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	03/19/2026

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must provide foot care and treatment, in accordance with professional standards of practice for two resident of six residents (Resident #23, and Resident #35) reviewed for quality of care.1.The facility failed to ensure Resident #23's feet did not have dry, flaky skin.2.The facility failed to ensure Resident #35 had his toenails trimmed.This failure could place residents at risk of decline in quality of care, increased skin irritation and skin breakdown. Findings included: 1.Record review of Resident #23's face sheet, undated, reflected was a [AGE] year-old female admitted [DATE] and readmitted [DATE], with diagnoses of closed fracture of neck of left femur (hip bone), heart failure (chronic, progressive condition where the heart could not pump enough blood to meet the body's needs), acute respiratory failure with hypoxia (life-threatening condition where the lungs could not adequately supply oxygen to the blood or remove carbon dioxide). Record review of Resident #23's quarterly MDS assessment, dated 03/09/26, reflected Resident #23 had a BIMS of 11 indicating she was moderately cognitively impaired. Resident #23 required partial/moderate assistance with ADLs of lower body dressing, showers, and footwear. During an observation and interview on 03/17/2026 at 9:58 a.m., Resident #23 was observed lying in bed. Observation revealed both feet were white, flaky, and dry skin. Interview with Resident #23 revealed staff did not put any lotion on her feet but would like them to. Resident #23 stated the podiatrist had not seen her at the facility, but she had a podiatrist when she lived at home. She stated she was not a diabetic. During an observation on 03/18/2026 at 1:23 p.m., Resident #23's feet were dry with flaky skin on both feet, especially more near the toes. During an interview on 03/18/2026 at 1:25 p.m., LVN N stated she would get lotion for Resident #23's feet. LVN N stated she noticed edema on Resident #23's feet and the dry, flaky skin on her feet, since admission. During an interview on dated?? at 1:29 p.m., LVN N stated Resident #23 had dry, flaky skin on both feet. LVN N stated Resident #23's daughter might put lotion on resident's feet. LVN N stated the facility had lotion to put on Resident #23's feet or she could reach out to the doctor to inquire about a prescription for lotion for residents with dry flaky skin. LVN N stated she should have gotten lotion for her to help with the dry, flaky skin on the resident's feet. During an interview on 03/19/2026 at 12:50 p.m., the DON stated she expected CNAs to put lotion on residents when they noticed dry, flaky skin. The DON stated they did not have in-house lotion they could use on shower days and as needed. She stated the risk to a resident was the skin could stay dry/flaky and could cause more skin concerns.2. Record review of Resident #35's face sheet, dated 03/19/2026, revealed a [AGE] year-old male, admitted [DATE]. Diagnoses included cerebral palsy (a group of conditions that affect movement and posture), unspecified lack of coordination (inability to control or coordinate muscle movements), muscle weakness, unspecified convulsions (sudden, involuntary, muscle contraction or jerking motions), and moderate intellectual disabilities (deficits in cognitive abilities and adaptive skills). Record review of Resident #35's MDS, dated [DATE], reflected a BIMs score of 00, indicating severe cognitive impairment. Resident #35 was dependent (helper does all the effort) for personal hygiene. Record review of Resident #35's care plan, dated revised 1/06/2026, revealed Resident #35 had ADL (continued on next page)

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

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

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	self-care performance deficit related to Cerebral Palsy. Record review revealed interventions for bathing included checking nail length and trim and clean on bath day and as necessary. Further record review revealed interventions for personal hygiene included the resident required total assistance with personal hygiene care. During an observation of Resident #35 on 03/17/2026 at 10:18 a.m. revealed Resident #35 was sitting in his wheelchair with his bare feet uncovered. Resident #35's toenails were observed to be about an inch longer than nailbed. Resident #35 was not interviewable. During an interview on 3/18/26 at 9:06 a.m., CNA K stated Resident #35's toenails were not cut because she felt he needed a Podiatrist, a medical professional who specializes in care for feet and ankles. CNA K stated that residents' groomed toenails were part of residents' dignity. During an interview on 3/18/26 at 9:15 a.m., CNA L revealed CNAs were responsible for nail care unless the resident was diabetic. CNA L stated she cut Resident #35's fingernails but because his feet looked bad, she left cutting his toenails to the Podiatrist. During an interview on 