STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455573	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Texoma Healthcare Center	1000 Hwy 82 E Sherman, TX 75090

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for one of eight residents (Resident #82) reviewed for ADL care. The facility failed to ensure staff provided consistent showers/baths for Resident #82. This failure could place residents at risk of not receiving needed hygiene care which could cause skin breakdown, a loss of dignity and self-worth. Findings include: Record review of Resident #82's 5-day MDS assessment, dated 10/12/24, reflected an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. He had a BIMS score of 10, which indicated he was moderately cognitively impaired. He had not rejected care and required substantial to maximum assistance with showers and baths. His active diagnoses included diabetes and aftercare following hip replacement surgery. Record review of Resident #82's care plan, initiated on 12/27/23, reflected, .The resident has an ADL Self Care performance deficit related to surgical aftercare .Interventions . Bathing: requires staff x 1 for assistance . Record review of Resident #82's ADL documentation survey report for November 2024 reflected showers was scheduled on Monday, Wednesday, and Friday. No showers on scheduled day for 11/01/24, 11/06/04, 11/11/24 and 11/15/24. In an interview with Resident #82 on 11/18/24 at 9:50 a.m., he stated he had only received one shower last week and that was on Friday (11/15/24). He stated he received a shower this a.m. (11/18/24) after he raised cane about not getting his showers last week. He stated he wanted his scheduled showers and should not have to keep asking for them. (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

Printed: 02/11/2025
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 11/20/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/19/24 at 01:15 p.m., CNA E stated she did not shower Resident #82 on 11/13/24. She stated she just forgot about it. She stated RN C asked her on Thursday (11/14/15) to shower him and when she was able to get to him in the afternoon, he was mad and did not want his shower at that time. She stated she did shower him first thing Monday (11/18/24) and stated another aide showered him on Friday (11/15/24) She stated she did not complete a refusal of shower for Resident #82 on (11/14/24) and stated she should had documented it in the electronic record. In an interview with ADON G on 11/19/24 at 12:30 p.m., she stated she was unable to locate any refusal of shower sheets for the month of November 2024 for Resident #82. In an interview on 11/19/24 at 01:15 p.m., RN I stated she worked last Wednesday (11/13/24) and Thursday (11/14/24). She stated Resident #82 was very upset when she made her rounds on 11/16/24 and complained about not getting his shower. She stated he told her he had not had a shower since last Friday (11/08/24). She stated she asked CNA E about it, and she told her she had forgotten him on Wednesday 11/13/24. She stated she told CNA E to give the resident a shower that day. She stated she assumed he had gotten it. She stated the CNAs were to turn in a refusal of shower sheet if a resident refused and she, the aide and the resident had to all sign off they were refusing the shower or see if they wanted a shower at a different time. She stated she did not recall getting a refusal of shower on him. She stated she was not sure what was in place for nurses to see if the showers was being provided as scheduled. She stated the CNAs were to document in the record when they provided a shower, but stated she does not see that information. In an interview with MA F on 11/20/24 at 08:46 a.m., she stated she had signed off on the electronic record on 11/13/24 that Resident #82 was provided a shower. She stated she did not shower him that day and stated she was only helping the CNAs out with their documentation. She stated no one told her they had showered him but stated the 2 CNAs who were assigned that hall were always good about providing their showers. She stated she realized now this was not a good idea because it appeared the resident received his shower when he had not. In an interview with the DON on 11/20/24 at 01:20 p.m., she stated residents was supposed to get showers according to the scheduled shower days and documented in the record, and it was the responsibility of the CNAs and the Charge nurse to make sure residents received their showers. She stated they had implemented a new system where any refusal had to be documented by the CNA, Charge nurse, and the resident to see if the resident wished for a shower at a different time or a different staff member. She stated the staff who provided the care should be documenting the care. She stated she and the ADONs was reviewing the dashboard each morning for any missed documentation of care, but if they are signing off care is provided when it is not, that will not alert them to an issue. She stated ultimately the Charge nurses need to be ensuring the care is provided. The DON stated the risk to residents not getting their showers was skin issues, hygiene, and loss of dignity. Record review of the facility's undated policy titled, Bath, Tub/shower, 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 day or with partial bathing as needed .Goal .The resident will experience improved comfort and cleanliness by bathing .The resident will maintain intact skin integrity .The resident will be free from soil, odor, dryness, and purities following bathing .

