

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455573	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Texoma Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 US Highway 82 East 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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to make prompt efforts to resolve grievances of resident rights and failed to follow their grievance policy for one of seven residents (Resident #1) reviewed for grievances, in that, The facility failed to document, resolve and follow-up with grievances on 06/09/26 and 06/12/26 for Resident #1 brought up by Resident #1's guardian concerns about Resident #1's dietary tray and milk being left longer than 1.5 hours. This failure could affect residents by placing residents at risk of a decline in quality of life and a delay in resolving grievances. Findings included: Review of Resident #1's face sheet undated reflected Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of multiple sclerosis (autoimmune disease that affects your brain and spinal cord), paraplegia (partial or complete paralysis of the lower half of the body, including both legs), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and dysphagia (difficulty swallowing). Resident #1 had a guardian listed on his face sheet as the responsible party for Resident #1. Review of Resident #1's quarterly MDS assessment dated [DATE] reflected Resident #1 had a BIMS of 4 indicating he was severely cognitively impaired. Resident #1 was substantial/maximal assistance to total dependent for ADLs of dressing, personal hygiene, bathing and mobility. Review of Resident #1's comprehensive care plan last reviewed 04/13/26 reflected The resident has impaired cognitive function/impaired thought processes r/t (related to) Dementia. It reflected The resident refuses to eat/resists feeding. Resident refuses to allow staff to remove his tray at times. Intervention included Staff will remove tray after 1.5 hours and offer snack if resident wants to continue eating. Record Review of Grievances for April 2026 to June 2026 reflected a grievance dated 06/03/26 was reported to DON about [Family member] is upset that his tray is still in his room, 1.5 hr after the meal. Findings include Spoke with staff and staff reports that resident refuses to allow staff to remove his tray, stating he is still eating. Corrective Action included Staff will continue to try to remove tray after meals. Care plan updated to reflect resident's desire to keep tray in room. It reflected grievance resolved. There were no grievances documented about the meal trays or milk being left in Resident #1's room from Resident #1's Guardian since 06/03/26. Record Review of Email reflected Resident #1's Guardian emailed the DON and Administrator on 06/09/26 at 1:07 AM the following: Please talk to [CNA B] about leaving milk for [Resident #1]. Tonight dinner was served at 4:54. He picked the tray up at 6:23 but left the milk and did not pick up the milk until 7:26. In the past, I have reached out to a couple of nurses asking them to remind [CNA B] not to leave milk. I can't verify if they did speak with him. This is nothing personal and he seems like a very nice person, but I think he hates to take the milk from [Resident #1] if [Resident #1] says he wants to keep it. I speculate that he feels compassion for him. However I do not want [Resident #1] getting sick because of dairy setting out too long. I do not want him to get into trouble, but I do request that you speak with him about the importance of removing the milk in a timely manner. I have been speaking with the state and they are telling me that it is on the nurse treatment plan and the nurses are ultimately responsible. This has been an ongoing discussion. Whatever the case, I just (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 455573 If continuation sheet Page 1 of 3

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	want the meals and the milk removed in a timely manner. Review of email response from DON dated 06/09/26 at 11:01 AM reflected Thank you. Record Review of Email reflected Resident #1's Guardian emailed the DON on 06/12/26 at 7:11 PM the following [CNA B] left [Resident #1's] milk again when he picked up his tray. After months of complaining about this, he had milk left too long every. Single. Meal. Today. Interview on 06/16/26 at 9:50 AM with Resident #1's Guardian revealed she was still having issues with facility staff removing the dietary meal trays after 1.5 hours of being given to Resident #1 and would leave his milk and shake in his room. She stated each time she had to call facility staff to get the staff to remove it. She stated she had reached out to the DON and Administrator about her concerns and she was still having issues with staff not picking up the meal tray or leaving his milk past the 1.5 hours. She stated she was not certain