STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F470	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Truman W Smith Children's Care Center	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 1 of 23 residents reviewed for environment. (Resident #48) 1. The facility failed to remove a green sputum filled suction canister over 3/4 full in the room of Resident #48 a timely manner. This failure placed resident at risk of exposure to growing bacteria from another resident, living in an uncomfortable environment and a decrease in quality of life and self-worth. Findings included: 1. Record review of the face sheet 01/14/25 indicated Resident #48 was a [AGE] years old male and was admitted on [DATE] with diagnoses including disease of upper respiratory tract (a common viral infection that affects the nose, throat and airways), major depressive disorder (a mental illness that causes a persistent low mood and loss of interest in activities) and other specified disorders of white blood cells (a category of blood conditions that affect white blood cell function). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #48 was usually understood and usually understood others. The MDS indicated a BIMS score of 14 indicating Resident #48's cognition was intact. The MDS indicated Resident #48 was dependent on staff for ADL's. During an observation on 01/12/25 at 10:04 A.M., near bed A on entrance of room revealed a suction canister filled with a green sputum substance dated 1/3/25. Further observations revealed on 01/13/25 at 8:14 A.M., near bed A at the entrance of the room was a suction canister filled with a green sputum substance dated 1/3/25. On 01/13/25 at 10:24 A.M., near bed A at the entrance of the room was a suction canister filled with a green sputum substance dated 1/3/25. On 01/14/25 at 8:43 A.M., near bed A at the entrance of the room was a suction canister filled with a green sputum substance dated 1/3/25. During observation and interview on 01/12/25 at 12:06 P.M., revealed Resident #48 returned to the facility via ambulance on droplet precautions due mycoplasma pneumonia (bacteria cause respiratory tract infections) stated by LVN I. (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: 45F470	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
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	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/12/25 at 2:03 P.M., Resident #48 said he did not notice the sputum in suction container at the entrance of the room. During an interview on 01/14/25 at 9:00 A.M., LVN I said respiratory staff was responsible for removing and replacing the dirty suction canisters. She said the canister belonged to a discharged Resident #69 that went to the hospital. She said the suction canister in Resident #48's room looked nasty. She said she thought the canister should have been removed when the previous resident went to the hospital. She said the resident had been gone for 6 days and it looked nasty. LVN I clarified the previous resident was admitted to the hospital on 1/8/25. During an interview on 01/14/25 at 9:05 A.M., LVN H said respiratory staff was responsible for removing and replacing the suction canisters by putting them in a biohazard bag and placing them in the biohazard room and as needed, but since it had been several days since the Resident #69 was admitted to the hospital the suction canister should have been removed. She said she was not sure on the number of days the canister was to be removed after a resident had left. She said but if a resident was in the room, when the canister got up to 1100ml they were supposed to remove the canister. She said some of the negative effects of the canister in the room was it was nasty to look at and it could have a potential to grow mold. During an interview on 01/14/25 at 9:46 A.M., RN J said respiratory staff was responsible for ensuring that the suction canisters were changed when they were dirty. She said she felt like if a resident was sent to the hospital and admitted the canister should have been removed. She said the suction canister could start to stink and grow bacteria since the resident had been gone for 6 days. She said the suction canister with green sputum was not nice to look at. During an interview on 01/14/25 at 9:55 A.M., RT K said respiratory staff were responsible for making sure suction canisters were changed out. He said normally they changed the suction canisters out when they were 3/4's full, 1200ml or at least once a month. He said the suction canister could grow mold in it. He said it was nasty to look at and it would not have been a bad idea to have removed the canister. He said he would not like to look at the green sputum filled canister in his home if it was not in use. During an interview on 1/14/25 at 12:48 P.M., RN N said respiratory staff were responsible for changing out the suction canisters. She said she thought the canister should have been changed and removed. She said she felt like when the resident came back to the facility the canister would have been changed. She said there was bacteria in secretions, and they were growing and sitting in the suction canister. She said she would not want that green sputum filled canister sitting in her house. During an interview on 1/14/25 at 1:15 P.M., the DON said respiratory staff were responsible for making sure the suction canisters were changed. She said she felt like if a resident had been gone for 6 days and had a suction canister was filled with green substance, it should have been removed. She said she would not want to look at that in her home if it was not in use. (continued on next page)

