2's and Resident #3's shower refusals, were not care planned and she was not made aware or she would have followed up with the residents to ensure their preferences were care planned. MDS Nurse O stated it was important to care plan a resident's shower preference or refusals so their preferences were honored. MDS Nurse O stated she was going to speak with the three residents (#1,#2,#3) and update their care plan. In an interview on [DATE] at 6:25 PM with CNA K, she stated that Resident #3 commonly refused showers and residents had the right to refuse showers. She stated when a resident refused showers there were shower refusal forms signed by the aide and the nurse and put in a box by the nurses' station. 4. Record review of Resident #9's face sheet, dated [DATE], reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), Hypertension (a condition in which the force of the blood against the artery walls is too high), and Cognitive Communication Deficit (refers to difficulties with communication that arise from impairment in cognitive processes). Record review of Resident #9's Quarterly Review MDS assessment, dated [DATE], reflected she had a BIMS score of 10, indicating she was moderately impaired cognitively. Section B1000 reflected she had adequate ability to see in adequate light, did not use corrective lenses. Record review of Resident #9's physical order summary dated [DATE] reflected an order on [DATE] May have Ophthalmologist Care. Order dated [DATE] reflected S.S. to make appt for patient cataract (a clouding or opacification of the normally clear lens of the eye that obscures the passage of light through the lens to the retina of the eye) surgery. Record review of Resident #9's physician's progress note dated [DATE] reflected .Assessments: 1. Cataract, unspecified cataract type, unspecified laterality .Discussion: Patient was seen and examined. She has cataracts. Patient to FU with [provider name] for surgery . Record review of Resident #9's Care Plan Review dated [DATE] reflected no mention of vision issues, need for eye care or eye surgery. Interview and observation of Resident #9 on [DATE] at 11:24 AM revealed she needed eyeglasses. She was observed wearing eyeglasses while she was looking at her tablet. She stated she needed to go to the eye doctor because she could not see from her left eye and had floaters in her right eye. She stated it's urgent she got to the eye doctor due to her declining vision. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Social Worker [DATE] at 2:16 PM revealed she had made several attempts to get Resident #9 to the eye doctor for a new eye exam because her previous eye exam was expired. She had an appointment for surgery on [DATE] but they had not accepted her due to needing a new vision exam. They then scheduled her new vision exam on [DATE] but the facility was unsuccessful in transporting her to the exam due to an incident in which she fell during transport. She had continued to try and look for options to get the eye evaluation done, to include finding a provider that could do the exam at the facility or finding a provider that would accept Resident #9 on a stretcher. The current provider,[provider name] stated they would not accept her on a stretcher. She stated she had not added any information about Resident #9's vision needs to the care plan. She stated she was actively working on trying to overcome the issues related to transporting her to the eye appointments. Interview with MDS Nurse O on [DATE] at 3:12 PM revealed the MDS nurses helped with the first comprehensive care plan and would add items for acute care upon request by nursing staff during meetings. Acute items were added to the care plan by the DON or ADON. Vision issues should be care planned when services were being provided or needed to be provided to the resident. Interview with ADON Q on [DATE] at 3:31 PM revealed she was aware of Resident #9's vision problem and the struggle they were having to get her to her eye evaluation. She was aware of the resident wearing corrective lenses but did not know the resident's vision was declining. She stated Resident #9's care plan should reflect limited vision but was unsure whether it was on her care plan. She did not know what the risk was of not having vision issues noted on the =care plan because the facility took care of all of Resident #9's needs and the vision impairment would be knowledge passed down by word of mouth and through staff completing rounds with their residents. She noted if Resident #9's vision was improved it would improve her quality of life. Interview with the Administrator on [DATE] at 4:37 PM revealed she did not know whether a vision impairment would go on a care plan because she was not clinical. She stated she believed Resident #9's care plan could read less vision than normal. She stated a care plan should be used to ensure residents were receiving all their services and did not believe care was involved with vision issues. The risk of not having an up-to-date care plan would be that staff would not know exactly how to take care of a resident. Interview with the DON on [DATE] at 5:25 PM revealed Resident #9's vision impairment should be noted on a care plan and the interventions or plan to care for the vision impairment should be included. The risk to the resident on not having vision impairment on their care plan would be they might not have gotten the treatment for their eyes. He stated that Residents #1, #2, and #3 shower/bathing refusals or preference for bed baths should be care planned to ensure they honored the residents' preferences. He stated that nurses should also chart in the resident's progress notes that a resident refused a shower so they were aware during the morning meetings and it would be care planned. Record review of the facility's Bathing/Shower Policy titled Bath, Tub/Shower, undated, 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 days or with partial bathing as needed . Procedure (continued on next page)

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	455573	A. Building B. Wing	06/18/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The resident will receive assistance with bathing according to their resident centered plan of care. 2. Become familiar with type and pattern of bathing, assistance or aids needed, skin condition, presence of dressing or casts . Record review of the facility's care plan policy, titled Comprehensive Care Planning, undated, reflected: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following - o The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and o the right to refuse treatment .