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 50910 Based on observation, interviews, and record review the facility failed to provide, based on the preferences of each resident, activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for nine of nine confidential residents reviewed for activities. The facility failed to provide activities to meet the residents' interests on Saturdays and Sundays for 9 confidential residents. These failures placed residents at risk for decline in quality of life, social and mental psychosocial wellbeing. Findings Include: During a confidential group interview on 11/19/24 at 10:02 a.m., with 9 residents, all residents stated that there are no weekend activities. They stated that they can attend church on Sundays, but no other activities are provided. They stated that they would love to have weekend activities, as it gets boring. They stated that the only time they have weekend activities is during holidays. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Texoma Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Hwy 82 E Sherman, TX 75090	

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Activities Director on 11/19/24 at 11:41 a.m., revealed that aides, nursing staff and the Activities Director assist residents to get to activities during the week. She stated that on the weekends the Activity Assistant would facilitate and ensure that residents get to planned activities Saturday and Sunday, however the Activities Assistant is no longer at the facility and has been gone since August 2024, which has made it difficult to offer activities during the weekend. She stated that for September and October she would put on the calendar on Saturdays and Sundays activities of Resident choice. When asked what choice of activities residents have, she stated that resident can play games. She stated that some residents have games in their room that they can share and invite others to participate in. When asked if there was any other games in the facility that anyone could use, she stated no. She stated that the residents that enjoy playing games will usually have a game in their room and invite others, but for residents that do not have games they do not have access to games unless they share with a resident that does have a game. She stated that the Solarium has puzzles and books for the residents to enjoy at any time. She stated that for November she has put some activities on the calendar and stated that last week a church group came into the facility to do a resident activity. She has been working on getting volunteers to facilitate weekend activities and stated that she comes to the facility at least one weekend a month to do activities. She reported the following activities for the month of November: November 3rd Church Group came to facility, November 2nd she facilitated Morning Coffee with fresh baked cookies, and November 16 she assisted with passing coloring sheets to residents. She stated that in September, October and November church services were provided to the residents on Sundays. She noted that the first Saturday of September she assisted with playing Bingo. She reported that not offering activities during the weekend has been temporary since losing her assistant. She stated that the negative outcomes of not having activities daily for residents would be that they can isolate themselves and their mental health can decline. The Activities Director was asked about in-room activities for those that cannot leave their room and she stated that the activities include reading, music, stimulation activities for the senses (smell, touch, textures), rubbing lotions on hands, coloring, and crafts. She stated that she meets with each resident on her schedule 3 times per week. These activities are for residents that cannot leave their room due mobility issues. During morning meetings, she will be notified of any new residents that are bed bound or not able to go to activities and will add them to her schedule. When asked how residents are notified about activities, she stated that activities calendars are posted on bathroom doors in every Resident room. She reported that staff will also remind residents what the activities will be as they are passed in the hall or if they are in the dining room. During an observation of the Solarium on 11/19/24 at 12:03 PM, revealed there were 3 shelves full of books, each shelve was about 4 foot wide and 1 foot deep. There were two 4-foot shelves full of 100-150-piece puzzles. During an interview with the Administrator on 11/19/24 at 12:07 PM, revealed that there is no plan to hire an assistant for the Activities Director, as it is not a normal practice at facilities to have an Activities Assistant. She stated that they have been working in QAPI (Quality Assurance Performance Improvement) to address the activities issue to identify activities that can be done on the weekend without an assistant like movie night, music performances and other groups coming in the facility to provide activities. The risk to the resident for not having activities on the weekend is boredom and lack of socialization. She is working with the Activities Director on finding out through residents what type of activities they are interested in that don't have to be staff directed. She stated that the expectation is that activities occur every day to include the weekends. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During confidential interviews on 11/19/24 at 1:44pm with 2 bed bound residents that cannot ambulate on their own, revealed they had not been offered one on one activities in their rooms, but neither of them were interested in having in-room activities facilitated by staff members. During an observation of a bed bound resident on 11/19/24 at 1:55 PM, revealed that they had markers, word puzzles and coloring sheets available to them in their room. During a record review of the Minutes for the Resident Council Meeting dated 9/24/24 in which 10 residents attended, when asked the question Do you receive activities over the weekend? the answer was no. During a record review of the Minutes for the Resident Council Meeting dated 10/2/24 in which 6 residents attended, when asked the question Do you receive activities over the weekend? the answer was no, only during special times. During a record review of the Minutes for the Resident Council Meeting dated 11/6/24 in which an unknown number of residents attended, when asked the question Do you receive activities over the weekend? the answer was yes. During a record review of Activities Calendar for September 2024, the following dates had no activities planned and stated activities of resident choice: 9/7/24, 9/14/24, 9/21/24 and 9/28/24. During a record review of Activities Calendar for October 2024, the following dates had no activities planned and stated activities of resident choice: 10/5/024, 10/19/24, and 10/26/24. During a review of Facility's policy Activity Programming from Manual 2011, revealed the following Standard: The Activity Director and staff will provide for ongoing Activity programs. 