3/18/2026 at 1:48 p.m., ADON A revealed CNAs cut resident's toenails unless the resident was diabetic in which case the Podiatrist cuts them. Resident #35 was not diabetic. ADON A stated she was unsure why Resident #35's toenails were not cut. She stated her expectation was for residents to be assessed and provided nail care on their shower days. During an interview on 3/18/2026 at 2:00 p.m., LVN E revealed she was unaware if CNAs assisted with nail care although they were responsible for hygiene. LVN E stated she thought Podiatry cut the toenails of all residents. LVN E stated she was unsure of her expectation regarding nail care. LVN E stated it was her responsibility to ensure residents received proper nail care. During an interview on 3/19/2026 at 12:44 p.m., the DON revealed CNAs were responsible for providing nail care for non-diabetic residents. The DON stated the expectation was for finger and toenails to be cut/trimmed as needed on shower days. The DON stated she, ADONs, and charge nurses were responsible for ensuring CNAs provided hygiene, including nail care for residents. The DON stated residents could have skin and dignity issues regarding uncut finger and toenails. Record review of facility's policy titled, Foot Care, undated, reflected, Foot Management is the daily assessment, bathing, lubrication and protection of the feet. It is done to promote cleanliness and peripheral circulation of the feet. Foot care is especially important in those residents with diabetes mellitus or peripheral circulatory condition because of their susceptibility to infection and skin breakdown.Procedure, 10. Apply lotion or oil preparation to dry areas. Record review of facility's policy titled, Nail Care from the Nail Policy and Procedure Manual, dated ??, revealed, Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticles are and is usually done during the bath. Goals: 1. Nail care will be performed regularly and safely.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assured the accurate acquiring and administering of all medications to meet the needs of each resident for three of six residents (Resident #9, Resident #96, and Resident #69) reviewed for pharmacy services. 1. The facility failed to ensure LVN E followed the manufacturer's instructions to prime the Novolin R Insulin (hormone) Pen for prior to dialing in the required amount of insulin to administered to Resident #9. 2. The facility failed to ensure LVN E followed the manufacturer's instructions to prime theHumalog pen (Insulin Lispro) (Hormone) prior to dialing in required amount of insulin to be administered to Resident #96. 3. The facility failed to ensure LVN D followed the manufacturer's instructions to prime theNovolog pen (Insulin Aspart) (Hormone) prior to dialing in required amount of insulin to be administered to Resident #69. These failures could place residents at risk of not receiving full dosage of medication. Findings included: 1. Record review of Resident #9's face sheet, dated 03/19/26, reflected a [AGE] year-old female admitted [DATE], diagnosis included type 2 diabetes mellitus (chronic condition where high blood sugar results from insufficient insulin production). Record review of Resident #9's Physician's Order for March 2026, reflected, Novolin R injection Solution 100 unit/ml.Inject per sliding scale; If . 201-230=5 units (the amount of insulin to be administered).before meals and at bedtime. with a start date of 02/27/26. Record review of Resident #96's face sheet, dated 03/19/26, reflected a [AGE] year-old female, admitted [DATE]. Diagnosis included type 2 diabetes mellitus (chronic condition where high blood sugar results from insufficient insulin production). Record review of Resident #96's Physician's Order for March 2026, reflected, Humalog KwikPen.100 unit/ml (Insulin Lispro) .Inject as per sliding scale; If.201-230=3 units.before meals and at bedtime. with a start date of 03/14/26. During an observation on 03/17/26 at 10:56 a.m., revealed LVN E was at the medication cart preparing to perform Resident #9's fingers stick blood sugar. LVN E entered Resident #9's room and pricked Resident #9's finger and obtained a blood sample with a reading of 204. LVN E checked the computer and stated the resident would be receiving 5 units of Novolin R per sliding scale. LVN E opened the medication cart reached into the medication cart and retrieved the insulin pen and dialed in 5 units without first priming (meaning removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly) the pen. She re-entered Resident #9's room and administered the insulin. During an on 03/17/26 at 11:01 a.m., LVN E was observed at the medication cart preparing to obtain a fingerstick blood sugar on Resident #96. LVN E entered Resident #96's room, pricked the resident's finger and obtained a blood sugar sample with a reading of 214. LVN E returned to the medication cart, checked the computer, and stated Resident #96 would receive 3 units of Lispro per sliding scale. LVN E reached into the medication drawer and retrieved the insulin