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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	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/14/25 at 3:37 P.M., the ADM said she could definitely see the suction canister with a green substance of a resident had been gone for 6 days a homelike environment issue. She said respiratory staff were responsible in changing the suction canisters and the suction canister should have been removed immediately after the resident left the facility. She said the canister was filled to the point that it should have been deposed of. She said she would not want to look at that in her home and there was a stigma attached to [NAME] and sputum, no one wanted to look at that. She said if Resident #48 had visitors they probably would not want to look at the dirty suction canister upon entrance of the resident's room. Record review of a facility policy revision date of February 2021 and titled, Homelike Environment Indicated that, Residents are provided with a safe, clean, comfortable and homelike environment and encourage to use their personal belongings to the extent possible . Record review of a facility policy dated of 12/07/23, Policy and Procedure Manual, Titled, Change-Out Supplies, Indicated that, Suction canisters will be changed out every month or when 3/4 full. New canisters will be labeled with the date of change out. Used canisters will be placed in a red biohazard bag disposed of properly in the biohazard room.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 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 in 1 of 1 kitchen reviewed for food safety requirements and kitchen sanitation. The facility failed to ensure all foods stored in the freezers, and dry pantry were not kept past their expiration dates and did not contain employee personal items. These failures could place residents at risk of foodborne illness and food contamination. Findings included: During an observation of the freezer on [DATE] at 9:20 AM, the following items were observed: (1) 32-ounce bag of frozen hashbrowns that was opened with approximately ,d+[DATE] of the bag remaining, wrapped in a plastic shopping bag with no label or date opened. During an observation of the dry pantry on [DATE] at 9:20 AM, the following items were observed: (1) Gallon container of distilled white vinegar that was approximately half full with an open date of [DATE] and an expiration date of [DATE]. During an observation and interview on [DATE] at 9:20 AM, the [NAME] said the open bag of hashbrowns in the refrigerator was her personal food. She took the bag out of the freezer and disposed of them. She said she should not have put them in the refrigerator, and she took responsibility for them. She said she knew she was not supposed to put personal food items in the refrigerators. She said she was supposed to keep personal food items in the employee refrigerator. During an interview on [DATE] at 9:15 AM, the Dietary Aide said the cooks were supposed to check the walk-in refrigerators and freezers for expired foods and the dietary aides were supposed to check the dry pantry area for expired foods on Wednesdays. She said she last checked the dry pantry area last week on Wednesday, but she was very busy that day and did not make it to the top shelf where the vinegar was, so she just missed it. She said the resident could get sick by a food borne illness by consuming expired foods. During an interview on [DATE] at 1:12 PM, the DM said that there was a cleaning schedule for both the cooks and the dietary aides. She said the cooks were responsible for checking the walk-in refrigerators and freezers for expired foods on Fridays of every week. She said the dietary aides were responsible for checking the dry pantry area on Wednesdays for expired foods. She said it was her responsibility to check behind them to make sure everyone is performing their job functions. She said the residents could get sick by a food borne illness by consuming expired foods. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 1:23 PM, the [NAME] said she was responsible for checking the refrigerators and walk in for expired food. She said the Dietary Aide was responsible for checking the dry pantry for expired foods. She said the DM was responsible for making sure that all the kitchen employees did their jobs. She said it could cause the residents to get sick by a food borne illness by consuming expired foods. During an interview on [DATE] at 2:25 PM, the Administrator said all foods should be used or disposed of by the use by date. She said food borne illness was a potential risk to the resident for consuming expired foods. Record review of facility policy titled Dry Storage dated [DATE], indicated: 5. All expired foods must be removed from the store room . Record review of facility policy titled Food Storage dated [DATE], indicated: Safe and sanitary conditions shall be maintained in storage, preparation, and distribution of food.Staff shall not store personal items within the food preparation and storage areas .

