

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

Printed: 10/09/2026
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 07/27/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for four of nine residents (Resident #3, #5, #6, and #8) reviewed for accident prevention. The facility failed to ensure Resident #6 did not have scissors and odor ban disinfectant spray in his room on 07/27/26. The facility failed to ensure Resident #5 did not have a container of Tide Pods laundry soap in her room on 07/27/26. The facility failed to ensure Resident #8 did not have Nystatin cream, scissors and safety pin in his room on 07/27/26. The facility failed to ensure that Resident #3 did not have scissors and 2 nail clippers in his room on 07/27/26. This failure could place residents at risk of injuries or accidents. Findings included: Record review of Resident #6's Face Sheet, dated 07/27/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with bipolar disorder (A condition where depressive episodes alternate with periods of abnormally high energy or mania). Record review of Resident #6's Quarterly MDS Assessment, dated 06/04/26, revealed a BIMS of 9 (moderate cognitive impairment). The MDS Assessment revealed the Resident needed Supervision with shower, upper body dressing, lower body dressing and putting on of footwear. It revealed he had a diagnosis of bipolar disorder. Record review of Resident #6's care plan revision dated 06/08/26 revealed, the resident has mood problem r/t bipolar with intervention to 1) Monitor/record/report to MD prn risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. 2) Monitor/record/report to MD prn risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons. During an observation and interview on 07/27/26 at 9:30 a.m. with Resident #6, it was observed that an odor ban disinfectant spray was hanging on his bed rails and a pair of scissors on his nightstand. He stated he got the odor ban from Walmart; he uses it because it stinks in his room and the scissors are used to trim his beard; he stated that he is not supervised when he uses it and does not need supervision. Record review of Resident #5's face sheet dated 07/27/26 revealed a [AGE] year-old female admitted to the facility on [DATE], she had a diagnosis of bipolar disorder (A condition where depressive episodes alternate with periods of abnormally high energy or mania) Record review of Resident #5's change in condition MDS Assessment, dated 04/22/26, revealed a BIMS of 11 (mild cognitive impairment). The MDS Assessment revealed the Resident needed substantial / Maximal assistance to Supervision with shower, upper body dressing, lower body dressing and putting on footwear. It revealed she had a diagnosis of bipolar disorder. Record review of Resident #5's care plan dated 03/11/26 revealed the (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 12

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident had an ADL Self Care Performance Deficit with intervention for Resident will ask for assistance as needed with ADLS and toileting, bathing. During an interview and observation on 07/27/26 at 9:40 a.m. with Resident #5 revealed Tide Pods container with Pods observed on her nightstand. She stated that she has had them there since she moved in, she stated that the staff moved her things in and kept the container of Tide Pods on her nightstand and it has been there ever since. She stated that she knew it should not be stored in the open because it could pose a danger to residents who are confused, she stated they can eat it if they get a hold of it. Record review of Resident #8's face sheet dated 07/27/26 revealed a [AGE] year-old male admitted to the facility on [DATE], he had a diagnosis of Lack of coordination, Need for assistance with personal care. Record review of Resident #8's Quarterly MDS Assessment, dated 06/10/26, revealed a BIMS of 14 (no cognitive impairment). The MDS Assessment revealed the Resident has medically complex conditions. Record review of Resident #8's care plan dated 03/11/26 revealed the resident has an ADL Self Care Performance Deficit with intervention to requiring 1 staff for ADL's and Encourage the resident to participate to the fullest extent possible with each interaction. During an observation and interview on 07/27/26 at 10:10 a.m. with Resident #8, it was revealed that a safety pin, pair of scissors and Nystatin cream was observed on his nightstand. He stated that they were given to him by the facility. He stated that he was not given any instructions on how to use them, but he is safe with them. He stated that he had a lock box that he locked them in that was stolen in September 2025 and was not found, a police report was filed. He stated that the facility had put a lock on his nightstand, but he has not had a key to it in the last 2 months and has complained to maintenance about it 2 months ago and it is still locked. Record review of Resident #3's Face Sheet, dated 07/27/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. The