pen and dialed in 3 units without first priming the pen. LVN E then re-entered the resident's room and administered the insulin. During an interview on 03/17/26 at 11:10 a.m., LVN E stated she only primed the insulin pen when it was first opened and was not aware it needed to be primed each time. She stated the purpose of priming the pen was to ensure the insulin was all the way to the end of the pen. She stated she could see where it should be done each time to prevent giving an air shot. She stated going forward she would always prime the pen. 2. Record review of Resident #69' face sheet, dated 03/19/26, reflected a [AGE] year-old female, admitted [DATE]. Diagnosis included type 2 diabetes mellitus (chronic condition where high blood sugar results from insufficient insulin production). Record review of Resident #69's Physician's Order for March 2026, reflected, Novolog Flexpen subcutaneous solution (Insulin Aspart) 100 unit/ml.Inject per sliding scale; Do not call DR unless it's over 400 twice in a row 400 > give 20 units. Recheck in 3 hrs. and if 400> call MD.before meals and at bedtime. with a start date of 11/23/25. During an observation on 03/17/26 at 11:12 a.m., LVN D was (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed at the medication cart preparing to obtain a fingerstick blood sugar on Resident #69. LVN D opened the medication cart and pulled out a piece of wax paper and placed the glucometer, alcohol pads, lancets and the whole bottle of test strips onto the paper and entered Resident #69's room. LVN D placed the wax paper with the supplies onto Resident #69's bedside table. LVN D pricked the resident's finger to obtain a blood sample and obtained a reading of 476. LVN D then placed the used test strip and lancet on the wax paper and then moved the glucometer and bottle of test strips onto the resident bedside table and wadded up the wax paper. LVN D then carried the glucometer and the test strips and placed them on top of the mediation cart while she disposed of the lancet and used test strip. LVN D performed hand hygiene, put on gloves, and retrieved a sani-wipe (germicidal wipe) and cleaned the glucometer. LVN D removed her gloves, performed hand hygiene, and checked the computer. She stated the resident would receive 20 units of Novolog per sliding scale and she would have to re-check her blood sugar in 3 hours and if it was still over 400 she would need to call the MD. LVN D opened the top of the medication cart and put the bottle of test strips back into the cart and retrieved the Insulin pen, re-entered the resident's room, and dialed 20 units without first priming the pen. LVN D administered the insulin and while leaving the room she stated, I forgot a step. She stated she was supposed to prime the pen with 2 units before dialing in the prescribed amount. During an interview on 03/17/2026 at 11:20 a.m., LVN D stated she was supposed to prime the pen with 2 units to ensure the air was out of the pen and make sure the resident received the full amount of insulin. She stated the risk of not priming the pen could be a resident not receiving the full amount of insulin prescribed. During an interview on 03/19/26 at 09:55 a.m., the DON stated the insulin pen was to be primed with 2 units before each injection to ensure the air was out of the pen and to determine if it was working correctly. She stated failure to do so could result in the resident receiving too little medication which could result in ineffective treatments and uncontrolled blood sugars. She stated all of the facility staff were trained on the proper protocol but stated they will In-service the staff again as well to ensure compliance. The DON stated they do not have a policy specific for insulin pens. She stated they follow the manufacturer's guidelines on the correct procedure for administration. Record review of the manufacture instructions for (Humalog)Lispro obtained from https://www.lillyinsulinlispro.com/ searched on 03/24/26 reflected, .Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your Pen, turn the Dose Knob to select 2 units. Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the Needle, and repeat priming steps. Record review of the manufacture instructions for (Novolog) Aspart obtained from https://www.novolog.com/ searched on 03/24/26 reflected, .Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your Pen, turn the Dose Knob to select 2 units. Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the Needle, and repeat priming steps. Record review of the manufacturer's instructions for Novolin R obtained from https://www.novo-pi.com/novolinr.pdf searched on 03/24/26, reflected, Giving the air shot before each injection Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to make sure you take the right dose of insulin: E. Turn the dose (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	selector to select 2 units. Hold your Novolin(R) R FlexPen(R) with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge.Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times.