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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** 35295 Based on observation, interview, and record review, the facility failed to establish and 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 1 of 2 residents observed for incontinent care infection control practices (Resident #79), and 3 of 3 residents observed for medication administration control practices. (Resident #'s 27, 91, 71). 1.CNA A did not change her gloves or sanitize her hands after performing incontinent care on the front perineal area for Resident #79 and touched clean areas. 2. The facility failed to ensure RN G performed hand hygiene before and after administering medications to 3 different residents. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: 1.Record review of the undated face sheet indicated Resident #79 was a [AGE] year-old female that admitted [DATE]. Record review of the physician's orders dated 1/14/25 indicated Resident #79 had diagnoses that included: Seizures (uncontrolled jerking, blank stares, loss of consciousness caused by abnormal electrical activity in the brain), failure to thrive (not growing as expected), Cerebral Palsy (a congenital disorder of movement, muscle tone, or posture due to abnormal brain development before birth), and gastrostomy (tube inserted into the abdomen and stomach to provide a route for feeding). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #79 had no speech, rarely or never understood others, and was rarely or never understood by others. She had short- and long-term memory problems. The MDS indicated Resident #79 was dependent for toileting hygiene. Record review of the undated care plan indicated Resident #79 was totally dependent on one staff for incontinent care due to Cerebral Palsy. The care plan indicated she had impaired cognitive function and required tube feeding. During an observation on 1/14/25 at 9:06 AM, revealed CNA A and CNA B provided incontinent care to Resident #79. They sanitized their hands and donned (put on) PPE for EBP. CNA A cleaned Resident #79's front perineal area and did not change her gloves or sanitize her hands before rolling the resident to her side and touching Resident #79's shoulder, bed pad, and bed. She then cleaned the resident's back side before changing her gloves and sanitizing her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/14/25 09:17 AM, CNA A said she was nervous and forgot to change her gloves after cleaning Resident #79's front before cleaning her backside. She said she did not realize she touched the resident's shoulder, bed, and bed pad with her dirty gloves. She said that could cause cross-contamination and spread infection. She said she was taught to always change her gloves and wash her hands after a dirty procedure and she should have changed them. During an interview on 1/14/25 at 9:18 AM, CNA B said she did not realize CNA A had not changed her gloves after cleaning Resident #79's front area, before going to her backside. She said they were taught to change their gloves and clean their hands when going from a dirty procedure to a clean area. She said CNA A should have changed her gloves. During an interview on 1/14/25 at 9:49 AM, LVN F said she was the Staff Coordinator/Trainer and she signed off that CNA A and CNA B had met the requirements for Pericare-Incontinent Care. She said they were taught to change gloves when going from dirty to clean. She said after CNA A cleaned Resident #79's front area, she should have changed her gloves and cleaned her hands before she cleaned her back side and before touching anything clean. She said not doing that was a risk of infection to staff and the residents, that could make staff and resident's sick. She said she would be reteaching both CNAs. During an interview on 1/14/25 10:32 AM, CNA C said during incontinent care, he always changed his gloves and cleaned his hands when going from dirty to clean. He said after cleaning a resident's front part staff would need to clean their hands and change their gloves because their gloves would be dirty. He said not changing gloves from a dirty procedure to a clean one could cause infections to staff and residents. During an interview on 1/14/25 at 1:28 PM, LVN D said staff should always change their gloves and clean their hands when going from dirty to clean. She said during incontinent care, after cleaning the front of a resident, staff should change their gloves and clean their hands before touching anything clean including the resident. She said if they did not change their gloves, it was a cross-contamination issue that could cause infection to residents and staff. During an interview on 1/14/25 at 1:31 PM, ADON E said staff must always change their gloves and clean their hands when they go from dirty to clean. She