3. Activity programs are be designed based on the resident's leisure interest and implemented to meet the needs (physical, cognitive, creative, social, spiritual, independent, and sensory) of the residents. 5. Those who cannot participate in group settings are provided individual programming. Inability to participate could include those who refuse to participate in activities, those who are in isolation, or physician ordered bed rest. Programs may take place in mornings, afternoons and/or evenings that span throughout the entire week.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on interview, observation, and record review, the facility failed to ensure that residents with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing for three of five residents (Resident #82, Resident # 85, and Resident #21) reviewed for quality of care. The facility failed to ensure LVN H provided Resident #82, Resident #85 and Resident #21 their physician ordered wound care on 11/16/24 and 11/17/24. This failure could place residents at risk of developing infections or worsening of their wounds. Findings included: 1. Record review of Resident #82's 5-day MDS assessment, dated 10/12/24, reflected an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. He had a BIMS score of 10, which indicated he was moderately cognitively impaired. He had not rejected care and required substantial to maximum assistance with ADL care and was occasional incontinent of urine and bowel and had 2 pressure ulcers upon admission. His active diagnoses included diabetes and aftercare following hip replacement surgery. Record review of Resident #82's Physician order summary report dated 11/20/24, reflected, . Wound care: Stage 2 Pressure ulcer to left distal medical (upper middle) buttock two times a day for wound treatment apply Zinc Oxide (skin protectant) to site and leave open to air . with a start date of 10/10/24. Record review of Resident #82's TAR (Treatment Administration Record) for November 2024 reflected, Wound care: Stage 2 Pressure ulcer to left distal medical buttock two times a day for wound treatment apply Zinc Oxide to site and leave open to air. No treatment was provided on the day shift on 11/16/24 and 11/17/24. Record review of Resident #82's care plan, revised on 10/01/24, reflected, .The resident has a stage 2 pressure ulcer to left buttocks .Interventions . Administer treatments as ordered and monitor for effectiveness . In an interview with Resident #82 on 11/18/24 at 9:50 a.m., he stated he was recovering from a left hip repair. He stated he had a place on his bottom they were treating, but stated the staff did not do anything to it Saturday and Sunday morning (11/16/24 and 11/17/24). He stated the staff treated it late in the day on those 2 days. On 11/18/24 at 10:00 a.m., the Treatment Nurse was observed prepping wound care supplies for Resident #82. She stated he had a stage 2 ulcer on his left buttocks that was moisture related. She stated they were cleaning the area with normal saline and applying zinc to the area and leaving it open to air. Treatment Nurse donned proper gown and gloves and cleaned the area with saline. Area was red and appeared to be an abrasion with no drainage or signs of infection. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #21's Quarterly MDS assessment, dated 10/21/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. She had a BIMS score of 14, which indicated she was cognitively intact. She had not rejected care and required substantial to maximum assistance with ADL care and was always incontinent of urine and bowel and had one stage 3 pressure ulcer and other moisture associated skin damage. Her active diagnoses included diabetes, heart failure and seizure disorder. Record review of Resident #21's Physician order summary report dated 11/20/24, reflected, . Wound care: MASD to buttocks and inner thighs every day shift cleanse site with peri wipes, apply Calazime cream (skin protectant) and anti-fungal powder to entire buttock and inner thighs, leave open to air .start date 09/19/24 . Wound Care: Right heel Stage. 3. Cleanse with normal saline, pat dry, apply collagen sheet (promotes wound healing) and then a calcium alginate (provide moist environment for wound healing) then cover with foam dressing every day shift .start date 10/30/24 . Record review of Resident #21's TAR for November 2024 reflected, Wound care: MASD to buttocks and inner thighs every day shift cleanse site with peri wipes, apply Calazime cream and anti-fungal powder to entire buttock and inner thighs, leave open to air .start date 09/19/24 .Wound Care: Right heel Stage 3. Cleanse with normal saline, pat dry, apply collagen sheet and then a calcium alginate then cover with foam dressing every day . No treatment was provided on 11/16/24 and 11/17/24. Record review of Resident #21's care plan, revised on 10/15/24, reflected, . [Resident #21] has pressure ulcer stage 3 pressure ulcer to right heel .Interventions . Administer treatments as ordered and monitor for effectiveness . In an observation and interview on 11/18/24 at 10:35 a.m., the Treatment nurse provided wound care to Resident #21's right heel. The old dressing removed from her right heel had minimal drainage. Unable to determine the date on the old dressing. Treatment nurse stated the treatment to the resident's bottom was clean with peri-wipe and Calazime cream and antifungal powder. In an interview with Resident #21 on 11/19/24 at 02:00 p.m., she stated she had the wound on her right heel for about 