Resident was diagnosed with Dementia (A progressive loss of memory, reasoning and communication skills) and Intermittent explosive disorder (sudden, intense fits of anger or physical aggression that are completely out of proportion to what caused them). Record review of Resident #3's Annual MDS Assessment, dated 05/22/26, revealed a BIMS of 6 (severe cognitive impairment). The MDS Assessment revealed the Resident had Medically Complex Conditions. Record review of Resident #3's care plan dated 06/27/25 revealed the resident has impaired cognitive function/dementia or impaired thought processes r/t intermittent explosive disorder, psychotic disorder with delusions due to now physiological condition and Dementia with intervention to Provide a program of activities that accommodates the resident's abilities. During an interview and observation on 07/27/26 at 10:45 am with Resident #3, it was observed that Resident #3 had scissors, 2 pairs of nail clippers and bleed stop in a clear plastic drawer in his room. He stated that he was not sure how they got in his room. He did not answer any other questions asked. During an interview on 07/27/26 at 3:23 p.m. with CNA F, she stated that these items should not be in the resident room. She stated that chemical sprays, tide pods, scissors and nail cutters are a hazard, the nystatin cream is a treatment and should be locked up in the treatment cart. She stated that residents could drink these items, she stated they can cut themselves with the scissors and get hurt bad. She stated that all nursing staff are responsible for making sure no hazards are left in any resident rooms. She stated that she has been in serviced about what items are not allowed in the residents' rooms. During an interview on 07/27/26 at 3:45 p.m. with CNA L, she stated that Resident #3 has had the Tide Pods in her room for a while even when she was in a different hall. She stated that the resident should not have the Tide Pods in her room. She stated that anyone can get a hold of it and eat it and get very sick. She stated that she takes out aerosol sprays if she sees them. She stated that these items can potentially hurt any resident. She stated that all staff that work in the halls are responsible for making sure no hazardous items are in the resident's (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room. During an interview on 07/27/26 at 4:31 p.m. with LVN C, he stated that the facility policy is that any chemicals, scissors and sharp objects should be locked up in a secure compartment and room checks should be done during rounds for these items. He stated that all chemicals should comply with the MSDS standard for the facility. He stated that all staff in the hall should be doing rounds to make sure that there are no safety hazards in any resident rooms. He stated that if any chemicals or sharp objects are in the room, the residents could cut themselves, and the chemicals could burn them or could be a fire hazard. During an interview on 07/27/26 at 5:07 p.m. with the DON, she stated that she has started a list of items that should not be in resident rooms and will pass it on to all staff when they do rounds and will also make sure families who bring in any prohibited items are educated. She stated that hazards could affect the residents, they can interact with their meds, they could be fire hazards, and someone who does not have the capability of using the items correctly can hurt themselves or others. During an interview on 07/27/26 at 5:47 p.m. with the Administrator, he stated that hazardous items should not be in residents' rooms, he stated that the challenge is that some residents order things online and due to resident rights, they cannot open the boxes for inspection. He stated that they make rounds to ensure that any hazardous items or sharp objects are not stored in the residents' rooms. He stated that every staff member is responsible for making sure no hazardous chemicals or sharp objects are in the resident's room. He stated that they do room rounds to check for items that are not allowed but they will have to do so more intently to remove the items. He stated that they educate the residents when any items that are not allowed in the facility are found in the rooms. Record review of the facilities undated list of Items not allowed in rooms (these items may be kept in the med rooms, labeled with the resident's name and room number) The med room next to B hall has many cubbies available to be labeled. Revealed the following items: Triple antibiotic ointment (Neosporin) Scissors Wound care products Tylenol (acetaminophen) Advil (ibuprofen) Aleve (naproxen) Pain cream Pain patches Air freshener Aerosol Cans (ie. Hairspray, deodorant) Deodorant of any kind Razors (electric razors are ok) Tide pods (laundry detergent of any kind) Vape pens Cigarettes Lighters Cleaning products Dish soap Sharp objects (knives) Chemicals of any kind Electric Tea kettles Microwave ovens Toasters