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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. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety for the facility's 1 of 1 kitchen.: The dietary staff failed to ensure temperatures were taken of all cooked and cold food before serving them to residents during lunch meal service on 3/17/26.The dietary staff failed to properly sanitize the thermometer while taking the temperature of each food. The dietary staff failed to use proper hand hygiene during lunch service on 3/17/26. These failures could place residents at risk for food-borne illness if consumed and food contamination. Findings included: Record review of two grievances filed by two anonymous residents on 2/23/26 reflected food was always undercooked, especially on the weekends. During an observation of the Dietary Manager of taking the temperature of the food on 3/17/26 at 11:40 a.m. revealed he took the temperature of the Gumbo, wiped the thermometer with a sanitizing pad and placed it on the counter. The Dietary Manager then stuck the thermometer in the rice to take the temperature The Dietary Manager then removed the thermometer and placed it on the counter. The Dietary Manager picked up the thermometer again and stuck it in the corn bread without sanitizing it. At 11:50 a.m. the Dietary Manager poured chicken strips and French fries that had been sitting in the metal baskets on the fryer into the metal trays on the warming table. The Dietary Manager was not observed taking the temperature of the chicken strips or French fries. The Dietary Manager and Dietary Aide B were observed serving plates of food on trays that had salads. The Dietary Manager was not observed taking the temperature of the salads on the food trays. At 12:05 p.m. the Dietary Manager served some chicken strips and French fries from the warming table without taking the temperature of them. During an observation of Dietary Aide B on 3/17/26 at 11:58 a.m., revealed Dietary Aide B stopped assisting with serving food and left to the pantry to obtain hamburger buns. Dietary Aide B was observed returning to the serving area with hamburger buns and a box of gloves. Dietary Aide B removed a glove from the box, put it on her right hand and proceeded to pull out a hamburger bun and placed it on a plate. Dietary Aide B removed her glove and proceeded to serve food. Dietary Aide B was not observed washing her hands or sanitizing her hands after removing her glove. During an interview with the Dietary Manager on 3/17/26 at 12:51 p.m., interview revealed all foods, hot or cold, should have the temperature taken before serving to residents. The Dietary Manager stated he had not taken the temperature of the salad because it had just been removed from the refrigerator. The Dietary Manager stated he should have taken the temperature anyway. The Dietary Manager stated he took the temperature of the fries and chicken tenders as soon as they came out of the fryer ,while they were in the basket, but he should have taken the temperature again when they were placed on the heating table. The Dietary Manager stated the thermometer should have been sanitized before and after each food and he should not have placed the thermometer on the counter because it had not been sanitized and the thermometer could have gotten contaminated. The Dietary Manager stated if he placed the thermometer on any surface the thermometer should have been sanitized again before using it. The Dietary Manager stated dietary staff were not required to wear gloves during meal service but they needed to follow proper handwashing and sanitizing. The Dietary Manager stated dietary staff should wash their hands between handling raw meats, after gloves were used or when they left the serving area and returned to resume food service. The Dietary Manger stated Dietary Aide B should have washed her hands when she returned from the pantry with the bread to serve the food and she should have washed her hands every time she removed her glove. The Dietary Manager stated the risk to the residents of not temping all foods was it could have made them sick. The Dietary Manager stated the risk of not properly sanitizing the thermometer after putting it on a surface that was not sanitized was cross contamination and possible illness. The Dietary Manager stated there was also a risk of cross contamination from not washing hands after having left the serving area and returning. During an (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview with Dietary Aide B on 3/17/26 at 1:10 p.m., interview revealed hands should have been washed when staff left the kitchen or serving area, touched their clothes and when gloves were removed. Dietary Aide B stated she had not washed her hands after she returned from having gotten the bread and stated she should have washed her hands. Dietary Aide B stated she should have washed her hands every time she took the glove off while serving the hamburgers. Dietary Aide B stated because she had not washed her hands . Dietary Aide B stated it was unsanitary and could have caused the spread of infection. During an interview with the Administrator on 03/19/2026 at 12:15 p.m., interview revealed he had been in the position for a month and had started to work on properly training dietary staff. The Administrator stated he would work