6 months. She stated the wound care doctor comes every Tuesday to see her. She stated she gets wound care every day but stated she does not remember getting it this past weekend (11/16/24 and 11/17/24), which was very unusual. She stated they were always good about providing her wound care. She stated she was not sure why she did not get her wound care done. 3. Record review of Resident #85's Quarterly MDS assessment, dated 09/18/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. He had a BIMS score of 14, which indicated he was cognitively intact. He had not rejected care and required substantial to maximum assistance with ADL care, had a foley catheter and was always incontinent of bowel. He was coded as high risk for pressure ulcers but had no skin condition at time of assessment. His active diagnoses included heart failure and malnutrition. Record review of Resident #85's Physician order summary report dated 11/20/24, reflected, . Wound care: Cleanse ulcer to coccyx with normal saline, pat dry, apply collagen sheet (promotes wound healing) then cover with foam dressing every day shift for wound treatment until healed . with a start date of 11/09/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #85's TAR for November 2024 reflected, Wound care: Cleanse ulcer to coccyx with normal saline, pat dry, apply collagen sheet then cover with foam dressing every day shift for wound treatment until healed. No treatment was provided on the day shift on 11/16/24 and 11/17/24. Record review of Resident #85's care plan, initiated on 11/11/24, reflected, .The resident has a potential for pressure ulcer development. Unstageable to coccyx .Interventions . Follow facility policies/protocols for the prevention/treatment of skin breakdown . In an interview with ADON G on 11/19/24 at 10:45 a.m., she stated the aides came to her yesterday morning (11/18/24) and told her Resident #85 did not have a dressing on his coccyx wound, so she went and did the wound care. She stated later that same morning the Treatment Nurse alerted her that several of the residents on B hall did not receive their wound care over the weekend. She stated she went and spoke with LVN H who had worked the day shift on 11/16/24 and 11/17/24, and she stated she had not done wound care over the weekend on some of the residents. She stated LVN H was a new nurse, and she was immediately in- serviced on the importance of providing the wound care and if she was not able to do the wound care, she had to alert another nurse, herself, or the DON. She stated the facility had a treatment nurse Monday through Friday, but on the weekends the nurses were responsible for providing the wound care. In an interview with CNA D on 11/19/24 at 11:33 a.m., she stated when she did her first morning rounds on Resident #85 on 11/18/24, he did not have a dressing on his coccyx wound. She stated he had frequent bouts of diarrhea, so she was not sure if the dressing had come off and they had just not replaced it. She stated she alerted the ADON G that he did not have a dressing on his wound, and she came and dressed it. In an interview on 11/19/24 at 01:00 p.m., Resident #85 stated he did not remember if his dressing was changed over the weekend or not. He stated they had changed it today. He denied any pain or discomfort. In an interview on 11/20/24 at 08:55 a.m., LVN H she stated worked the 6 am to 6 pm shift this past weekend (11/16/24 and 11/17/24). She stated she did some of the wound care that she was comfortable with but had not done some of the other. She stated she did not reach out to anyone or call the ADON or DON to let them know she needed some help. She stated she received counseling on 11/19/24 and they were going to send her with the treatment nurse for more training before she worked another weekend shift. She stated she understood by not doing the wound care the residents wounds could worsen or become infected. In an interview on 11/20/24 at 09:10 a.m., the DON and the new DON stated LVN H had been in serviced on the expectation of wound care provision on the weekends. She stated she would be getting some additional training on wound care before her next weekend shift. The DON stated LVN H was checked off on wound care upon hire and had not expressed to anyone she needed additional training. She stated the risk for not getting wound care is worsening of the wounds and infections. In an interview with the Treatment Nurse on 11/20/24 at 11:00 a.m., she stated she had not noticed any decline to the wounds on Resident's #82, #85 or #21. She stated the Wound care Nurse practitioner was here on 11/19/24 and stated all the wounds had shown improvement. She stated she was going to work with LVN H to ensure she was comfortable with providing the wound care on her assigned hall. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of LVN H's Nurse Proficiency Audit date 10/29/24 under skilled observed, Treatment Procedures .Dressing changes .Satisfactory . Record review of the Facility's policy, Pressure Injury: Prevention, Assessment and Treatment, dated August 2016, reflected, .Early prevention and/or treatment is essential upon initial nursing assessment of the condition of the skin on admission and whenever a change in skin status occurs .The treatment nurse/designee will: Notify the physician of pressure sore and obtain and follow any orders as directed by the physician .