Heating pads Personal heaters Large amounts of money Unsecured credit cards Curling irons Blow dryer		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure that residents, who needed respiratory care, were provided care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 3 of 9 residents (Residents #5, #7 and #1) reviewed for respiratory care. The facility failed to ensure Resident #5's Oxygen Nasal Canula and breathing treatment masks storage bags were changed every 7 days on 07/27/26. The facility failed to ensure Resident #7's breathing treatment masks storage bag was changed every 7 days on 07/27/26. The facility failed to ensure Resident #1's CPAP storage bag was changed every 7 days on 07/27/26. These failures could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Record review of Resident #5's face sheet dated 07/27/26 revealed a [AGE] year-old female admitted to the facility on [DATE], she had a diagnosis of bipolar disorder (A condition where depressive episodes alternate with periods of abnormally high energy or mania) and COPD. Record review of Resident #5's change in condition MDS Assessment, dated 04/22/26, revealed a BIMS of 11 (mild cognitive impairment). The MDS Assessment revealed the resident needed substantial / maximal assistance to supervision with shower, upper body dressing, lower body dressing and putting on footwear. The MDS revealed she was on oxygen therapy. Record review of Resident #5's care plan dated 03/11/26 revealed the resident had oxygen therapy with intervention to administer oxygen at 2-4 liters per nasal canula. Record review of Resident #5's physician order dated 07/22/26 revealed an order for Oxygen LPM: 2-4 Via: nasal canula every shift related to COPD. During an observation and interview on 07/27/26 at 9:40 a.m. with Resident #5, it was observed that a breathing treatment mask storage bag dated 07/17/26 was hanging on the wall and a nasal canula storage bag on the oxygen machine was dated 07/02/26. She stated that she is not sure how often it should be changed but that they needed to be changed. She stated that she does not want to get sick from any contamination. Record review of Resident #7's face sheet dated 07/27/26 revealed a [AGE] year-old female admitted to the facility on [DATE], she had a diagnosis of Acute Respiratory Failure (sudden, life-threatening condition where your lungs can no longer get enough oxygen into your blood or get rid of enough waste carbon dioxide). Record review of Resident #7's Quarterly MDS Assessment, dated 06/12/26, revealed a BIMS of 11 (mild cognitive impairment). The MDS Assessment revealed the resident was coded for Acute Respiratory Failure. Record review of Resident #7's care plan dated 11/07/25 revealed the resident had altered respiratory status/Difficulty Breathing / Shortness of Breath and hx of ACUTE RESPIRATORY FAILURE with intervention to Administer medication/puffers as ordered. Monitor for effectiveness and side. Record review of Resident #5's physician order date 06/09/26 revealed an order for Budesonide Inhalation Suspension 0.25 MG/2ML (Budesonide (Inhalation)) 1 vial inhale orally via nebulizer two times a day related to RESPIRATORY DISORDERS. During an observation and interview on 07/27/26 at 10:25 a.m. with Resident #7, breathing mask storage bag dated 07/02/26 and 2 undated bags were observed. She stated she is not sure what the schedule was for changing the bag, she stated that they should be thrown away at this time since they may be contaminated. Record review of Resident #1's face sheet dated 07/27/26 revealed a [AGE] year-old male admitted to the facility on [DATE], he had a diagnosis of COPD and sleep apnea (sleep disorder where a person's breathing repeatedly stops and starts throughout the night). Record review of Resident #1's MDS Assessment, dated 07/17/26, revealed a BIMS of 14 (no cognitive impairment). The MDS Assessment revealed the Resident was coded for COPD and sleep apnea. Record review of Resident (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#1's physician order dated 07/10/26 revealed an order for BIPAP - Settings IPAP 10.0 cm H2O EPAP 4.0 cm H2O every night shift related to SLEEP APNEA. During an observation and interview on 07/27/26 at 10:35 a.m., Resident #1 stated that all he has to say is that some staff members should leave their problems at home. BIPAP mask storage bag was dated 7/10/26 on the nightstand. He stated he did not want to answer any questions at this time. During an interview on 07/27/26 at 4:31 p.m., LVN C stated that the nebulizer and oxygen bags should be changed weekly and as needed if soiled. He stated that the charge nurse, ADON, and DON are responsible for making sure that they are changed as ordered. He stated that an in-service was conducted on 07/14/26 on changing the oxygen tube and nebulizer mask bag. He stated that if the bags are not changed, it could get molded, the plastic of the nebulizer could get stiff and irritate the residents' nose and ear. During an