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	12/09/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 (Resident #1) residents reviewed for infection control.The facility failed to ensure the treatment nurse changed gloves and washed her hands while providing wound care for Resident #1 on 10/07/2025.This failure could place residents at risk of cross-contamination and development of infections.The findings included:Record review of Resident #1's Face Sheet, dated 10/07/2025, reflected the resident was an [AGE] year-old male who admitted on [DATE]. Resident #1 had diagnoses which included aftercare following surgery of a closed left femur (bone in upper leg) fracture (crack or break in bone) with routine healing, hypertension (high blood pressure), and chronic kidney disease (kidneys are damaged and do not filter like they should). Record review of Resident #1's Quarterly MDS Assessment, dated 08/29/2025, reflected severely impaired cognition with a BIMS score of 05. Section M (Skin Conditions) indicated Resident #1 was treated for one pressure wound that was present on admission Record review of Resident #1's Comprehensive Care Plan, dated 07/15/2025, reflected Resident #1 had a pressure wound to the left heel. One intervention was to provide treatment as ordered by the physician. During an observation and interview on 10/07/2025 at 9:58 AM, the treatment nurse provided wound care for Resident #1. The treatment nurse parked the treatment cart outside of Resident #1's door. The treatment nurse put on gloves and removed a sanitizing wipe from a container on top of the treatment cart. She entered Resident #1's room and wiped the top of his bedside table. She removed the gloves and returned to the treatment cart. She did not used hand sanitizer. She put on a pair of gloves and placed a piece of wax paper on top of the treatment cart. She removed a tube of medicated ointment from the cart and squeezed the ointment into a small medicine cup on the wax paper. She removed gauze and dressings from the cart and placed them on the wax paper. She did not remove the gloves. The treatment nurse carried the wax paper with supplies into Resident #1's room and placed it on the bedside table. Resident #1 was sitting in a wheelchair with a foam boot on his left foot. Resident #1 agreed to the surveyor observing wound care. The treatment nurse removed the foam boot and sock from Resident #1's left foot. She removed the dressing from his left heel and used gauze with wound cleanser to clean his left heel. She removed the gloves and put on clean gloves. She did not use hand sanitizer. She applied the medicated dressing and bordered gauze to cover the wound. She removed her gloves, took a marker from her pocket to initial and date the dressing and returned the marker to her pocket. She did not use hand sanitizer between changing gloves. She applied gloves and put the sock and foam boot on Resident #1's left foot. She closed the bag of trash and washed her hands in the resident's restroom before exiting the room. The treatment nurse stated she should have washed her hands or used hand sanitizer between glove changes. She stated she usually had hand sanitizer with her. She stated it was important to prevent spreading anything to the residents because they were already vulnerable. During an interview on 10/07/2025 at 10:31 AM, the ADON stated the treatment nurse should have washed her hands or used hand sanitizer each time she removed her gloves. She stated the treatment nurse should have sanitized her hands prior to entering Resident #1's room. She stated it was important to prevent the spread of infection. During an interview on 10/07/2025 at 4:10 PM, the DON stated the treatment nurse should have washed her hands or used hand sanitizer every time when she changed gloves. She stated it was important to prevent the spread of infection. The DON stated she had already provided wound check off, hand hygiene, and infection control in-services to the treatment nurse. Review of the facility's policy Fundamentals of Infection Control Precautions, undated, reflected Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene. before and after changing a dressing.after removing gloves.Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections.Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use, and hands can become contaminated during removal of gloves.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Observation on 10/07/25 at 10:08 AM revealed ice accumulation on left side doorway of 1 to 3 inches width for about 2 feet length, 1-3 inches covering the top of the doorway, and about 1-2 inches on inner part of the freezer door covering the bottom and top of the door. Walk-in freezer door was unable to latch open about 1/4 inch with ice accumulation seen on bottom and right side of doorway. Interview on 10/07/25 at 10:11 AM with Dietary [NAME] A revealed the facility had been having issues for about 2 months with the walk-in freezer having excess ice accumulation and not latching. She stated it had gotten worse the last month. Interview on 10/07/25 at 10:13 AM with Dietary Aide B revealed the last month the walk-in freezer had a lot of ice accumulation daily. She stated they try to scrap off the ice in the walk-in freezer daily. She stated with the ice accumulation they could not latch the door. Interview on 10/07/25 at 11:02 AM with Dietary Manager revealed about a month ago contractor came out to replace the seal for the walk-in freezer. He stated they had to readjust the door latch. He stated the dietary staff had to de-ice the freezer 2x daily to keep the ice accumulation down so the door would latch. He stated the Dietary [NAME] was responsible to ensure walk-in freezer was de-iced in the morning and in the afternoon. He stated the risk to walk-in freezer having excess ice accumulation was it placed food at risk for contamination, freezer burn and deterioration. He stated the door latch not closing properly could place and placed the freezer at risk for contamination. He stated he did not have a log or a written schedule to ensure dietary staff were de-icing the freezer twice daily. Interview on 10/07/25 at 3:58 PM with Maintenance Supervisor revealed last week a contractor was supposed to come out to look at the walk-in freezer to determine what needed to be fixed and how much it would cost. He stated last month he replaced the door handle himself and seal was replaced. He stated he thought it was working properly until the beginning of last week with the excess ice accumulation so he reached out to the contract company. He stated they were supposed to send someone on Friday of last week but they did not show up. He stated he was not working on Friday and became aware of it when he returned this week after being off. He stated the facility did not have issues with walk-in freezer temperatures. He stated the contract company is sending someone out tomorrow to determine what needs to be fixed and replaced to keep the ice accumulation down. He was not aware the door was not latching properly. Review of facility contract company service estimate dated 07/01/25 reflected walk-in freezer was temping at 13 degrees.Checked the freezer and found the door gasket with ice on it preventing it from closing. Removed ice and the door doesn't shut and the door handle is broken. Contacted a subcontractor and he has put door gasket on the schedule. Review of facility's policy Storage Refrigerators dated 2012 reflected All storage refrigerators shall be maintained clean and have a proper temperature for food storage and to ensure a proper environment and temperature for food storage.7. Refrigeration equipment is to be routinely defrosted and compressor cleaned. The policy did not specify about the freezer maintenance. The facility did not have a specific policy on freezer maintenance or storage per the Dietary Manager.