

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 45F470	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2026
NAME OF PROVIDER OR SUPPLIER Truman W Smith Children's Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 W Upshur Ave Gladewater, TX 75647	

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)
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the appropriate treatment and services to prevent complications was provided for 2 of 6 residents reviewed for feeding tube management. (Resident #1 and Resident #2)The facility failed to follow the physician's orders for Resident #1's feeding tube (medical device to deliver nutrition, hydration, and medication directly to the stomach) rate (how fast it was given) of delivery on 3/16/26 and 3/17/26.The facility failed to follow the physician orders for Resident #2's feeding tube duration of administration and total volume (amount) of feeding on 3/17/26.These failures placed residents at risk for vomiting, aspiration (accidental breathing in food, liquid, or foreign material into airway/lungs which increased the risk of pneumonia (lung infection), malnutrition, and weight gain or loss.Findings included:1. Record review of Resident #1's face sheet dated 3/17/26 indicated Resident #1 was an [AGE] year-old male admitted to the facility initially on 6/16/15 and re-admitted on [DATE]. Resident #1 had diagnoses including chronic respiratory failure, gastrostomy (feeding tube placed through the abdomen into the stomach, used to deliver nutrition, fluids, and/or medication), developmental disorder of speech and language, and congenital hydrocephalus (rare, birth-present condition characterized by excess fluid buildup in the brain).Record review of Resident #1's quarterly MDS assessment dated 2/2326 indicated Resident #1 did not complete the BIMS questionnaire due to the resident being rarely or never understood. Resident #1 had unclear speech. Resident #1 was totally dependent on staff for all ADLs. Resident #1 had a feeding tube.Record review of Resident #1's undated care plan indicated Resident #1 required gastrostomy tube related to unable to take anything by mouth with interventions including Resident #1 was total assistance with tube feeding . see MD orders for current feeding orders. Resident #1 had a potential for nutritional problem requiring gastrostomy feedings with interventions including providing and serving diet as ordered.Record review of Resident #1's Order Summary Report dated 3/17/26 indicated he received PediaSure Peptide (nutrition) at 150 ml/hr for a total volume of 240 ml twice daily through his gastrostomy tube, with a start date of 11/25/25.Record review of Resident #1's Enteral (nutrition delivered directly into stomach or small intestine) TAR dated 3/1/26-3/31/26 indicated he was administered PediaSure peptide 150 ml/hr for a total volume of 240 ml twice daily at 9:00 AM and 4:00 PM from 3/01/26 through 3/17/26.Record review of Resident #1's weights indicated he weighed 57.4 pounds on 2/6/26 and 58.1 pounds on 3/6/26 indicating weights were stable.During an observation on 3/17/26 at 2:30 PM, Resident #1 was sitting up in a high back wheelchair watching television in the common area. Resident #1 was alert, awake, and constantly moving his hands and making verbal noises, but was unable to speak. There was a feeding pump attached to a pole on his wheelchair, and it was turned off. The feeding pump tubing was hanging on the pole and was not connected to Resident #1.During an observation and interview on 3/17/26 beginning at 2:45 PM, LVN A said she had worked at the facility for 17 years. LVN A said Resident #1 had returned from school today (3/17/26) and he went to school Tuesday through Friday. LVN A said she set up the feeding pump with the rate of administration and the total volume to be given, and the school should not be changing the settings on the feeding pump. LVN A said the school administered a (continued on next page)</p>