interview on 07/27/26 at 5:07 p.m., the DON stated that the expectation is that the nasal canula bags and nebulizer mask bags should be changed every 7 days and dated, she stated that this applied to all respiratory apparatus including CPAP and BIPAP masks. She stated that the nurses are responsible for making sure that the bags are changed and dated. She stated that it is an infection control issue. She stated that for residents with respiratory issues, it can cause an infection for them and worsen their condition. Record review of the Facility's undated Policy for Oxygen Administration revealed: The amount of oxygen by percent of concentration or L/min, and the method of administration, is ordered by the physician. The administration, monitoring of responses, and safety precautions associated with it are performed by the nurse. The resident will be free from infection. Record review of the facility's undated policy for Aerosolized Hand-Held Nebulizer revealed: A compressor-driven nebulizer will be used (unless piped-in oxygen is available), to administer aerosolized medication as ordered by a physician. Change nebulizer set-up every 7 days and more often if necessary.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm 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 observations, interviews, and record review, the facility failed to ensure the resident was treated with respect and dignity and care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life by recognizing the resident's individuality for one of nine residents (Residents #2) reviewed for residents' rights and dignity. The facility failed to ensure that Resident #2's Foley bag was in a privacy bag while in his wheelchair on 07/27/26. This failure could place the residents at risk of not having their right to a dignified existence maintained. Findings included: 1. Record review of Resident #2's Face Sheet, dated 07/27/26, revealed a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate causing trouble with peeing). Record review of Resident #2's Quarterly MDS dated [DATE], revealed that the resident had a BIMS of 10 which is indicative of moderate cognitive impairment. The MDS assessment revealed that the Resident had an indwelling catheter. The MDS assessment revealed Resident #2 required supervision or touch assistance for personal hygiene and toileting. Record review of Resident #2's Physician Order, dated 06/05/26, revealed an order to Ensure foley bag is in privacy bag while in bed or w/c every shift related to BENIGN PROSTATIC HYPERPLASIA WITH LOWER URINARY TRACT SYMPTOMS; OBSTRUCTIVE AND REFLUX UROPATHY, UNSPECIFIED (enlarged prostate causing trouble with peeing). Record review of Resident #2's care plan dated 06/05/26 revealed that The resident has (Indwelling) Catheter: r/t obstructive uropathy with intervention to Check tubing for kinks and maintain the drainage bag off the floor; Ensure tubing is anchored to the residents leg or linens so that tubing is not pulling on the urethra (pipe that carries urine from bladder out of the body), Monitor and document intake and output as per facility policy, and Perform Catheter care at least every shift and at each incontinent episode. The care plan revealed the resident has an ADL self-care performance deficit with intervention requiring staff x 1 assistance for bathing, bed mobility, dressing and toilet use and the residents require a lift for all transfers. During an interview and observation on 07/27/26 at 10:45 a.m., Resident #2 was in his power chair in hallway C, his Foley bag was not covered in a privacy bag, he stated that it is usually covered but could not find the privacy bag. He found the bag under his food tray and placed the foley bag in a privacy bag when he got into his room. He stated that he usually does his own foley care and does not ask for help. During an interview on 07/27/26 at 3:23 p.m. with CNA C, she stated that the expectation is to have a privacy bag over the foley bag to maintain the residents' privacy and dignity. She stated that Resident #2 is very particular about how he wanted things done. She stated that she checks on the resident to see if the bag is full and needs to be emptied, she stated that the resident insists on emptying the bag himself. She stated that the privacy bag needs to be in place to prevent others from seeing that he has a foley catheter. She stated that the resident can get upset and angry if the bag is not covered with a privacy bag. During an interview on 07/27/26 at 3:45 p.m. with CNA L, she stated that privacy bags are supposed to always be in place, he stated that Resident #2 always takes his privacy bag off. She stated that the privacy bag should be in place to maintain the residents' dignity. She stated that if his dignity is not maintained it could make him feel depressed and uncomfortable know that others can see what is going on with him. She stated that she tries to encourage him to have the privacy bag on, but the resident is alert and