said during incontinent care staff should change their gloves and clean their hands after cleaning the front perineal area and before going to the back because their gloves would be dirty. She said if staff touched clean areas with dirty gloves that was cross -contamination which could cause infection to residents and staff. During an interview 01/14/25 2:19 PM, the DON said staff should always change their gloves and sanitize their hands when going from dirty to clean. She said when staff were performing incontinent care they should change their gloves and clean their hands after cleaning the front perineal area and before touching anything clean, or going to the back area. She said if they did not change their gloves or clean their hands, they were risking cross-contamination and infections to residents and staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/14/25 at 2:48 PM, the ADM said staff should change their gloves anytime they were moving from dirty to clean. She said during incontinent care staff should change their gloves after cleaning the front perineal area and before touching anything clean. She said touching anything clean with dirty gloves was cross-contamination and had the potential to cause infection to residents and staff. Record review of a Pericare-Incontinent Care competency dated 10/2/24 indicated CNA A had met the requirements. The competency was signed by evaluator, LVN F. Record review of a Pericare-Incontinent Care competency dated 10/2/24 indicated CNA B had met the requirements. The competency was signed by evaluator, LVN F. Record review of a Perineal Care Policy with a revised date of 4/16/24indicated: Perineal Care Purpose The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. 2. Record review of Resident #27's face sheet, dated 01/14/25, indicated she was a [AGE] year-old female was admitted to the facility on [DATE]. Her diagnoses included dependence on respiratory (ventilator) status (breathing machine), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), Chronic respiratory failure (a long-term condition that makes it difficult to breathe because the lungs cannot exchange oxygen and carbon dioxide properly), personal history of pneumonia (a medical record that indicates a person has had pneumonia in the past) and gastrostomy status (the presence of a surgical opening in the abdomen that allows for nutritional support or gastric decompression). Record review of Resident #27's quarterly MDS assessment, dated 12/26/24, indicated she did not perform a BIMS assessment (a 15-point cognitive screening measure that evaluates memory and orientation and includes free and recall items), because she was rarely/never understood and rarely/never understood others. Record review of Resident #27's care plan, dated 01/13/25, indicated eating and nutrition the resident needs total assistance with tube feeding and water flushes, see MD orders for current feeding orders. Check for tube placement and gastric contents/residual volume per facility protocol and record. The resident is totally dependent on one staff for nutrition via G-Tube. The resident is dependent with tube feeding and water flushes, see MD orders for current feeding orders. Interventions: review infection control techniques with resident such as frequent handwashing and use of hand sanitizer. Remind the resident and caregivers to refrain from physical contact. For example, practice social distances with no handshaking or hugging and remaining six feet apart when possible. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #71's face sheet, dated 01/14/25, indicated she was a [AGE] year-old female was admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), pseudomonas (is a [NAME] of bacteria commonly found in wet environments like soil and water), acute respiratory distress (condition in which fluid collects in the lungs' air sacs, depriving organs of oxygen) and cystic fibrosis (an inherited life-threatening disorder that damages the lungs and digestive system). Record review of Resident #71's quarterly MDS assessment, dated 10/17/24, indicated she did not perform a BIMS assessment, because she was rarely/never understood and rarely/never understood others. Record review of Resident #71's care plan, dated 04/17/24, indicated provide local care to G-Tube site as ordered and monitor for signs and symptoms of infection. 