with the Dietician to ensure the appropriate in-services and training were provided for dietary staff. The Administrator stated the expectation was for dietary staff to have proper hand hygiene, temp all foods and maintain a clean and sanitized kitchen to prevent the spread of illness. Record review of the facility's policy titled, Infection Control, dated revised 2012 reflected, .Careful hand washing by personnel will be done in the following situations: a. prior to entering the work area and reporting to the workstation. B. between handling of dirty dishes boxes or equipment and handling clean food or utensils. Record review of the facility's policy titled, Daily Food Temperature Control, dated revised 2012 reflected, We will assure that food is served at a safe temperature. Temperatures of all hot and cold food shall be taken prior to every meal service and recorded on the Temperature Log.Procedure: 1. There is a thermometer available for use in the department to test the temperatures of foods which is sanitized between food testing. 2. Prior to meal service, the cook shall take the temperature of all hot and cold foods.4. All hot foods shall be cooked and held for service at temperatures of 140 degrees Fahrenheit or above.6. Cold foods shall be less that 41 degrees Fahrenheit. Record Review of Review of Food and Drug Administration Food Code, dated 2022, reflected, . 2 - 19 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLESP and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; P (B) After using the toilet room; P (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); P (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS, eating, or drinking; P (E) After handling soiled EQUIPMENT or UTENSILS; P (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; P (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; P (H) Before donning gloves to initiate a task that involves working with FOOD; P and (I) After engaging in other activities that contaminate the hands. Record Review of Review of Food and Drug Administration Food Code, dated 2022, reflected, .3-501.19 Time as a Public Health Control. (A) Except as specified under (D) of this section, if time without temperature control is used as the public health control for a working supply of TIME/TEMPERATURE CONTROL FOR SAFETY FOOD before cooking, or for READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is displayed or held for sale or service. (B) If time without temperature control is used as the public health control up to a maximum of 4 hours: (1) Except as specified in (B)(2), the FOOD shall have an initial temperature of 5 C (41 F) or less when removed from cold holding temperature control, or 57 C (135 F) or greater when removed from hot holding temperature control.Record Review of Review of Food and Drug Administration Food Code, dated 2022, reflected . 4-7 Sanitization of Equipment and Utensils 4-701 Objective 4-701.10 Food-Contact Surfaces and Utensils. Equipment food-contact surfaces and utensils shall be sanitized.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for six of eight (Resident #96, Resident #9, Resident # 69, Resident # 70, Resident #46 and Resident #8) observed for infection control. 1.The facility failed to ensure LVN E sanitized the glucometer with a recommended germicidal wipe between resident use when she obtained a fingerstick blood sugar on Resident #9 and then proceeded to obtain a fingerstick blood sugar on Resident #96 with the contaminated glucometer and then placed the un-sanitized glucometer back into the medication cart on 03/17/26. 2. The facility failed to ensure LVN D prevented cross-contamination of the bottle of test strips when she carried the bottle of strips into Resident #69's room, placed them on the resident's bedside table and then returned them to medication cart without sanitizing the bottle. 3. The facility failed to ensure RN C utilized Enhanced Barrier Precautions while performing G tube medication administration for Resident # 70 on 03/18/26. 4. The facility failed to ensure CNA F and CNA H utilized Enhanced Barrier Precautions during incontinence care and a mechanical lift transfer for Resident # 46 on 03/17/26. 5. The facility failed to ensure CNA G and CNA M utilized Enhanced Barrier Precautions during incontinence care and a mechanical lift transfer for Resident # 46 and failed to ensure CNA G disposed of a soiled brief and wipes in a plastic bag instead of on the floor on 03/18/26. 6. The facility failed to ensure CNA J performed hand hygiene and glove changes during incontinence care of Resident #8, and before leaving the resident's room on 03/17/26. These failures could place residents at risk for infection and cross contamination.Findings included:1. Record review of Resident #9's face sheet, dated 03/19/26, reflected a [AGE] year-old female admitted [DATE], diagnosis included type 2 diabetes mellitus (chronic condition where high blood sugar results from insufficient insulin production). Record review of Resident #96's face sheet, dated 03/19/26, reflected a [AGE] year-old female, admitted [DATE]. Diagnosis included type 2 diabetes mellitus (chronic condition where high blood sugar results from insufficient insulin production). During an observation on 03/17/26 at 10:56 a.m. revealed LVN E was at the medication cart preparing to perform Resident #9's fingers stick blood sugar. LVN E removed the glucometer from the medication cart and placed it on a piece of wax paper with a few test strips, alcohol pads, and lancets. LVN E performed hand hygiene, put on gloves, and entered Resident #9's room and placed the wax paper with the supplies on the resident's bedside table. LVN E pricked Resident #9's finger and obtained a blood sample with a reading of 204. LVN E returned to the medication cart, disposed of the lancet and test strip and placed the used glucometer back in the top drawer of the mediation cart. LVN E removed her gloves and performed hand hygiene, checked the computer, and stated the resident would be receiving 5 units of Novolin R per sliding scale. LVN E opened the medication cart reached into the medication cart and retrieved the insulin pen and dialed in 5 units. LVN E re-entered Resident #9's room and administered the insulin. LVN E returned to the medication cart and placed the insulin pen back into the medication cart and then proceeded to the next resident's room.During an observation on 03/17/26 at 11:01 a.m. LVN E was observed at the medication cart preparing to obtain a fingerstick blood sugar on Resident #96. LVN E opened the medication cart and pulled out a piece of wax paper and placed the un-sanitized glucometer, a few test strips, alcohol pads, and lancets on the wax paper. LVN E performed hand hygiene, put on gloves, and entered Resident #96's room and placed the supplies on the resident's bedside table. LVN E pricked the resident's finger and obtained a blood sugar sample with a reading of 214. LVN returned to the medication cart, disposed of the lancet and used supplies, and placed the used glucometer back in the top of the mediation cart without disinfecting the glucometer. LVN E then checked the computer and stated Resident #96 would receive 3 units of Lispro per sliding scale. LVN E reached into the medication drawer and retrieved the insulin pen and dialed in 3 units. LVN E then (continued on next page)

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	455573	A. Building B. Wing	03/19/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	re-entered the resident's room and administered the insulin. During an interview on 03/17/26 at 11:10 a.m., LVN E stated she was supposed to sanitize the glucometer between each resident and stated she had failed to do that. She stated by placing the glucometer back in the cart she contaminated the medication cart. She stated she just got so nervous and had just forgotten that step. She stated the risk of not disinfecting the glucometer was the spread of blood borne pathogens. 2. Record review of Resident #69' face sheet, dated 03/19/26, reflected a [AGE] year-old female, admitted [DATE]. Diagnosis included type 2 diabetes mellitus (chronic condition where high blood sugar results from insufficient insulin production).During an observation on 03/17/26 at 11:12 a.m., LVN D was observed at the medication cart preparing to obtain a fingerstick blood sugar on Resident #69. LVN D opened the medication cart and pulled out a piece of wax paper and placed the glucometer, alcohol pads, lancets and the whole bottle of test strips onto the paper and entered Resident #69's room. LVN D placed the wax paper with the supplies onto Resident #69's bedside table. LVN D pricked the resident's finger to obtain a blood sample and obtained a reading of 476. LVN D then placed the used test strip and lancet on the wax paper and then moved the glucometer and bottle of test strips onto the resident bedside table and wadded up the wax paper. LVN D then carried the glucometer and the test strips and placed them on top of the mediation cart while she disposed of the lancet and used test strip. LVN D performed hand hygiene, put on gloves, and retrieved a sani-wipe (germicidal wipe) and cleaned the glucometer. LVN D removed her gloves, performed hand hygiene, and checked the computer. She stated the resident would receive 20 units of Novolog per sliding scale and she would have to re-check her blood sugar in 3 hours and if it was still over 400 she would need to call the MD. LVN D opened the top of the medication cart and put the bottle of test strips back into the cart and retrieved the insulin pen, re-entered the resident's room, and dialed 20 units and administered the insulin.During an interview on 03/17/2026 at 11:20 a.m., LVN D stated she should not have laid the used glucometer or the bottle of test strips on the resident's bedside table. She stated she should have carried the necessary supplies into the room and should have left the glucometer and the bottle of strips on the wax paper until she sanitized them. She stated the risk was cross contamination of the medication cart.3. Record review of Resident #70's face sheet, dated 03/19/26, reflected a [AGE] year-old female, admitted [DATE]. Diagnoses included Alzheimer's disease and dysphagia (difficulty swallowing).An observation on 03/1/8/26 at 7:40 a.m. of G-Tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach) medication administration revealed Agency RN C at the medication cart outside of Resident #70's room. An Enhanced Barrier sign was posted outside of the door and a cart containing gowns was inside of the resident's room. RN C prepared the medication for Resident #70, sanitized her hands but did not put on gloves and