oriented and does not always follow the direction and does things his way. During an interview on 07/27/26 at 4:31 p.m. with LVN C, he stated that the privacy cover should (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	always be on. He stated that Resident #2 is forgetful and leaves the privacy cover off sometimes. He stated that he is not sure of any challenges with him keeping the privacy bag on. He stated that the privacy cover should be on to maintain the resident's dignity and not everyone should know if he has a foley catheter. He stated that he could have depression and not see himself as a normal person and a constant reminder of his condition if the privacy bag is not in place. He stated that all nursing staff and other employees are responsible for making sure that the privacy bag is always in place. During an interview on 07/27/26 at 5:07 p.m., the DON, she stated that it is expected that every foley should always have a privacy cover. She stated that it's a dignity and privacy issue and his care and condition should be between him and his nurse and doctor. She stated it could affect him emotionally and take away his dignity. She stated that nursing and CNAs are responsible for making sure that the privacy bag is always on.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary care team to reflect a residents changed in condition following a fall for one of nine residents (Resident #9) reviewed for care plan implementation. The facility failed to ensure Resident #9's comprehensive care plan was updated following a fall resulting in a left ankle fracture on 07/02/26. These failures could place the residents at risk of not having their needs met and receiving the necessary care and services. Findings included: Record review of Resident #9's Face Sheet, dated 07/27/26, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #20 had a diagnosis Age related osteoporosis (Thinning bones) and muscle weakness. Record review of Resident #9's Quarterly MDS Assessment, dated 07/27/26, revealed a BIMS of 7, indicative of severe cognitive impairment. The Quarterly MDS Assessment did not reveal a history of falls. Record review of Resident #9's care plan dated 12/22/26 revealed the resident was at a risk for falls, goal that the resident will be free of falls and will not sustain serious injury through the review period, interventions included to anticipate and meet Resident's needs, be sure the Resident's call light is within reach and encourage the Resident to use it and review information on past falls and attempt to determine cause of falls, record possible root cause, alter any potential causes if possible. Educate resident/family/caregivers and IDT as to causes. During an interview on 07/27/26 at 10:15 a.m., Resident #9 stated that transferred herself to the bathroom and she fell when she was coming out of the bathroom and hurt her leg, she stated that she tried to land on her bed but missed and landed on the floor. She stated that she was lucky to be alive. She was observed with a boot on her left leg. She stated that she is unable to recall the details of the events that led to the fall. During an interview on 07/27/26 at 3:23 p.m., CNA F stated that she looks as the Kardex to know the type of care each resident needs. She stated that the Kardex is usually updated and if she notices any changes she reports to the nurse to update the Kardex. She stated that if the Kardex is not updated and level of care changes for a transfer can cause injury for the residents and staff involved in the care. During an interview on 07/27/26 at 3:45 p.m., CNA L stated that she cares for the residents based on the direction on their Kardex. She stated that the Kardex is always updated and she tries to keep up. She stated that the MDS and therapy keep the Kardex updated. She stated that if the Kardex is not updated she reports to the charge nurse. She stated that if the Kardex is not updated the right care that is needed would not be provided. During an interview on 07/27/26 at 4:31 p.m., LVN C stated that the MDS coordinator updates the care plan, he stated that there should be communication for any change in condition. He stated that rounds should be made by the MDS coordinator daily to find out any changes in resident conditions. He stated that due to the facility being short staffed a lot of times it is hard for the MDS coordinator to keep up, he stated that he has not noticed any management nursing staff do rounds to check on any changes with the residents. He stated that he reports changes in resident conditions to the ADON and the DON. He stated that the care plan needs to be updated so that PRN Staff who don't work regularly will know what is going on with each resident so they can provide the proper care and the expectation of the care for each resident. He stated that if the care plan is not updated the resident care would not be provided and the resident condition could deteriorate. He stated that the care plan should be updated