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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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>feeding at 9:00 AM daily when the resident was at school. LVN A said the nurse would administer the 9:00 AM feeding when Resident #1 was not at school and the feeding at 4:00 PM daily. LVN A said Resident #1's feeding pump would still be set on what she had previously set the feeding pump to administer before Resident #1 went to school the morning of 3/17/26. Resident #1 was sitting in the common area watching television. LVN A went to Resident #1 and turned on his feeding pump, and she said the feeding pump was set wrong. LVN A said a staff member made pre-printed labels instead of them having to write on the feeding bags for each resident's feedings. The feeding pump was set at 240 ml/hr and 240 ml had been administered. There was a pre-printed label on the feeding bag that read 240 ml/hr with a total volume of 360 ml. LVN A said she had set the feeding pump for 240 ml/hr with a total volume of 360 ml per the pre-printed label. LVN A said the feeding pump showed Resident #1 received the right volume of 240 ml over an hour. LVN A said if the enteral feeding order was correct at 150 ml/hr with volume of 240 ml total and it was given at 240 ml/hr then Resident #1 received the feeding faster than what the physician ordered. LVN A said if a resident received an enteral feeding too fast, it could cause him to throw up. LVN A said it was her second day in Resident #1's section in a while. LVN A said she should have checked her orders and not just gone by the pre-printed label because it did not come from a pharmacy. LVN A said she would have set Resident #1's feeding pump yesterday (3/16/26) to the same setting as printed on the pre-printed label. LVN A said she would have administered Resident #1's enteral feeding 3/16/26 at 9:00 AM and 4:00 PM at the 240 ml/hr with a total volume of 360 ml as printed on the pre-printed label. LVN A said the school would have administered Resident #1's enteral feeding 3/17/26 at 9:00 AM at the 240 ml/hr with a total volume of 360 ml because she had set the feeding pump prior to Resident #1 going to school and the school was not allowed to change the feeding pump settings. LVN A said there was a binder in their medication room with the pre-printed labels in it. LVN A said, The nurse putting the milk in the bag would be responsible for ensuring the labels matched the orders. LVN A said administering a resident an enteral tube feeding faster than the MD's order could cause vomiting or maybe make them poop, and would be the only negative things she could think of. During an interview on 3/17/26 at 3:15 PM, LVN B said she had worked at the facility for about 12 years. LVN B said she checked her MAR against the pre-printed labels to ensure the was correct. LVN B said the MAR was always accurate with any changes, where the pre-printed label was not. LVN B said if a resident was ordered enteral feedings at 150 ml/hr and it was given at 240 ml/hr, it could cause the resident abdominal discomfort and could cause them to vomit (throw up). 2. Record review of Resident #2's face sheet dated 3/17/26 indicated Resident #2 was a [AGE] year-old female and admitted to the facility initially on 6/08/21 and readmitted on [DATE]. Resident #2 had diagnoses including spastic quadriplegic cerebral palsy (damage to the brain usually occurring before, during or shortly after birth), gastrostomy, protein-calorie malnutrition (lack of protein and energy to meet nutritional needs), feeding difficulties, dependent on a ventilator (machine that breathes for resident), and dysphagia (difficulty swallowing). Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated Resident #2 did not complete the BIMS questionnaire due to the resident being rarely or never understood. Resident #2 had no speech. Resident #2 was totally dependent on staff for all ADLs. Resident #2 had a feeding tube. Record review of Resident #2's undated care plan indicated Resident #2 gastrostomy tube related to unable to take anything by mouth with interventions including Resident #1 was dependent with tube feeding . see MD orders for current feeding orders. Resident #2 had a potential for nutritional problem requiring gastrostomy feedings with interventions including providing and serving diet as ordered. Record review of Resident #2's Order Summary Report dated 3/17/26 indicated her Enteral Feed Order was Compleat Pediatric Reduced Calorie at 68 ml/hr by gastrostomy tube for 18 hours with a total volume of 1174 ml administered with a start date of 3/04/26. Record review of Resident #2's Enteral TAR dated 3/1/26-3/31/26 indicated she was administered Compleat Pediatric Reduced Calorie at 68 ml/hr for 18 hours for a total volume of 1174 ml daily at 9:00 AM from 3/04/26 through 3/17/26 with a start date of 3/04/26. Record review of Resident #2's weights (continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>indicated she weighed 73.2 pounds on 2/6/26 and 72.9 pounds on 3/6/26 indicating there was no significant weight loss. During an observation and interview on 3/17/26 beginning at 4:17 PM, LVN C said she had worked at the facility since December 2025. LVN C accompanied the surveyor