gown. RN C checked for residual, flushed the tube with water, and then administered the medication and flushed with water following the medication administration and then provided Resident #70 her bolus feeding (a large amount of liquid administered over a short period of time). RN C then returned to the medication cart and performed hand hygiene.During an interview with RN C on 03/18/26 at 8:00 a.m., she stated any resident with a G-tube was required to be on Enhanced Barrier Precautions. She stated she should have worn a gown and gloves and just overlooked it when she entered the room. She stated she had the gloves in her pocket. She stated the risk of not following Enhanced Barrier Precautions was the spread of MDROs.4. Record review of Resident #46's face sheet, dated 03/19/26, reflected a [AGE] year-old female admitted [DATE]. Diagnoses included Alzheimer's Disease and multiple sclerosis (chronic autoimmune disease of the central nervous system causing communication issues between the brain and body).During an observation on 03/17/26 at 9:30 a.m., a sign was posted outside of Resident #46's room which indicated she was on Enhanced barrier precautions. Upon entering the room, CNA G and CNA M were observed placing a clean brief under Resident #46 and then placed the mechanical lift sling under the resident to get her up for the day. The staff did not have a gown during this observation. Resident #46 was observed to have a dressing on her inner left leg calf and knee with a date of 03/17/26. Once the resident was positioned on the sling, CNA G and CNA M (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	raised her up with the mechanical lift and positioned her in her wheelchair. Both staff removed their gloves and washed their hands before leaving the room.During an interview on 03/17/2026 at 9:55 a.m., CNA H stated she realized they both forgot to put on a gown when they went in to provide Resident #46 care. She stated Resident #46 was on Enhanced barrier precautions due to her wounds. She stated the risk of not following the requirements was the spread of infection. During an interview on 03/17/2026 at 10:00 a.m., CNA F stated she realized they both forgotten to put on a gown when they went in to get Resident #46 up for the day. She stated any type of care they provided for someone who was on enhanced barrier precautions required them to wear a gown and gloves. She stated the purpose was to decrease the risk of the spread of germs and infections.During an observation on 03/18/2026 at 1:15 p.m., CNAs G and CNA M were requested by ADON A to lay Resident #46 down so wound care could be provided. Upon entering Resident #46's room, CNA G and CNA M were observed at the bedside placing a clean brief under the resident. Both staff had on gloves but were not wearing a gown. A soiled brief with bowel movement and multiple soiled wipes were noted on the floor. Both staff positioned the resident in the bed and then CNA G picked up the soiled brief and wipes and placed them in the trash can and removed the bag from the trash can. Both staff removed their gloves and washed their hands and notified ADON A, who was outside the resident's door, she was ready for wound care. During an interview on 03/18/2026 at 1:40 p.m., CNA G and CNA M stated they were supposed to have a gown on to transfer the resident plus provide incontinence care due to the resident wounds and had failed to so. They stated they had received training on the purpose of Enhanced barrier precautions and knew any resident with a wound required the use of gown and gloves. CNA G stated she had thrown the dirty brief and wipes on the floor because she was not prepared to change Resident #46 when they went to lay her down, and once they had gotten her into bed realized she had a bowel movement and needed to be changed. She stated she could have used the trash can but stated she just was not thinking. 5. Record review of Resident #8's face sheet, dated 03/19/26, reflected a [AGE] year-old female admitted [DATE]. Diagnosis included a fracture left femur (thigh bone).During an observation on 03/17/2026 at 2:45 p.m., CNA J and CNA I entered Resident #8's room, washed their hands and put on gloves. CNA J unfasted the resident's brief and stated she was not wet. Both staff rolled the resident on her left side revealing she had a small bowel movement. CNA I wiped from the front to back. Resident started having more bowel movement and CNA I stated she needed to go to the cart to get some more wipes and gloves. CNA I removed her gloves and left the room without performing hand hygiene. CNA I returned to the room and put on gloves without performing hand hygiene and continued to perform peri care to the resident. With the same gloves used to clean Resident #8's buttocks, CNA I applied barrier cream. CNA I then removed her gloves and re-gloved without performing hand hygiene and placed a clean brief under the resident. Both staff repositioned the resident onto her back and fastened the brief. Both staff removed their gloves and performed hand hygiene.During an interview on 03/17/2026 at 2:45 p.m., CNA J and CNA I, both stated they were supposed to perform hand hygiene before care, after they changed their gloves and before they left the room. CNA J stated she had failed to perform hand hygiene when she left the room to get more supplies and