after any significant change in condition or fall in the case of Resident #9. During an interview on 07/27/26 at 5:07 p.m., the DON stated that the expectation is that the nurses, MDS or the DON should (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	update the care plan when a resident is readmitted into the facility. She stated that updating the care plan is to make sure that everyone knows and is updated on how to care for the residents. She stated that if the care plan is not updated it will affect their safety during care. She stated that the CNAs have an update on the Kardex and plan of care whenever the care plans are updated. The DON stated that they should have updated the fall care plan for Resident #9 after the fall and that it was an oversight on their part. Record review of the facility's policy, undated Fall Policy revealed: Preventing falls requires an interdisciplinary program that focuses on modifying the extrinsic factors, correcting intrinsic factors, and educating the resident and family. A Fall Risk Assessment will be completed on admission and after each fall. The MDS 3.0 will also assist in determining a resident who is a fall risk. Fall Risk Assessment The Fall Risk Assessment Tool will be completed at admission and after each fall occurrence. The assessment should be completed by reviewing the resident's medical history, social history, and current functional status. Information may be obtained by reviewing current medical records, interview with resident/family, or conference with the interdisciplinary team members. The assessment tool should be scored and interventions implemented as indicated. The MDS completed on admission quarterly and upon significant change will also assess for fall risk. Appropriate interventions will be addressed immediately on the interdisciplinary plan of care. Reassessment will occur after each fall. The DON or designee will be responsible for investigating all resident falls to attempt to determine the cause and need for new interventions as required.		

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 07/27/2026
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.			
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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure parental fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive care plan and the resident's goals and preferences for 1 of 9 residents (Resident #4) reviewed for PICC lines (Peripherally Inserted Central Catheter). The facility failed to change the PICC line (an intravenous catheter that is suitable for long term infusion therapy) dressing on Resident #4 for more than 7 days on 07/27/26. These failures placed the residents at risk of infection or dislodgement. Findings included: Record review of Resident # 4's face sheet dated 07/27/26 revealed he was a [AGE] year-old-male admitted on [DATE] he was diagnosed with Severe Sepsis without septic shock (blood pressure remains stable enough to avoid a critical drop). Record review of Resident #4's Quarterly MDS assessment date 07/02/26 revealed a BIMS score of 9 (moderate cognitive impairment), it revealed active diagnosis of septicemia (blood poisoning, which occurs when bacteria or other germs from an infection elsewhere in the body enter and multiply in the bloodstream), it revealed the resident is on antibiotics due to infection. Record review of Resident #4's physician order dated 06/30/26 revealed an order for Vancomycin HCl in NaCl Intravenous Solution 1.5-0.9 GM/500ML-% (Vancomycin HCl-Sodium Chloride) Use 500 cc intravenously at bedtime for foot until 8-6-26. During an interview and observation on 07/27/26 at 10:57 a.m., with Resident #4, he was observed sitting in his wheelchair, clean, well-groomed and free of odors, his PICC line dressing located on the residents right arm was dated 07/16/26. The dressing was intact and no redness was noted on insertion site. He stated that he is not sure if it should be dated and how often it should be changed. During an interview on 07/27/26 at 4:31 p.m., LVN C stated that the expectation is that the PICC line dressing should be changed every 7 days, it is a standard order for the facility or follow the current order from the physician. He stated that the nurse is responsible for making sure that the orders are followed by changing the dressings. He stated that if the PICC line dressing is not done as ordered, it could lead to infection and deterioration of the skin under it. During an interview on 07/27/26 at 5:07 p.m. with the DON, she stated that the expectation is that PICC line dressings should be changed every 7 days and as needed if soiled. She stated that this is to prevent infection to the PICC line insertion site. She stated the nurses are responsible for making sure the PICC line dressing is changed as ordered. She stated if the PICC line dressing is not changed as ordered and infection can occur and this could be detrimental to the resident.