into Resident #2's room. Resident #2 was lying in bed with the head of bed elevated and her feeding pump was infusing into her gastrostomy tube at 68 ml/hr for 17 hours. The printed label on the feeding bag read 68 ml/hr for 17 hours with a total volume of 1156 ml and had a handwritten date of 3/17 with a time of 6:00 AM and initials of RN D. LVN C said Resident #2 was not her resident that day (3/17/26) and she would have to check to see what her feeding was ordered at. LVN C went to the nurse's station briefly and returned and stated Resident #2's order was for 68ml/hr for 18 hours, but the total volume was wrong on the order. LVN C the order had a total volume of 1174 ml, but it should have been a total volume of 1224 ml. LVN C said the duration of the feeding and the total volume was incorrect. LVN C said they had pre-printed labels made by the nurses, but they should check the label with the orders to make sure the order had not changed. LVN C said Resident #2 would not have received 68 ml of her feeding with the feeding pump set to deliver 68 ml/hr over 17 hours instead of the ordered 18 hours. LVN C said if the feeding pump had been set to deliver 68 ml/hr over 18 hours and the total volume was entered as the order read 1174 ml, Resident #2 would not have received 50 ml of nutrition. LVN C said the nurse who transcribed the order did not figure the total volume correctly and it should have read 1224 ml. LVN C said if the resident was not receiving the correct feeding dose as ordered, it could affect the resident's nutrition and output. LVN C said if a tube feeding was given faster than it was ordered, it could cause the resident to have nausea and vomiting. During an interview 3/17/26 at 4:30 PM, RN D said she had worked at the facility for a little over a year. RN D said she did not work yesterday (3/16/26) but was scheduled for today (3/17/26) and tomorrow (3/18/26). RN D said she set up Resident #2's feeding the morning of 3/17/26. RN D said the night shift nurse set up their feeding bags with the pre-printed labels already on the feeding bag for them to use on day shift. RN D said she set up the feeding pump to whatever was on the label. RN D said sometimes the feeding orders did change and would have to look at the MAR. RN D said they knew when changes occurred based on what was written on the Kardex (centralized, quick-reference tool) where they sit at the nurse's station. RN D said they would also tell them in report if something changed. RN D said there were new orders written on the Kardex, but the pre-printed label was not updated, but she was not sure what happened, but that was what she was guessing if there was a new order and the label was not correct. RN D said the nurse was responsible for ensuring what she was administering was what was ordered. RN D said Resident #2 could get less feeding than what was ordered and then she could possibly lose weight. RN D said the nurse should be following the MD orders at all times to provide the best outcome for the resident. During an interview on 3/17/26 at 4:40 PM, ADON E said she was the ADON for the [NAME] wing. ADON E said she had worked at the facility for about 30 years. ADON E said they made their feeding bags up every 24 hours. ADON E said Resident #2 had gone to a doctor's visit and came back with a new order to increase her feedings to 18 hours and the nurse did not put the total volume in correctly. ADON E said the nurse who received the new order, would have also put it on the Kardex. ADON E said if Resident #2 did not receive 68 ml/hr for a total of 18 hours it could have cheated her out of 68 ml daily. ADON E said if the total volume was not correct, Resident #2 still would have missed calories. ADON E said the nurses should still be checking the pre-printed labels against the Enteral MAR/orders. ADON E said she checked Resident #2's weights and she had not lost weight, and they had corrected the order to read total volume of 1224 ml. ADON E said the staff should be following the physician orders and not the pre-printed label. ADON E said it was the law to follow the MD orders/orders, and it was for the benefit of the resident. During an interview on 3/17/26 at 4:53 PM, the DON said Resident #1's feeding rate was incorrect, and the feeding was given too fast, but the total volume was correct. The DON said administering the feeding too fast could make the resident feel sick to his stomach. The DON said it could cause nausea and vomiting. The DON said it was important to check the orders to ensure the (continued on next page)</p>		

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