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560 Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications for 1 (Resident #75) of 2 residents reviewed for enteral nutrition. The facility failed to ensure Resident #75's water flush administered via tube feeding pump was not being administered as ordered by the physician. This deficient practice could affect residents who receive tube feedings by not receiving the appropriate nutrition/ hydration. The findings were: Review of Resident #75's Annual MDS assessment dated [DATE] revealed that Resident #75 was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included Hypertension (high blood pressure), Cerebrovascular Accident (stroke or blood flow to the brain is suddenly cut off), Gastrostomy status (surgical opening into the stomach for administering feeding , hydration, and medication), Malnutrition (inadequate amount of nutrients in the body to function properly), Respiratory Failure (lungs cannot get adequate oxygen from the blood) and Aphasia (language disorder that affects ability to understand and express language). Resident #75 had a gastrostomy tube. BIMS score for Resident #75 was not conducted indicated on the Annual MDS since Resident #75 was rarely/never understood. Review of Resident #75's comprehensive care plan revised 08/20/2024 reflected, Focus: [Resident #26] requires tube feeding related to Dysphagia. Goal: [Resident#75] will remain free of side effects or complications related to tube feeding through review date. Intervention: [Resident #75] Discuss with the resident/family/caregivers any concerns about tube feeding, advantages, disadvantages, potential complications. Review of Resident #75's Physician order dated 9/4/2024 reflected, Enteral Feed Order every shift for Enteral Feed related to gastrostomy status; start continuous enteral feeding. Isosource 1.5 [Tube feed formula] at 65ml/hr. with water flush at 50ml/hr. for 22 hours. Review of Resident #75's Physician order dated 07/25/2024 reflected, NPO (Nothing by mouth) diet related to dysphagia. In an observation on 11/18/24 at 09:42 AM, revealed Resident #75 was awake, lying in his bed in room, Resident #75 had limited verbal communication. Tube feed pump was infusing tube feed formula Isosource 1. 5 at 65ml/hr. and water flush at 60ml/hr. to Resident #75. The tube feeding pump settings read water flush 60 ml/hr. The hung date on the tube feed and flush bag was 11/18/24. (continued on next page)

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 11/20/2024
NAME OF PROVIDER OR SUPPLIER Texoma Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Hwy 82 E Sherman, TX 75090	

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 11/18/24 at 2:32 PM, RN C revealed resident had tube feed pump running with water flush infusing at 60ml/hr. RN C looked up tube feed orders in the Electronic Health record and stated resident had physician orders for water flush at 50ml/hr. She stated that the current pump settings were incorrect and did not reflect correct physician orders for the water flush. She stated for all tube fed dependent residents, tube feeding infusion via pump should match physician orders. She stated nurses were responsible for programming and administering the tube feed formula and water flush via the pump. She stated that usually night nurses started the tube feedings for all pump residents, however she should have checked when she rounded on the resident when she started her shift. She stated that risk to residents for not following correct physician order for enteral water flush was hydration concerns and possible decreased quality of care, especially for tube fed dependent residents. In an interview on 11/20/24 at 09:35 AM, the DON stated that her expectation was tube feed pump setting should match physician order. She stated that all nurses were responsible for checking the accuracy of the tube feeding infusions, including checking for accuracy of water flush. She stated that the risk for residents for not following physician orders for water flush was hydration concerns and decreased quality of care. She stated that as a DON of the facility she rounded on residents daily and conducted random audits to ensure quality of care was maintained. Record review of facility policy titled Enteral nutrition revised 2/13/2007 reflected, We will provide nutritionally complete enteral or parenteral feedings as ordered by the physician for the nourishment of residents who are unable to eat by mouth.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring and administering of all medications to meet the needs of each resident for two of seven residents (Resident #15 and Resident #97) reviewed for pharmacy services. 1. LVN J failed to follow the manufacturer's instructions to prime the Lantus Insulin (Hormone) Pen prior to dialing in required amount of Insulin to be administered to Resident #15. 2. LVN J failed to follow the Physician orders and facility procedures for administering one medication at a time with water flush between each medication when she crushed Resident #97's Sertraline (antidepressant) 25 mg 1 tablet and Levothyroxine (hormone) 50 mcg 1 tab and combined them in one medication cup for administration on 11/18/24. These failures placed residents at risk of not receiving full dosage of medication and potential for drug interactions. Findings included: 1. Review of Resident #15's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female with an admitted [DATE]. Her BIMS was 13 which indicated she was cognitively intact. Active diagnoses included diabetes mellitus. Record review of Resident #15's Physicians order summary report with a start date of 09/13/24, reflected, Lantus Solostar Subcutaneous Solution Pen-injector 100 unit/ML Inject 20 units subcutaneously An observation on 11/18/24 at 08:05 a.m., of the medication pass revealed LVN J pulling Resident #15's Insulin pen from the medication cart. LVN J placed a needle on the insulin pen and dialed 20 units of Lantus insulin without priming the pen first. LVN J then entered Resident #15's room and administered the Insulin. Interview with LVN J on 11/18/24 at 08:10 a.m., she stated she was aware the insulin pen had to be primed. She stated the purpose of priming the pen was to ensure there was no air in the pen, so the resident received the full dose of medication. 2. Record review of Resident #97's Admission MDS assessment, dated 09/02/24, reflected a [AGE] year-old female with an admitted [DATE]. Staff assessment for mental status reflected resident was moderately cognitively impaired. The resident received 51% or more of total calories through a feeding tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach). Diagnoses included dysphagia (difficulty swallowing food), and adult failure to thrive and anorexia (eating disorder). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Texoma Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Hwy 82 E Sherman, TX 75090	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #97's physician orders summary report with a start date of 09/02/24, reflected, every shift flush tube with 30 ml water before and after medication and feedings .Flush with at least 5 ml of water between each medication . There were no orders to cocktail (mix together) medications. An observation 11/18/24 at 08:35 a.m., revealed LVN J at the medication cart preparing Resident #97's medication for gastrostomy tube (a feeding tube inserted through the abdomen that delivers nutrition directly to the stomach) administration. LVN J placed 2 plastic medication cups on top of the medication cart. She stated she combined the medications because the resident becomes very antsy during medication administration. LVN J pulled 1 tablet of Vitamin C 500 mg, 1 tablet of Vitamin D 25 mg, 1 tablet of Zinc 50 mg (all supplements), and 1 tablet of Cetirizine (antihistamine for allergy) 10 mg and placed them in one cup. LVN J then pulled 1 tablet of Sertraline 25 mg and 1 tablet of Levothyroxine 50 mcg and placed them on the other cup. LVN J then crushed the medication in both cups. LVN J then reviewed the MAR (Medication Administration Record) and stated she was supposed to flush with 5 ml between each medication. She stated she had to re-do the medications and discarded the cup containing the vitamin supplements and allergy medication, but not the cup containing the Sertraline and Levothyroxine. LVN J re-pulled the vitamin supplements and allergy tablet and placed them in individual cups and crushed them separately. LVN J entered the resident's room and obtained a cup of water from the resident's bathroom. LVN J checked placement of the G-tube (Gastrostomy Tube) through air auscultation and checked for residual. LVN J flushed the G-tube with 30 ml of water, dissolved each of the vitamins and allergy tablet with 5 ml of water and administered them individually with 5 ml of water between each tablet. LVN J then diluted the cocktailed Sertraline and Levothyroxine with 10 ml of water and administered it via the G-tube and flushed with 10 ml of water. LVN J completed the medication administration and flushed with 30 ml of water. In an interview with LVN J on 11/18/24 at 08:50 a.m., she stated the reason she did not separate the Sertraline and the Levothyroxine was because the levothyroxine was so small it did not create much volume. She stated since she had combined the two medications, she doubled the amount of water to dilute them and flush afterwards. She stated she was not sure why the medications should be administered separately. In an interview with the facility Pharmacy Consultant on 11/20/24 at 08:31 a.m., she stated across the board it was best practice to give each medication via a G-tube separately. She stated the risk of cocktailing medication was a medication could not be compatible with another medication which could reduce its effectiveness. She stated instead of having to check each individual medication for compatibility it was just best practice to give them individually. She stated there were no compatibility issues between the Sertraline or the levothyroxine. In an interview with the DON on 11/20/24 at 09:00 a.m., she stated they follow the manufactures guidelines for Insulin pens which indicated they needed to be primed first to ensure they removed the air and ensured the resident received the required amount of Insulin. She stated the facility's policy had always been to give each medication separately with water flush between each medication when giving medication through a G-tube. She stated the only time they would not was if they had an order from the physician to combine the medications. She stated failing to follow procedures could result in residents not receiving the full amount of medication ordered. She stated each staff member is skills checked upon hire and annually thereafter. She stated they are assigned to a nurse on the floor for 3 to 5 days for training and if any new concerns arise, they are provided additional training. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of manufacture instructions for Lantus Insulin Pen obtained from searched on https://www.lantus.com/how-to-use/how-to-inject 11/20/24 reflected, .STEP 3. PERFORM A SAFETY TEST o Dial a test dose of 2 Units. o Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. o If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again .Always perform the safety test before each injection. Never use the pen if no insulin comes out after using a second needle . Record review of the Facilities policy titled, Enteral Medication Administration, dated January 2013, reflected, .Administer one medication at a time with a flush of 5-10 ml water or the amount ordered by the physician, between each medication and after the final medication is administered .

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NAME OF PROVIDER OR SUPPLIER: Texoma Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Hwy 82 E Sherman, TX 75090	

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50910 Based on observation, interview and record review, the facility failed to provide food that accommodates resident preferences for 2 of 32 residents (Resident #76 and Resident # 31) reviewed for resident food and drink preferences. The facility failed to follow the breakfast menu and obtain resident input on changes made to the menu. This failure could affect residents by contributing to dissatisfaction, poor intake, and weight loss. Findings include: Review of the quarterly MDS, dated [DATE], revealed Resident # 76 was a [AGE] year old male admitted to the facility on [DATE]. He had a BIMS score of 11, which indicated he was moderately cognitively impaired. His active diagnosis included: Diabetes and Malnutrition (unintentional weight loss). Review revealed Resident #76 required setup assistance with meals and no chewing or swallowing issues. Review of the physician orders dated 7/10/24 revealed Resident #76 was on a regular texture diet. Review of Resident #76's care plans dated 7/11/24 revealed .Determine food preferences and provide within dietary limitations . Interview with Resident #76 on 11/18/24 at 9:09AM revealed the resident stated the food at the facility was not good, breakfast was the same thing every day (oatmeal, grits, and eggs) and he did not get a choice on his breakfast. During a sample tray testing on 11/19/24 at 12:34 PM, the lunch tray arrived with the following items: Baked BBQ chicken thigh and leg, hash brown potatoes, cheesy biscuit, banana pudding with wafers, coleslaw, tea, and butter. Chicken was cooked all the way through, and tasted like BBQ sauce, the hashbrown potatoes were difficult to chew and crunchy with no taste, the biscuit was warm and tasted appropriate. No salt or pepper was provided, coleslaw was cold, and cabbage was crunchy, banana pudding was appropriate at cool temperature, and no other concerns were noted. The tray reflected what was on the ticket. Interview with Administrator on 11/19/24 at 12:44 PM, revealed she tasted the hashbrown potatoes from the same tray . She stated the potatoes had a lot of flavors and were fully cooked and when questioned on the potatoes appearance. she stated, from what you are showing me it does not appear cooked through. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Dietary Manager 11/19/24 at 01:31 PM revealed he had tasted the hashbrowns. When asked about the hashbrowns on the test tray, the Dietary Manager stated they tasted done to him. He stated that he checked their temperature, and the hash browns were 172 degrees at the time of serving. He stated that he cooked them for over 2 hours in the oven and that it was a hashbrown casserole. He stated that he put sour cream, cheese, and pimentos in the hash browns. He stated this was the first time he ever cooked them so he was unsure if they should be crunchy, but because he cooked it in the oven, the top layer might have been a little toasted. When asked about the menus and why the breakfast was the same daily, he stated that the menu items listed for breakfast were general menu items but stated that when he printed the tickets the day before it will specify on some of the tickets the type of bread and for the ones that isn't specified he will just choose the bread for them. He stated that they gave the resident choices on how they cooked eggs whether they wanted it scrambled, fried etc. He then stated that every other day they alternated the hot cereals between cream of wheat, grits, and oatmeal. He stated that all 5 cold cereals were out and available to the residents. He then stated that they typically served sausage to the residents but knew that residents got tired of it and they can give them bacon. When asked if the dietician approved the changes he made to the menu items, he stated that he usually signed off on them and then presented them to the dietician and she signed off on it. He stated at times they will give potatoes and other breakfast items to give the residents more variety. When asked how the residents were notified of any menu changes, he stated he went off what was on the tickets. Observation on 11/19/24 at 12:50 p.m., in dining room revealed daily meal posting for Breakfast, Lunch and Dinner matched the posted menu. Interview with Resident #76 on 11/20/24 at 8:54am revealed that his breakfast was different then what was on the menu, he stated that he got toast instead of a biscuit. He reported that he was never asked what he was going to eat, how he wanted his eggs or whether he was getting bacon or sausage. He stated that the ticket came with the tray in the morning, but he never selected any of it. Resident reported that had never approved any changes made to breakfast, lunch or dinner and was never notified when there was a change. He stated, we get what we get. Resident reported that lunch and dinner had gotten better. Resident stated he had no complaints about lunch yesterday. Review of Resident #76 breakfast meal ticket for 11/20/24 revealed the following: .4 fluid oz of Orange Juice, 1/2 Hot Cereal, @ Sl Bacon, 1/4 C Scrambled Egg, 2 oz Grilled Cheese Sandwich, 1 Ea Assorted Breakfast Bread, 1 Tbsp Mayonnaise, 1Tbsp Jelly, 1 ea Margarine, 8Fl oz Whole Milk Interview with CNA K on 11/20/24 at 10:40am, revealed that Resident #76 was always provided a grilled cheese with every meal, because he likes them. She reported that she has received complaints from Resident #76 about breakfast being the same food every week and the amount of food that was being given. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Texoma Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Hwy 82 E Sherman, TX 75090	

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Dietician on 11/20/24 at 11:55am, revealed that the menus were created by their parent company. She reported that regarding the breakfast menu, the Dietary Manager could switch out foods. She stated that she was not aware that residents were complaining about the same food every day. She stated that if a resident requested a change in their food, they could put in the change in the menu system. She reported that Resident's preferences were assessed when they were first admitted to the facility by the Dietary Manager. She would also ask residents when admitted about preferences for food. She reported that the Dietary Manager should touch base with residents quarterly to update preferences. She stated that she would randomly talk to residents during mealtime to see how the food was, when she was at the facility. She reported that she was unaware of how residents were notified of any changes in menu items, however she would imagine that they would post on the menu board if they changed an item. She reported that risk to the resident of them being unhappy with their meal due to it being the same menu item or being changed without them knowing would be that they may not eat as much and may lose weight. Interview with Administrator on 11/20/24 at 12:08 p.m., revealed that she had not noticed that the menu items for breakfast were the same daily. She stated breakfast was a strange meal due to a lack of breakfast options. She stated that she knew there were breakfast options for bread or eggs. She stated they must follow the menus while taking the resident preferences into account. She stated that they decided on bacon or sausage based on preference of the resident at the time that the Dietary Manager was meeting with them for their preferences. Regarding the type of bread, the facility provided to the resident, she stated that the Dietary Manager decided what to serve. She stated that any deviations from the posted menu would be on the daily meal posting board in the dining room. She reported that her expectation was that whatever they were serving should be posted. She reported that residents can ask for something different and if it becomes a