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure prescribed medications were stored in a locked compartment for 1 of 9 residents (Resident #6) reviewed for medication storage. The facility failed to ensure Resident #1's prescribed medications were not left on top of the resident's bed side table by MA D on 07/27/26 These failures could place residents at risk of wrong medication administration, not getting the full benefit of the medication, accidental overdose, misuse of medications, diversion and possible adverse reactions. Findings include: Record review of Resident #1's face sheet dated 07/27/26 revealed a [AGE] year-old male admitted to the facility on [DATE], he had a diagnosis of COPD and sleep apnea (sleep disorder where a person's breathing repeatedly stops and starts throughout the night). Record review of Resident #1's MDS Assessment, dated 07/17/26, revealed a BIMS of 14 (no cognitive impairment). The MDS Assessment revealed the resident had medically complex conditions. Record review of Resident #1's care plan dated 01/07/26 revealed, Adverse medication effect and behavior Monitoring with intervention to Monitoring and accurate documentation of the resident's response to any treatment (such as, lab results, vital signs, progress notes, behavior flow sheets, medication administration records and the consultant pharmacist's drug regimen review) is essential to evaluate the ongoing effectiveness, benefits as well as risks of nonpharmacological approaches and medications. During an observation and interview on 07/27/26 at 10:35 a.m., with Resident #1, a medication cup with medication in it was observed on the resident's bedside table while he was asleep. He was easily aroused. He stated he was asleep when the nurse came and she left the medication on the table for him to take after breakfast. He stated that he gets his medication after breakfast and dinner. During an interview on 07/27/26 at 4:19 p.m. with MA D, she stated that she should observe the following protocol for medication pass right resident, right dose, right time, right route, right medication and to make sure the resident took the medication before she moved on to the next resident. She stated that she had given Resident #1 his medication but was distracted by the roommate and assumed the resident took his medication. She stated that if the resident does not take his medication as scheduled, he will not get the full therapeutic effects of the medication prescribed for him. She stated that if the medications are not taken it could lead to a worsening of his health conditions or an overdose if he takes it close to the next dose. She stated that she has been in serviced on medication pass. She stated that she reports any medication errors to the DON or the charge nurse During an interview on 07/27/26 at 4:31 p.m. with LVN C, he stated that the expectation is that medication administration should be observed and not left at the bedside for the resident to take. He stated that the resident could take it close to the next dose or the roommate can take it when it's not meant for them and this could be life threatening. He stated that the medication aide and the charge nurse are responsible for making sure that all medications should be administered by facility protocol for the resident's safety. During an interview on 07/27/26 at 5:07 p.m. with the DON, she stated that the medications should never be left with the resident, she stated that it is expected that the MA /Nurse should observe the resident take the medication and take the medication cup with her as she leaves the room. She stated that the resident will not get as much medication as they should, to make sure they are not chocking on the meds, to make sure they are fully swallowing the medication and not pocketing it in their mouths and to prevent other residents from getting a hold of the medication which is not meant for (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them and have an allergic reaction. She stated that whoever is giving the medication is responsible for making sure they are taken as ordered by the resident. Record review of the facility's V3 2025 Medication Storage in the Facility revealed Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations orthose of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staffmembers lawfully authorized to administer medications. Record review of the facility's V3 2025 Medication Administration and General Guidelines revealed Medications are prepared, administered, and recorded only by licensed nursing, medical, pharmacy, or otherpersonnel authorized by state laws and regulations to administer medications.Medications are administered at the time they are prepared. Medications are not pre-poured.Medications supplied for one resident are never administered to another residentAdheres to the 6 Rights of Medication Administration:1) Right Dose2) Right Route3) Right Resident4) Right Medication5) Right Time6) Right Documentation Observes the resident take the medications		