

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 45E631	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2025
NAME OF PROVIDER OR SUPPLIER Schleicher County Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 104 N US Hwy 277 Eldorado, TX 76936	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure all residents had the right to formulate an advance directive for 3 of 9 residents (Residents #1, #8, and #33) reviewed for advance directives. The facility failed to ensure Resident's #1, #8, and #33 Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) forms were completed correctly. This failure could place residents at risk of having their end of life wishes dishonored, and of having CPR performed against their wishes. Findings included: Resident #1 Review of Resident #1's admission Record, dated [DATE], revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a neurological condition causing memory problems), closed fracture of the left and right leg, diabetes (a condition where the body cannot process insulin correctly), chronic obstructive pulmonary disease (lung disease making it difficult to breathe), seizures, heart problems, and urinary tract infections. Review of Resident #1's Significant Change MDS Assessment, dated [DATE], revealed: Resident #1's BIMS score was 8 of 15, indicating moderate cognitive impairment. Review of Resident #1's Care Plan, initiated [DATE], revealed Resident #1 was a DNR status. Review of Resident #1's Order Summary, dated [DATE], revealed orders that Resident #1 was a DNR dated [DATE]. Review of Resident #1's DNR form completed [DATE] revealed: Section A: Resident #1 signed the DNR on [DATE]. Section B: Resident #1's legal agent signed the DNR on [DATE]. Section Two Witnesses: The Public Notary Signed the DNR on [DATE] but no witnesses were present. Physician's Statement: Resident #1's NP signed the DNR (not a physician licensed by the Texas Medical Board) and did not include the date, his printed name, or his license number. Resident #8 Record review of Resident #8's admission record dated [DATE] reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Dementia (A loss of brain function that worsens over time and affects memory, thinking, behavior, and language), and Congestive Heart Failure (A chronic condition in which the heart does not pump blood as well as it should). Record review of Resident #8's quarterly MDS assessment dated [DATE] reflected a BIMS score of 3, indicating cognition was severely impaired. Record review of Resident #8's quarterly care plan dated [DATE] revealed Resident #8 was a DNR status. Record review of Resident #8's medical orders reflected an OOH-DNR order dated [DATE]. Record review of Resident #8's OOH-DNR dated [DATE] revealed: Physician's Statement - Signed by Staff #D, a NP, not a physician licensed by the Texas Medical Board and did not include the date or his license number. There was no physician signature in the bottom section stating, All persons who have signed above must sign below, acknowledging that this document has been properly completed. Resident #33 Review of Resident #33's admission Record, dated [DATE], revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, high cholesterol, and heart problems. Resident #33 discharged on [DATE]. Review of Resident #33's Significant Change MDS, dated [DATE] revealed: He had long and short-term memory problems with severely impaired decision-making abilities. This was an acute onset of mental status change. Resident #33 had a life expectancy of less than 6 months. Review of Resident #33's Care Plan initiated [DATE], revealed the resident was a DNR status. Review of (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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 45E631	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2025
NAME OF PROVIDER OR SUPPLIER Schleicher County Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 104 N US Hwy 277 Eldorado, TX 76936	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #33's Physician Order Summary as of [DATE] revealed:Resident #33 was admitted to hospice diagnosis Alzheimer's disease dated [DATE].Resident #33 was a DNR dated [DATE]. Review of Resident #33's Facility DNR form documented.Section B: Resident #33's authorized representative signed the form, but did not date it. Physician's Statement: The NP signed the form and dated it [DATE], but did not include his license number.There were not two qualified witnesses witnessing the form as signed and valid. Review of Nurse's Notes dated [DATE] at 4:16 PM revealed: Received a call from Hospice asking if we had a copy of the DNR for the resident. Nurse informed Hospice that Nurse sent her a copy [DATE] and gave a copy to Hospice Nurse this morning when she came to get consents from the family member]. Hospice went on to explain that the DNR we had was not witnessed for the [family member] signature, therefore not valid and that resident needed to be placed on a full code status until they could get a DNR signed from the [family member] and hospice physician tomorrow. Discontinued DNR order, full code order implemented, notified ADON, charge nurse to put on 24 hour report and administration. Review of the Hospice OOH-DNR signed [DATE] revealed:Section C: Resident #33's [family member] signed and dated the OOH-DNR on [DATE].Physician's statement: The Hospice physician signed and dated the OOH-DNR on [DATE].The notary signed the form on [DATE].There were no witnesses to the signing of the form. In an interview on [DATE] at 2:53 PM the ADON said the blank OOH-DNR forms go with the resident to the clinic visit with the provider, the form was completed at the clinic visit and sent back to the facility to be scanned into the electronic medical record. The ADON said that the staff person scanning in the OOH-DNR's does not review them for accuracy/completion. Review of the Instructions for Issuing an OOH-DNR Order (included in the OOH-DNR Order) used by the facility and published by the Texas Department of State Health Services, revised [DATE], revealed:Purpose: The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order was for use by qualified persons or their representatives to direct health professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity. Section A - If an adult person is competent and at least [AGE] years of age he/she will sign and date the Order in Section A.Section B - If and adult person is incompetent or otherwise mentally or physically incapable of communication and has a legal guardian, agent in a medical power of attorney, or proxy in a directive to physician, the guardian, agent, or proxy may execute the OOH-DNR Order by signing and dating it in section B.Section C - If the adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, or proxy, then a qualified relative may execute the OOH-DNR by signing and dating it in Section C.Section D - If the person is incompetent and his/her attending physician has seen evidence of the person's previously issued proper directive to physicians or observed the person competently issue an OOH-DNR in a nonwritten manner, the physician may execute the Order on behalf of the person by signing and dating it in Section D-In addition, the OOH-DNR must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C or E and if applicable., have witnessed a competent adult person making an OOH-DNR Order by non-written communication to the attending physician, who must sign in section D, and also the physician's statement section. Optionally, a competent adult person or authorized declarant may sign the OOH-DNR in the presence of a notary-public. However, a notary cannot acknowledge witnessing the issuance of an OOH-DNR in a nonwritten manner, which must be observed and only can be acknowledged by two qualified witnesses.		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 45E631	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2025
NAME OF PROVIDER OR SUPPLIER Schleicher County Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 104 N US Hwy 277 Eldorado, TX 76936	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure in accordance with professional standards of practices, the medical records on each resident were accurately documented for 2 of 3 residents (Residents #33 and #34) reviewed for accurate medical records. The facility failed to accurately document the type of discharge for Residents #33 and #34. This failure could affect residents whose records are maintained by the facility and could place them at risk for errors in care and treatment. The findings included: Resident #33 Review of Resident #33's admission Record, dated [DATE], revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, high cholesterol, and heart problems. Resident #33 discharged on [DATE]. Review of Resident #33's Exit MDS, dated [DATE] documented a Death in Facility. Review of Resident #33's Nurse's Note, dated [DATE] at 8:31 AM, revealed, Nurse went in around 0818 to resident was found unresponsive, no respirations noted, no pulse, pupils were dilated and fixed, skin was cold to the touch, and there was generalized cyanosis noted. Charge nurse, RN, listened for any heart sounds and respirations for a full 2 minutes and none were noted. Resident #33 was pronounced dead at 0818 AM. Review of Resident #33's Physician's Discharge summary, dated [DATE], documented resident died in the facility. Review of Resident #33's Transfer/Discharge Report, printed [DATE], revealed he was transferred/ discharged on [DATE] to a nursing home: nursing home unknown/ TBD Resident #34 Review of Resident #34's admission Record, dated [DATE], revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (a condition where blood flow to the brain is interrupted leading to brain cell damage or death), Chronic Kidney Disease (a chronic disease of the kidneys leading to kidney failure) and Vascular Dementia (a group of thinking and social symptoms that interferes with daily functioning). Resident #34 was discharged on [DATE]. Review of Resident #34's Exit MDS, dated [DATE] documented a Death in Facility. Review of Resident #34's Record of Death, dated [DATE] revealed the time of Resident #34's death was 10:32 AM on [DATE]. Review of Resident #34's Physician's Discharge summary, dated [DATE], documented the resident died in the facility on [DATE]. The medical provider signed the report. Review of Resident #34's Transfer/Discharge Report, completed [DATE], revealed Resident #34 was transferred/discharged on [DATE] to a nursing home: nursing home unknown/ TBD. An RN signed the report. Interview on [DATE] at 2:31 PM, the administrator said Residents #33 and #34 did pass away and the NC struggles with the electronic medical record and computers in general. The administrator confirmed NC had received training. Interview on [DATE] at 2:53 PM with the ADON and NC, the ADON said Residents #33 and #34 did die at the facility. The ADON said the charge nurse on duty at the time of a death or discharge/transfer completes the Transfer/Discharge Report, prints it, signs it, and adds it to a file for things to be scanned into the electronic medical record. The NC said she does not double-check the accuracy of records when she scans them in. Interview on [DATE] at 3:08 PM, the ADON stated the discharge summary had to be checked for the wrong box if the documentation program was checked as a drop-down screen. The ADON said whoever scanned in the discharge summary looked at it but we have a lot of paper to scan. The ADON stated any nurse could do the transfer/ discharge summary. The ADON looked at Resident #33 and #34's discharge summary and said the same nurse did each discharge summary. The ADON said it was probably on the 2p.m. - 10 p.m. shift when things always went wrong. The ADON stated the Nurse printed the discharge summary, signed it, and the summary went in the accordion file to be scanned. Review of the facility's policy Documentation in Medical Record revised [DATE], revealed in part: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 45E631	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2025