4. Record review of Resident #91's face sheet, dated 01/14/25, indicated he was a [AGE] year-old male was admitted to the facility on [DATE]. His diagnoses included chronic respiratory failure (a long-term condition that makes it difficult to breathe because the lungs cannot exchange oxygen and carbon dioxide properly), pseudomonas (is a [NAME] of bacteria commonly found in wet environments like soil and water) and encounter for attention to tracheostomy (a medical appointment specifically focused on managing and caring for a patient's tracheostomy). Record review of Resident #91's quarterly MDS assessment, dated 12/25/24, indicated he did not perform a BIMS assessment, because he was rarely/never understood and rarely/never understood others. Record review of Resident #91's care plan, dated 04/17/24, indicated his level of staff assistance during care during transfer assistance and feeding assistance. Interventions enhanced barrier precautions (EBP). Follow facility fall protocol. Seizure precautions: Do not leave residential one during a seizure, protect from injury, if resident is out of bed, help to the floor to prevent injury, remove or loosen tight clothing, do not attempt to restrain resident during a seizure as this could make the convulsions more. During an observation on 01/13/25 at 7:29 A.M., revealed RN G did not wash or sanitize her hands before preparing medication for Resident #71. RN G did not wash or sanitizer her hands prior to administering Resident #71's meds and administered Resident #71's G-Tube feeding and did not wash or sanitizer hers hands afterwards. During an observation on 01/13/25 at 7:49 A.M. revealed RN G did not wash or sanitize her hands before preparing medication for Resident #27. RN G did not wash or sanitizer her hands prior to administering Resident #27's meds and did not wash or sanitizer hers hands afterwards. During an observation on 01/13/25 at 8:04 A.M. revealed RN G did not wash or sanitize her hands before preparing medication for Resident #91. RN G did not wash or sanitizer her hands prior to administering Resident #91's eyedrops. During an interview on 01/13/25 at 8:06 A.M., RN G said it was normally a habit for her to wash or sanitize her hands during med pass and between residents. She said she was nervous, so she forgot to sanitize her hands. She said staff should sanitize their hands between residents unless their hands were soiled, then they should wash their hands with soap and water. She said she should have sanitized her hands before giving meds and after she gave the meds to reduce the spread of infection rate. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/13/25 at 10:43 A.M., LVN M said before a nurse started giving a medication, they should wash their hands. She said the nurse should wash their hands before and after administering meds. She said nurses' hands played a part to the chain of infection. She said not washing her hands could had made her and the residents more susceptible to infections. During an interview on 01/14/25 at 9:00 A.M., LVN I said nurses should be washing their hands before and after a med pass to prevent cross contamination. During an interview on 01/14/25 at 9:46 A.M., RN J said when a nurse administered medications, they should wash their hands before and after giving the medications. She said hand hygiene between residents should be performed. She said hand hygiene was the number one infection control prevention. During an interview on 1/14/25 at 12:48 P.M., RN N said when a nurse administered meds they should wash their hands before a med pass, after the mad pass and before going to another resident. She said it was infection control and they could carry infections to another resident with their hands. She said nurses should always start fresh by washing their hands. During an interview on 1/14/25 at 1:15 P.M., the DON said during med pass she expected the nurses to wash their hands. She said handwashing was for infection control measures. She said the nurses should wash their hands during med pass and between each resident. She said a negative effect of improper hand hygiene was the spread of infection. During an interview on 1/14/25 at 3:17 P.M., the ADM said she excepted the nurses to wash their hands during med pass and between residents. She said a negative effect of improper hand hygiene was the risk of infection. Record review of RN G Nurses: GT Med/Feeding administration check-off sheet dated 12/2/24 indicated RN G had met the requirements. The competency was signed by evaluator, RN N. Record review of the facility's Handwashing/ Hand Hygiene Residents policy, last revised 1/25/23, indicated: this facility considers hand hygiene the primary means to prevent the spread of infections . 2. Residents may be trained and encouraged on the importance of hand hygiene in preventing the transmission of infections . 4. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, wipes etc.) shall be readily accessible and convenient for resident use to encourage compliance with hand hygiene policies . Record review of the facility's Infection Prevention and Control Program policy. Last revised 01/01/24, indicated: an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of communicable disease and infection. 48958