stated she should have changed her gloves and performed hand hygiene before she put the barrier cream on the resident. She stated the risk was the spread of infection and germs. During an interview on 03/19/26 at 09:45 a.m., the DON stated staff were to change their gloves and perform hand hygiene after they performed incontinence care and before applying the clean brief and always before going from clean to dirty. She stated they were never to throw soiled briefs, wipes or linens on the floor and would expect them to be prepared for incontinence care anytime they laid a resident down. She stated by not following proper hand hygiene it placed residents at risk of urinary tract infections. She stated they had done extensive in-services with the staff on infection control, especially hand hygiene and the use of Enhanced barrier precautions. She stated any resident with a wound, a catheter or a G-tube required the use of gown and gloves during any high contact care, including G-tube medication administration. She stated in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	addition they made rounds and watched care to ensure the staff were following correct procedures. She stated the staff had also been trained on the proper sanitizing of glucometers and when to perform hand hygiene during glucose monitoring and they were to only carry in the supplies needed to perform the necessary test. She stated the risk of not following the proper procedures was cross contamination and potential for the spread of blood borne pathogens. Record review of the facility's undated policy titled, Fundamentals of Infection Control Precautions, reflected, A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility.Hand Hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situation that require hand hygiene.When hands are visibly soiled.Before and after assisting a resident with personal care.After handling soiled or used linens, dressing, bedpans, catheters and urinals.After contact with a resident's mucous membranes and body fluids or excretions.After removing gloves.Resident Care equipment and articles.Equipment that is visibly soiled with blood or body fluids will be cleaned immediately with an approved disinfectant by the nursing assistant.Record review of the facility's policy titled, Enhanced Barrier Precautions, dated April 2024, reflected, Multidrug-resistant organism (MDRO) transmission is common.Enhanced Barrier Precautions (EBP) refer to an infection control intervention design to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during having contact resident care activities.EBP are indicated for residents with any of the following.Wounds and/or indwelling medical devices.examples.urinary catheters, feeding tubes.Facilities should remember to have an appropriate disposal container available in the resident room to allow for removal of PPE inside the room.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles and in compliance with the state laws, which included the appropriate accessory and cautionary instructions and the expiration date when applicable for the facility's one of two (ADON C's office refrigerator) refrigerators reviewed for medication storage. The facility failed to ensure a vial of Tuberculin Purified protein derivative that was opened and used, was dated in ADON C's refrigerator used for medication storage. This failure could place residents at risk of diminished effectiveness and not receiving the therapeutic benefits of the medications. Findings included:During an observation on 03/19/26 at 7:55 a.m., ADON C office refrigerator with ADON C revealed an undated opened vial of Tuberculin Purified protein derivative (used to detect tuberculosis infection) which was filled on 07/22/25.During an interview on 03/19/26 at 8:00 a.m., ADON C stated the Tuberculin Purified protein derivative (substance used for skin test for tuberculosis), had to be dated when opened. She stated once it was opened it would only be good for 30 days. She stated the risk of not dating it once opened was the potential for false positive or an inaccurate test, which could lead to a missed infection. She stated since she had been at the facility the Tuberculin Purified Protein, flu vaccines, pneumonia, and Hepatitis C vaccines were stored in the refrigerator in her office. She stated she was responsible for ensuring the medications were not expired. She stated she could not recall the last time she used the Tuberculin Purified protein derivative but stated she would discard this vial since she had no way of knowing how long it was opened.During an interview on 03/19/26 at 9:00 a.m., the DON stated she and the ADONs were responsible for monitoring the medication storage room and refrigerators to ensure expired medications were removed from possible use. She stated any multiple use vial was required to be dated once opened. She stated the Tuberculin Purified protein was only good for 30 days after it was opened. Record review of the facility's undated policy titled, Medication Storage in the Facility, reflected, Medications and biologicals are stored safely, securely and properly following manufacturers recommendations or those of the supplier.Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secures closures are immediately removed from stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exist.