if the DON even read her emails and did not follow up with her grievance. Interview on 06/16/26 at 4:00 PM with CNA B revealed last Sunday (06/14/26) when he was working Resident #1 wanted to keep his health shake when he picked up the meal tray he stated he would be back to pick it up within 20 minutes but he got busy with other residents so there was a delay. He could not recall if it was on Friday (06/12/26) he had left the milk in his room. He stated he did his best to pick up the meal tray in the evenings for Resident #1 within the 1.5 hours but Resident #1 did not want him to take the health shake so he left it in his room. He stated it was not communicated to him when the meal tray was placed for Resident #1 for supper. He stated he was aware the meal tray for Resident #1 needed to be picked up in 1.5 hours. He stated the charge nurse would alert him if meal tray or shake was left in room too long. He stated no one from administration had specifically spoke to him about being late picking up Resident #1's meal tray and shake. He stated if resident wanted him to leave the shake in his room he did and did not understand why the meal tray including shake had to be removed. Interview on 06/16/26 at 5:06 PM with RN A revealed Resident #1's guardian did text her at 7:08 PM on Friday (06/12/26) she looked at her phone to know the time she received the text and stated the text revealed CNA B had left the milk/shake in Resident #1's room. She stated Resident #1 would reach out to her if the meal tray or shake was left past the 1.5 hours in his room since there was an electronic monitoring device in Resident #1's room. She stated she did not understand why the health shake needed to be picked up. She stated when the staff start their shift at 6 pm they try to pick up meal trays first. She stated prior shift did not communicate to them when Resident #1 received his meal tray so they would know when to pick it up by to meet the 1.5 hour timeframe. Interview on 06/16/26 at 4:45 PM with DON revealed at the care plan conference it was agreed upon for meal trays including the shake/milk to be picked up within 1.5 hours. She stated she started a monitoring tool to check 1 of the meals each day where it was written down when meal received and if tray was picked up within the 1.5 hours. The DON stated there should be a grace period of 15 to 30 minutes from that 1.5 hour period. She stated the weekend shifts were more difficult for staff to adhere to the 1.5 hours. She stated nurses would receive a phone call from Resident #1's guardian since he has an electronic device in room if meal tray or shake was left in resident room past the 1.5 hours. She stated after the care plan conference on 06/03/26 the nurses and CNAs were in-serviced to ensure meal trays including dairy shake was removed within the 1.5 hours of receiving the tray. She stated she had received an email on Friday (06/12/26) and had not had an opportunity to follow up with Resident #1's guardian yet. She stated she was not sure if she followed up with Resident #1's guardian about her email on 06/09/26. She stated it was difficult for staff to understand that Resident #1's meal tray including dairy shake needed to be removed within 1.5 hours since resident wanted it kept in his room. Interview on 06/16/26 at 5:15 PM with Administrator revealed Resident #1's guardian did voice continued concerns about Resident #1's meal trays including shake/milk not being picked up within the 1.5 hours of receiving the tray. He stated DON participated in the care plan conference with Resident #1's guardian and he was not in the care plan conference. He stated he thought the DON had responded to Resident #1's guardian's emails saying they would address it. He stated it was important to document grievances, follow-up with grievances to ensure concerns were being met for residents. The (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator stated he was responsible for overseeing the grievance process. Review of facility's policy Grievances last revised 11/02/16 reflected The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. Procedure.2. The grievance official of this facility is the administrator or their designee. 3. The grievance official will Oversee the grievance process Receive and track grievances to their conclusion Lead any necessary investigations by the facility.Issue written grievance decisions to the resident.6. All written grievances decisions will include: The date the grievance was received A summary statement of the residents grievances The steps taken to investigate the grievance A summary of the pertinent findings or conclusions regarding the resident's concern(s) A statement as to whether the grievance was confirmed or not confirmed Any corrective action taken or to be taken by the facility as a result of the grievance The date the written decision was issued.		