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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 label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 (D hall Nurses Cart) of 2 medication nurses carts reviewed for pharmacy services in that: The facility failed to ensure RN U responsible for the D hall Nurses Cart removed medications in unsecure containers from the Nurses Cart. This failure could place residents at risk of not having the medication available due to possible drug diversion. The findings included: Record review and observation on 06/17/25 at 11:58 AM of D hall Nurses Cart, with RN U revealed the blister pack for Resident #8's APAP/codeine 300-30 mg tablet (controlled medication used for pain) had 1 blister seal broken and the pill still inside the broken blister and tapped over. Interview on 06/17/25 at 12:04 PM, RN U stated the count was done at shift change and the count was correct. She stated she did not check the blister packs during the count. She stated she was unaware when the blister pack seal was broken, and she was not aware of who might have damaged the blister. She stated the risk would be a potential for drug diversion. She stated the nurses were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated when a broken seal was observed, she would waist the pill with another nurse. Interview on 06/17/25 at 3:49 PM, the DON stated he expected if a blister pack medication seal was broken the pill should be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened. The DON stated the risk would be potential for drug diversion and infection control issue. He stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADONs were supposed to check the carts randomly for monitoring. Record review of the facility's policy titled Medication Storage in the Facility, undated, revealed in part . Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy if a current order exists .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed. The facility failed to ensure the dining room's ice machine's drip tray was cleaned and sanitized, and free from build-up of slime, mold, and an old, used and soaked paper napkin. This failure placed residents at risk of food contamination and foodborne illness. Findings included: Observation of the dining room ice machine on 06/17/25 at 09:45 AM, revealed the presence of buildup of a grayish slime/mold, and an old, used and soaked paper napkin within the drip tray of the ice machine. In an interview on 06/17/25 at 9:46 AM, the DFN looked at the ice machine drip tray and stated it looked dirty with a used paper napkin there. He stated the ice machine supposed to be cleaned daily after each meal. He was unable to recall the last time the machine had been cleaned and sanitized. He stated he had to check the daily cleaning schedule log. He stated it was his responsibility and the responsibility of the kitchen staff and the housekeeping staff to make sure the beverage bar machines was cleaned, sanitized and free of buildup. The DFN stated the importance of doing so was to keep the environment and equipment sanitary for the health and benefit of the residents, staff, and visitors. Observation of the dining room's ice machine on 06/17/25, at 1:10 PM, revealed the ice machine and its components had been effectively cleaned and sanitized and the concerning areas of grayish slime/mold were no longer present. Review of the kitchen's daily cleaning schedules revealed the ice machine under the title of Beverage Bar [Before each meal] was to be sanitized daily and the log showed the machine had been cleaned on 06/01/25-06/02/25-06/04/25-06/05/25-06/08/25-06/09/25-06/12/25 for the two weeks of June 2025 schedule. In an interview on 06/17/25, at 5:09 PM, the ADM stated that it was his expectation that the beverage bar machines were kept cleaned, sanitized and free of any build up. She stated it was the responsibility of all staff including dietary staff, housekeeping staff, and herself to make sure the beverage bar machine was kept cleaned, and sanitized. She said it was important because a clean and sanitary environment prevented residents, staff, visitors, and others from getting sick. Review of the facility's Dietary Services Policy & Procedure Manual 2012, Cleaning of the Ice Machine policy revealed the following: The ice machine shall be cleaned and sanitized according to manufacturer's instructions to maintain sanitary conditions in order to prevent food contamination and the growth of disease producing organisms and toxins . 3. Clean any hard water deposits with delimer, per manufacturer instructions for mixing and use .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure an effective pest control program was implemented so the facility is free of pests and rodents for 1 of 9 residents (Resident #7), 1 out of 5 halls (hall A) and 1 out of 5 exterior perimeters of resident halls (hall A) reviewed for pest control. 