pattern that they were changing an item, they will meet with the resident and update their preferences. Review of the quarterly MDS, dated [DATE], revealed Resident # 31 was a [AGE] year old female admitted to the facility on [DATE]. She had a BIMS score of 12, which indicated she was moderately cognitively impaired. Her active diagnosis included: Diabetes and Hyperlipidemia (a genetic disorder that causes high levels of cholesterol and other fats in the blood). Review revealed that resident required setup assistance with meals. Review of the physician orders dated 3/16/24 revealed Resident #31 was on a regular texture and regular consistency diet. Review of Resident #31 care plans dated/revised 10/31/24 revealed Determine food preferences and provide within dietary limitations . Interview with Resident #31 on 11/20/24 at 10:45 am, revealed that she was unhappy with her breakfast. She stated she got the same thing every day. She stated that she doesn't like sausage and had been getting sausage every day since she can remember. She stated that she will ask for bacon, and they will bring it, but she did not understand why they keep giving her sausage. Record review of Weekly Menu for the month of November 2024 revealed the same breakfast items every day. The breakfast items are as follows: choice of Juice, Hot or cold Cereal, Fresh Pasteurized Eggs, Bacon or Sausage, Breakfast Bread, Margarine/Jelly, Milk and Coffee. (continued on next page)

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 11/20/2024
NAME OF PROVIDER OR SUPPLIER Texoma Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Hwy 82 E Sherman, TX 75090	

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Facility policy named Resident Menus from the Dietary Services Policy & Procedure Manual 2012 reflects that following: We will strive to assure the resident's nutritional needs are provided based on the RDA. The standard menu will ensure nutritional adequacy of all diets, offer a variety of food in adequate amounts at each meal, and standardize food production . 3. Alternates for noon and evening meal will be planned and recorded. Alternates shall be of comparable nutritive value and the alternate food shall come from the same food group. If a resident does not want the food prepared on the menu, nor the alternate, then soup, salad, and/or sandwich will be offered. If the resident does not choose to eat any of the above, a glass of fortified milk or house supplement will be offered. If none of these is accepted, the resident will be allowed to choose not to eat the meal, and a larger snack may be offered at the next scheduled snack time 4. If any meal served varies from the planned menu, the change and reason for the change shall be noted on the substitution log

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48560 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen. 1. The facility failed to ensure food items in the facility walk-in refrigerator were covered, labeled, and dated. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: Observation on 11/18/24 at 7:50 AM of the walk-in refrigerator revealed: - 8 to 10 hamburger patties in a quart size Ziplock bag was not labeled or dated, - Sliced raw onions in plastic bag not labeled or dated, petite cut carrots were not covered or dated, - Cheese slices in Ziplock bag with some white mold-like growth that were not labeled or dated, and - Tortillas were not covered or dated. In an interview on 11/19/24 at 10:23 AM, the Dietary Manager stated the cooks and himself are responsible for dating and labeling all food items in the kitchen. He stated that his expectation was all food items in the kitchen should be marked with received date once they arrive at the facility and used by date for leftovers and opened food items. He stated it was his expectation that all food items should be appropriately dated, covered, and labeled by the kitchen staff. He stated he discarded the food items such as hamburger patties, sliced onions, cheese, carrots, and tortillas that was either not dated, covered, or labeled appropriately. He stated the risk of not dating, labeling, covering food items could cause cross contamination resulting in food borne illness. He added as the dietary manager, he started an in-service regarding dating, covering and labeling food items appropriately to all kitchen personnel on 11/18/24. In an interview on 11/19/24 at 1:07 PM, Dietary Aide A revealed that she had worked in the facility for about 3 months. She stated everyone working in the kitchen including cooks, dietary aide, and the dietary manager was responsible for covering, dating, and labeling food items. She stated they would add use by date to food items once the food was opened or leftover food items from previous meals. She stated the risk to the residents of not covering, labeling, dating any food items was cross contamination and could make them sick. (continued on next page)

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 11/20/2024
NAME OF PROVIDER OR SUPPLIER: Texoma Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Hwy 82 E Sherman, TX 75090	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview 11/19/24 at 1:12 PM, [NAME] B revealed she had been working in the facility as a cook for about a month. She stated cooks, dietary aides, and the dietary manager was responsible for covering, dating, and labeling food items in the kitchen. She stated as a cook she was always cognizant of expiration dates and use by dates on opened food items so they can use the items before they discard them. She stated not covering, labeling, and dating food items could cause cross contamination and potentially cause illness in residents. Record review of facility policy titled Food Safety undated reflected, . We will insure all food purchased shall be wholesome and manufactured, processed, and prepared in compliance with all State, Federal, and local laws, and regulations Food is to be wrapped or sealed and covered in clean containers. Opened food shall be labeled, dated, and stored properly. Perishable opened foods shall be used within 7 days or less . Review of the Food and Drug Administration Food Code, dated 2022, reflected, .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food 3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety