

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 11/18/2025
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	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 24 residents (Resident #63) reviewed for resident rights. The facility failed to ensure RT C acknowledged Resident #63 while providing care on 11/16/25. This failure could place residents at an increased risk of anxiety and a diminished quality of life. The findings included: Record review of the order summary report, dated 11/18/25, reflected Resident #63 was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of obstructive hydrocephalus (buildup of fluid in cavities called ventricles deep within the brain, which increases the size of the ventricles and puts pressure on the brain), neuromuscular scoliosis (sideways curvature of the spine), chronic respiratory failure with hypoxia (condition where you don't have enough oxygen in the tissues in your body), anoxic brain injury (damage to the brain due to a loss of oxygen supply), spastic quadriplegic cerebral palsy (brain condition caused by damage or abnormal development of the brain before, during, or shortly after birth, which causes tight stiff muscles to all four limbs [arms and legs]), and obstructive sleep apnea (characterized by repeated interruptions in breathing during sleep due to a blockage in the airway). Record review of the annual MDS assessment, dated 10/20/25, reflected Resident #63 had no speech, was rarely/never understood, and was rarely/never to understand others. Resident #63 had poor long and short-term memory, no recall ability and had severely impaired decision making skills. The MDS reflected Resident #63 had no behavior or refusal of care and he liked to participate in his favorite activities. Resident #63 was totally dependent on staff for his ADLs. Record review of the comprehensive care plan, initiated on 11/13/23, reflected Resident #63 required total assist from the staff for meeting emotional, intellectual, physical, and social needs. The interventions included: all staff converse with resident while providing care. Record review of the comprehensive care plan, revised on 12/11/24, reflected Resident #63 had a tracheostomy. The interventions included: provide means of communication and procedural information, reassure that help is available immediately, provide paper and pencil if needed, work with resident to develop a communication system that will work in an emergency, and reassure resident to decrease anxiety. During an observation on 11/16/25 beginning at 10:46 AM, Resident #63's oxygen and heart rate monitor started beeping while a respiratory therapist was in the room with his roommate. The respiratory therapist yelled from the doorway for RT C's assistance. RT C entered the doorway and was looking at Resident #63's machine while she was putting on her isolation gown and gloves. RT C immediately walked to Resident #63's bed, swiftly lifted him up, shoved a pillow under his back, then laid him back down. RT C then proceeded to provide tracheal suctioning. RT C completed the tracheal suctioning, then rolled the suctioning tubing, placed it under Resident #63's pillow. Resident #63's oxygen and heart rate monitor returned to normal. RT C removed her PPE, left the room, then returned with a new pulse oximeter that attached to Resident #63 and replaced it. RT C did not speak or explain the care she was providing to Resident #63 during the observation. During an interview on 11/18/25 beginning at 9:48 AM, RT C interrupted an interview with the Respiratory Director. RT C stated generally upon going into a patient's room, the staff should knock, introduce themselves, and then explain the care that was going to be provided. RT C stated in an emergency situation, she did not always think about explaining what she was doing or talking to the resident. RT C explained Resident #63 was desaturating [his oxygen level was decreasing] and his pulse rate was elevated. RT C stated he was unable to cough so she had to perform the tracheal suctioning. RT C stated immediate action was needed to intervene and she said she just did not think about talking to him while providing care. During an interview on 11/18/25 at 10:23 AM, the DON stated facility staff should have knocked, introduced themselves, and talked to the residents while providing care. The DON stated talking to the residents while providing care was hard for the staff to remember because a lot of the kids were not able to respond back. The DON stated in-service education was provided regularly to the staff, specifically on dignity and making sure the staff was talking to the residents while providing care. She said it was important to ensure the staff were talking to the residents while providing care because it helped put them at ease. During an interview on 11/18/25 at 1:32 PM, the Administrator stated she expected staff to always acknowledge the residents while providing care. The Administrator stated she had not identified any issues with staff failing to acknowledge the residents' while providing care and did not have a system for monitoring. The Administrator stated it was important to ensure staff were acknowledging and talking to the</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>(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 - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 11 residents (Resident #18) reviewed for enteral nutrition. The facility failed to ensure Resident #18's head of the bed was elevated while receiving a tube feeding (delivers liquid nutrition through a flexible tube that goes directly into your stomach or small intestine) on 11/16/25. This failure could place residents with gastrostomy tube at risk for complications from feeding tube administration such as aspiration and pneumonia. The findings included: Record review of order summary report, dated 11/17/25, reflected Resident #18 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of dysphagia (difficulty swallowing) and gastrostomy status (surgical procedure that creates an artificial opening through the stomach wall and abdominal wall, allowing for the insertion of a gastrostomy tube that provides a conduit between the stomach and the outside of the body). The order summary report further reflected Resident #18 had an order, which started on 06/26/23, to elevate the head of the bed to 30 degrees every shift. Record review of the quarterly MDS assessment, dated 10/08/25, reflected Resident #18 had no speech and was rarely/never understood by others. Resident #18 had poor short and long-term memory, no recall ability, and severely impaired decision-making skills. He had no behaviors or refusal of care. The MDS reflected Resident #18 had a feeding tube and received 51 % or more of total calories through the feeding tube. Record review of the comprehensive care plan, revised 10/13/23, reflected Resident #18 required tube feeding. The interventions included: Resident #18 needed the head of the bed elevated 45 degrees during and thirty minutes after tube feeding. Record review of Resident #18's MAR, dated November 2025, reflected the nurses were signing off and checking Resident #18's head of the bed was elevated to 30 degrees every shift, including 11/16/25 for day and evening shift. During an observation on 11/16/25 at 10:27 AM, Resident #18 was lying flat on his mattress that was positioned on the floor. There were no wedges to lift the head of the bed observed under the mattress. He had a tube feeding that was going at 100 milliliters per hour from kangaroo pump. During an interview on 11/18/25 at 9:28 AM, RN D stated she had worked at the facility for 6 years. She stated residents who received feedings from a feeding tube should have the head of the bed, elevated at least 35 degrees. RN D stated elevating the head of the bed at least 35 degrees was the standard general rule unless the residents had issues where the head of the bed was unable to be elevated. RN D stated none of the residents on her side had issues that would prevent the head of the bed from being elevated. She stated if residents' mattresses were on the ground, the staff used wedge pillows under the bed to keep the head of the bed elevated. RN D stated Resident #18 would have kept the head of the elevated and did not move around much. She stated she was unsure why Resident #18 did not have the wedges under his mattress. RN D stated it was important to ensure the head of the bed was elevated while the residents received tube feedings to prevent aspiration. During an interview on 11/18/25 at 10:23 AM, the DON stated the head of the bed should have been elevated while residents received tube feedings. She stated the nurses were responsible for ensuring the head of the bed was elevated. The DON stated residents with mattresses on the ground should have wedges under the mattress to ensure the head of the bed was elevated. She stated she was unaware Resident #18 had no wedges under his mattress. The DON said she expected the staff to ensure wedges were utilized. The DON stated she did not know what the facility policy was on positioning residents during feeding, but she looked it up. She said the policy did not specifically address how residents with a feeding tube should have been positioned. The DON stated that residents who received tube feedings should not have been laid flat because it placed them at risk for aspiration. During an interview on 11/18/25 at 1:32 PM, the Administrator stated she expected staff to ensure the head of the bed was elevated while residents received tube feedings. The Administrator stated that any clinical staff were responsible for monitoring to ensure the head of the bed was elevated. The Administrator stated it was important to ensure the head of the bed remained elevated while residents received tube feedings to prevent aspiration. Record review of the Enteral Nutrition policy, reviewed 06/25/25, reflected Adequate nutritional support through enteral nutrition is provided to residents as ordered. The recommendation to initiate the use of enteral nutrition is based on the results of the comprehensive nutritional assessment, and is consistent with current standards of practice. the provider will consider the need for supplemental orders, included: . head of bed elevation Risk of aspiration may be affected by: improper positioning of the resident during</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public, for 1 of 1 laundry room reviewed for environment. The facility failed to ensure the air filters in the laundry room were clean, the air filters were dirty with a thick dark gray substance. This failure could place the residents at risk of living and working in an unsafe, unsanitary and uncomfortable environment. Findings included: During an observation and interview on 11/17/25 at 2:24 P.M., the laundry room had dirty air filters on the ceiling on the dirty and clean side of laundry room. The air filters had a thick dark gray substance on them. Laundry Aide B said the facility kept the air filters clean. She said the air filters were usually changed once a week. She said the maintenance man usually changed the air filters; she said she thought he changed the air filters last Thursday. She said the air filters got dirty, because the staff opened and closed the doors all the time and the area she worked in had a lot of lint. During an interview on 11/18/25 at 12:34 P.M., with Laundry Aide B, said Maintenance Man A came once a week, brought a new air filter and pulled the old air filter down, then put a new air filter in vent. She said that Maintenance Man A changed the air filters yesterday. She said she thought Maintenance Man A was responsible for changing the air filters as far as she knew. She said a negative effect of the dirty air filters would be improper air flow throughout the building. During an interview on 11/18/25 at 12:43 P.M., Maintenance Man A said the air filters were changed in the laundry room every Thursday; unless the staff told him the air filters were getting clogged, then he would change them as needed. He said he changed the air filters by taking the dirty air filter down and cut the material off the roll to fit the bracket, then slid the filter back into place. He said he was the primary person responsible for changing the air filters. He said a negative effect of the dirty air filters was if they got too dirty or clogged it would cause the air conditioning unit to freeze. During an interview on 11/18/25 at 12:51 P.M., with the DON she said she does not know how often the air filters were changed in the laundry room. She said the air filters in the laundry room looked like they needed to be changed. She said she does not know the process of changing the air filters in the laundry room. She said her guess was the maintenance man or housekeeping were responsible for changing the air filters. She said a negative effect of the dirty air filters was it would make everything in the laundry room dusty. During an interview on 11/18/25 at 2:30 P.M., with the Administrator she said due to the amount of laundry the facility had to do there the air filters may look like they had not been changed in a while or not within a reasonable timeframe, because the amount of lint that was on the air filters. She said the air filters were changed once a week. She said she had not observed the air filters changed in the laundry room. She said Maintenance Man A was responsible for changing the air filters in the laundry room and throughout the facility, but the laundry aides or anyone should notify Maintenance Man A if the air filters were dirty. She said a negative effect of a dirty air filter had potential for clogging the air conditioner unit. Record review of Homelike Environment Policy dated February 2021 provided by the Administrator indicated: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible .2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized homelike setting . a. Clean, sanitary and orderly environment. e. clean bed and bath linens that are in good conditions.</p>