NAME OF PROVIDER OR SUPPLIER Schleicher County Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 104 N US Hwy 277 Eldorado, TX 76936	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain an infection control program designed to prevent the development and transmission of infections for 1 of 4 (Resident #21) reviewed for infection control. The facility failed to ensure Resident #21's oxygen nasal cannula tube was bagged when not in use and CNA A touched the nasal cannula with her bare hands to place it on the resident's nose. This failure could place the residents at risk of infection. Findings included: Record review of Resident #21's admission record, dated 09/24/2025, indicated she was admitted to the facility on [DATE] with diagnoses of dementia and COPD chronic obstructive pulmonary disease (COPD is an ongoing lung condition caused by damage to the lungs). She was [AGE] years of age. Record review of Resident #21's physician order report dated 09/24/2025 indicated in part: Oxygen via at 1-2 LPM via nasal cannula continuously every shift. (LPM=liters per minute). Record review of Resident #21's care plan dated 04/22/2025 indicated in part: The resident is at risk for impaired gas exchange r/t COPD, hypoxemia and cough. Resident will maintain an oxygenation saturation within personal goal range. Administer oxygen as prescribed or per standing order. (r/t = related to). Record review of Resident #21's MDS dated [DATE] indicated in part: BIMS of 3 indicating the resident had severe impairment. Functional Limitation in Range of Motion - Upper extremity (shoulder, elbow, wrist, hand) is dependent - A helper completed all the activities for the resident. Respiratory treatments - Oxygen therapy. During an observation and interview on 09/24/2025 at 10:42 AM CNA A assisted Resident #21 to her wheelchair. The resident's oxygen nasal cannula tube was seen wrapped around the oxygen tank which was attached to the back of the resident's wheelchair. CNA A took the nasal cannula with her bare hands, touched the part that goes into the resident's nasal area and then placed it on the resident's nose. CNA A said Resident #21 was not able to remove the oxygen nasal cannula and tube by herself and that some other staff member must have removed it and placed it on the oxygen tank. The CNA said they normally placed the oxygen nasal cannula tube on the oxygen tank and had never noticed a storage bag on the tank to store the oxygen nasal cannula tube. During an observation and interview on 09/24/2025 at 1:40 PM Resident #21 was awake and alert in her bed resting. The resident said she did not remove the nasal cannula from her nose as she was unable to. Resident #21 said the staff were the ones that would do that and store it in the storage bag as she was unable to do that. During an interview on 09/24/2025 at 1:46 PM CNA A said that she had not noticed that Resident #21 did not have a bag on the oxygen tank to store the oxygen nasal cannula tube. CNA A said not having a bag to store the oxygen nasal cannula tube could lead to the nasal cannula becoming contaminated and possibly introduce bacteria into the resident's nose. CNA A said she had reported it to a nurse and the nurse had already placed a bag on the resident's wheelchair to store the oxygen nasal cannula tube. During an interview on 09/24/2025 at 1:52 PM RN B said when the oxygen nasal cannula tube was not in use, the staff were supposed to store it in the plastic bag. RN B said it was supposed to be stored to prevent contamination of the nasal cannula. RN B said she had recently placed a bag on Resident #21's oxygen tank so the staff could store the oxygen nasal cannula tube in it. During an interview on 09/25/2025 at 12:15 PM the ADON said it was expected for the oxygen nasal cannula tube to be stored in a bag when not in use. The ADON said the purpose of that was to prevent infections. The ADON was made aware of the observation of CNA A touching the nasal cannula with her hands and placing it on Resident #21's nose. The ADON said the aide should not have touched the nasal cannula with her hands as that could lead to contamination. The ADON said they would conduct training on making sure staff knew not to touch the nasal cannula and to store it in a bag when not in use. During an interview on 09/25/2025 at 2:44 PM the Administrator said it was expected for staff to store the oxygen nasal cannula tube in a bag when not in use. The Administrator was made aware of the observation of the oxygen tube and nasal cannula not bagged and then touched by the CNA. The Administrator said they would make sure (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 45E631	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2025
NAME OF PROVIDER OR SUPPLIER Schleicher County Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 104 N US Hwy 277 Eldorado, TX 76936	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there were enough bags to store the oxygen nasal cannula tube. The Administrator said not storing the oxygen nasal cannula tube in a bag could have an outcome of infections. Record review of the facility's policy titled Oxygen Administration and dated 05/12/2025 indicated in part: Policy - Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. Keep delivery devices covered in plastic bag when not in use. Record review of the facility's policy titled Infection prevention and control program dated 01/15/25 indicated in part: This facility has established and maintains 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 as per accepted national standards and guidelines. Standard precautions- All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures.		