1. The facility failed to effectively treat Resident #7's room for ants. 2. The facility failed to keep an effective pest control program, so the facility was free of ants on the exterior perimeter of resident hall A. 3. The facility failed to keep an effective pest control program, so the facility was free of ants in 2 rooms in the A hall. These failures placed residents at risk for the spread of infection and disease, and a reduced quality of life. Findings included: 1. Record review of Resident #7's MDS, dated [DATE], reflected she was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of Hypertension (high blood pressure), Diabetes (a condition resulting in too much sugar in the blood) and Edema (excessive accumulation of fluid in the body's tissues, leading to swelling. She had a BIMS score of 15 (little to no cognitive impairment). Resident #7 was discharged from the facility on 1/14/25. Record review of Resident #7's care plan dated 1/23/25 reflected .Resident is on enhanced barrier precautions .Resident has a surgical site to: Cutaneous abscess of abdominal wall .Resident has an ADL Self Care Performance Deficit .bed mobility requires staff X1 for assistance .The resident is at risk for falls r/t weakness . Interview with LVN T 6/17/25 at 10:50am revealed she was the nurse who found the ants in Resident #7's room. She stated she went in the room and the resident was complaining of itching, and she was completing the head-to-toe assessment when she noted ants on the bedrail coming from the window seal. Resident's bed was a few feet away from the window. When she pulled the bed covers, she saw ants on the bed. Resident #7 had opened food at the time of the observation. During the assessment she found two pinpoint bites one on each thigh. She stated Resident #7 had never complained about ants in her room. It was the first time of her complaining about itching. There were no other residents at that time complaining about itching or ant bites. Since then, she had not noted any ants or bugs at the facility. The resident was at risk of infection due to the ant bites. If she was to observe any ants or bugs in a resident room, she would make sure the resident was safe and assess the resident for bite marks. Record review Resident #7's progress note date 1/14/25 at 1:55pm reflected .Describe any injuries: 2 pinpoint non blistered areas - 1 left midthigh, 1 right midthigh, resident reported she had 2 ants in her room. Resident was moved to another facility. Skin assessment completed; doctor assessed resident . (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation of the outside facility perimeter and interview with Maintenance Director on 6/17/25 at 12:59pm revealed 1 3 to 5 -inch ant hill with about 20 black ants on the southwest corner outside of the A Hall, and a resident room window was about 2 feet away from the ant hill. The Maintenance Director acknowledged the ant hill and stated he would take care of it. He stated that he had seen an increase in work orders for ants due to the weather being hot. He stated the reports were just for black sugar ants and he usually took care of it by spraying pesticide. He stated he received work orders to his phone via the app for maintenance of the building. He stated anyone, staff or residents, could scan the QR code that was posted throughout the building to put in a work order. He stated he was the only one that had access to the work orders. He reported the facility was fumigated about 2 weeks ago by their pest control company. Review of the facility invoice from the pest control company dated 1/21/25 reflected .General Comments: Pest Control on Site for additional service regarding ants and rodents. Upon arrival I met with staff member in the business office who informed me admin and DM were offsite. Staff member was able to reach out to MD (Maintenance Director) who confirmed ants in 120 and 122. I learned resident in B4 reported ants as well. I began service by inspecting resident room B4 where upon inspection no ants were observed .Moving along I came to vacant resident rooms [ROOM NUMBERS]. Both units were inspected an no pests observed at this point. A liquid residual product was applied to the perimeter of both vacant units including the restrooms. Both a dry flowable and ant bait gel may attract t more ants at first but should dissipate after four to five days .Still seeing ants after last week treatment - rooms 102, 122. Told maintenance do not spray pesticides as they interfere with, the products we use, but he can spray warm soapy water to resolve any immediate issues as they pop up until we can arrive . Review of a facility invoice from the pest control company dated 2/12/25 reflected .General Comments .I then met with MD (Maintenance Director) and located logbook finding no new entries .I follow up on rooms with ants not finding any and cleaning staff reported non seen .before leaving I met with New administrator and went over her concerns for ants and rodent explaining treatment methods and preventative measures . Review of a facility invoice from the pest control company dated 3/11/25 reflected .General Comments . Met with MD (Maintenance Director) upon arrival, he stated no reports of pest at this time. I located logbook finding no new entries .On the exterior I services all rodent stations finding no activity. I then applied a granular ant bait due to high winds . Review of a facility invoice from the pest control company dated 5/18/25 reflected .General Comments .when I arrived, I checked in with the front desk also check in with MD (Maintenance Director) . The Director of Maintenance asked if there were any issues or concerns that needed my attention . He said if I can inspect room B10's restroom stated that they were seeing cockroach activity .also checked the service journal no notes of any kind were made . Review of a facility invoice from the pest control company dated 6/6/25 reflected .General Comments . met with MD he stated no issues inside other than a snake sighting .on the interior I located logbook finding no new entries at this time . Review of Pest Control Binder reflected the following log entries: - 1/14/25 ants/mouse in MSU 121 (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 1/15/25 binder checked by pest technician - no pest entries for February 2025 -2/12/25 binder checked by pest technician -no pest entries for March 2025 - 3/11/25 binder checked by pest technician - 3/17/25 binder checked by pest technician -4/10/25 B10 room roaches in restroom -4/16/25 binder checked by pest technician - no pest entries for May 2025 -5/8/25 binder check by pest technician -no pest entries for June 2025 -6/6/25 binder checked by pest technician Record review of the facility maintenance task report (from the QR code) dated 12/10/24 to 06/17/25 reflected the following reports: -5/8/25 ants in therapy room; sprayed room and did not see -5/29/25 B15 ants in room; sprayed, no ants -1/14/25 E121 ants; sprayed for ants and pest control will come tomorrow -1/17/25 B4 resident stated she had ants in her room yesterday and thinks she has bites on her arm; nurse and myself checked room for ants, none noted. -1/20/25 E120 ants at threshold; room was sprayed, pest control is scheduled. -1/20/25 B4 Ants in room; room was sprayed, pest control scheduled. -2/5/25 Microwave, ants noted on microwave; ants were on tray from another source, no ants detected on or around microwave or cabinet. -2/10/25 B7 bed B ants by bed; pest control scheduled -3/3/25 A1 ants reported in bathroom, no ants visually detected, sprayed insect repellant. (continued on next page)

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	455573	A. Building B. Wing	06/18/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3/5/25 dining red tiny ants noted all over the dining room floor; no visual ants detected, will monitor periodically. -3/31/25 A1 ants crawling around resident's refrigerator; no visual on bugs or ants. -4/22/25 Therapy- ants by window and emergency exit door; spayed pesticide, no visual ants -4/29/25 Therapy- ants in office (sugar ants); sprayed for ants, no ants were visible. -4/29/25 Therapy really bad sugar ant problem, can't find source; sprayed for ants, no ants visible. -5/9/25 A9 need to spray for ants; sprayed pesticides for ants, did not see any -5/8/25 Therapy- ants along wall, electrical outlet and desks next to emergency exit; sprayed for ants. -5/8/25 ants in therapy room; spayed room and did not see -5/28/25 Therapy - ants by emergency exit around electrical outlets and over wall and desks; spray for ants and did not see. -5/29/25 B15 ants in room; spayed no ants -5/30/25 Chapel - ants multiple; sprayed -6/1/25 B15 Ants all around his bedside dresser; sprayed for ants. -6/4/25 C2 Ants in room by bedside table; all opened food thrown away, sprayed for ants, need to keep foods in container. -6/4/25 Chapel - ants all over trashcan; sprayed ants, did we put it in the pest control binder -6/6/25 B15 Ants in room; sprayed for ants did not visually see them -6/10/25 Chapel - lots of ants; sprayed for ants, visually checked today, no ants -6/12/25 B7 ants in bed and on wall; checked for ants did not see any, did spray baseboard and under bed -6/14/25 B15 ants all over bed and floor, residents bed window wall and floor, trash. -6/15/25 A1 ants in resident's bed yesterday, sprayed for ants no ants visually; removed the resident for 1 hour. Interview with Housekeeper R on 6/17/25 at 10:40am revealed she had not been aware of any insects or bugs in the MSU hall. She stated if she saw any bugs, ants or insects she would scan the QR code posted on the wall, which would submit a work order for maintenance. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Housekeeping Manager on 6/17/25 at 1:23pm revealed he would notify maintenance of issue with pest such as ants and would remove any open food in the resident's room. He stated he was not aware of the facility having any issues with ants. Observation and interview with the resident in room A1 on 6/17/25 at 2:41pm revealed she had history of having had ants in her bed but the facility had sprayed and took care of the problem. Observation of the room revealed no ants. Observation and interview with the resident in room A9 on 6/17/25 at 2:48pm revealed she had a history of ants in a previous room but had not had any issues with ants on her side of the room since she moved to the new room. She noted she had previously seen ants by her roommates window in her current room but the facility staff had sprayed and hadn't seen anymore ants. Observation of the room did not reveal any ants. Interview with ADON Q on 6/17/25 at 3:31pm revealed she hadn't had any resident complain in a long time about ants in their rooms. If she would receive a complaint, she would have maintenance take care of it immediately. She stated she hadn't had any residents bit by ants. When asked about Resident #7 she stated she did not recall the resident. Interview with the Maintenance Director on 6/17/25 at 3:48pm revealed the maintenance logs from the QR code were not provided to the pest control company. He stated the only way the pest control company would know about the pest control issues reported through the QR code was if the staff noted it in the pest control binder. He stated he had never provided the log to pest control and was unsure of how to print the log. He stated it would be beneficial for them to have the log and did not have a reason for not providing it to them. He did not believe providing the pest maintenance log to the pest control company posed a risk to the residents because he stated he usually handled the complaints made on the log. He stated the only time he would request for the pest control company to come out immediately was if there was an issue with something he could not catch like rats or mice. He stated the pest control company comes monthly regardless of whether he called them for emergency purposes. Interview with the Service Manager from the pest control company on 6/17/25 at 4:08pm revealed the facility was on a monthly pest control service or as needed for pest control service. If the facility called for an issue, they would come out same day or next day. If it was an issue with a pest that bit or stung, such as ants, wasps, or bees, they would come out immediately. They provided the facility a Pest Control Binder for the facility staff to log issues with pest and the technicians checked it every visit and signed off they checked it. If the facility had a separate maintenance log with pest issues, he would recommend they put a copy of it in the log. He was unsure if the facility had a separate log. He stated all his technicians would do a summary of everything they treated and would notate complaints that were relayed to them at the time of treatment. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Technician S from the pest control company on 6/17/25 at 4:13pm revealed he had not provided service for the facility in the past two months and noted it was another technician. He stated when he entered a facility, he would look at the pest control binder first. He would then speak to the Administrator or the Director of Maintenance to see if they had any issues or complaints that were not noted in the binder. He stated the facility had never provided him another log of issues reported by staff and residents. He stated he had treated things that were not in the logbook if it was reported to him verbally. If something was reported to him verbally, he would include it in the service report notes. Interview with the Administrator on 6/17/25 at 4:37pm revealed she had some issues with ants since she became the administrator in late February, early March of 2025. She stated when a problem with ants arose, they cleaned the bedroom, sprayed insecticide, and had pest control come out. They have also treated the outside as necessary. If they treated and they still did not fix the problem they would have pest control come out or if it was an enormous problem they would have them come out. She stated either her or the Maintenance Director would call the pest control company in those situations. She stated there have been no residents that had complained about ant bites since she started. She was unsure if the maintenance logs were provided to the pest control company during their visits but stated they could be beneficial to help treat the pest in the facility. She stated she would teach the Maintenance Director how to print them and put them in the pest control binder. She stated there was no risk to the residents of not providing the logs to the pest control company because the Maintenance Director was taking care of the problems noted in the logs regarding the pests, the pest control company was coming out routinely and no residents had complained about ant bites. She stated ants were a risk to residents because it could lead to a massive problem with residents getting ant bites, but it's not there yet. She stated she did morning and evening rounds of the exterior daily with the Maintenance Director and he will address any ant hills observed immediately. She was informed about the ant hill observed earlier and she stated she was sure the Maintenance Director would take care of it. Interview with the Administrator on 06/18/25 at 9:05 AM revealed they did not have a policy for pest control. The facility did not submit a pest control policy by the date, 06/18/25 and time of exit.