STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675879	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrell Healthcare Center	204 W Nash Terrell, TX 75160

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, receiving, dispensing and administering of all drugs and biologicals, to meet the needs of each resident and determined that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 2 of 3 residents (Resident #2 and Resident #1) reviewed for pharmacy services. The facility failed to ensure MA A administered Resident #2's buspirone 5 mg (medication used to treat anxiety) as ordered by the physician. The facility failed to ensure Resident #1's sertraline 100 mg (medication used to treat depression) was removed from the medication cart after it was discontinued on 01/28/2026. These failures could place residents at risk of receiving medications that were not ordered and medication errors.Findings included: 1. Record review of a face sheet dated 03/05/2026 indicated Resident #2 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included chronic systolic congestive heart failure (heart is unable to pump enough force to push enough blood into circulation) and generalized anxiety disorder (mental illness defined by feelings of excessive uneasiness, worry, and fear). Record review of Resident #2's Quarterly MDS assessment dated [DATE] indicated, he was understood by others and understood others. Resident #2's MDS assessment indicated he had a BIMS score of 15, which indicated his cognition was intact. Resident #2's MDS assessment indicated he received antianxiety and antidepressant medications. Record review of Resident #2's Order Summary Report dated 03/05/2026, indicated he had an order for buspirone 5 mg give 1 tablet by mouth three times a day for anxiety with a start date of 01/16/2025. Record review of Resident #2's Medaid [sic] Medication Administration Record from October 2025-March 2026 indicated Resident #2's buspirone 5 mg was documented as administered three times (morning, midday, and bedtime) on a daily basis except for on 02/20/2026 when it was documented he was out of the facility for his midday dose. Record review of Resident #2's care plan revised 08/01/2025, indicated he used an antianxiety medication, buspirone, to administer the medication as ordered by the physician. During an observation and interview on 03/04/2026 at 11:03 AM, MA A administered Resident #2's buspirone. Resident #2's medication card had 42 tablets remaining, and the date dispensed was 11/24/2025. MA A said she did not have any overstock of buspirone for Resident #2 on the medication cart or in a medication storage room. During an interview and observation with MA A on 03/05/2026 at 7:04 AM, revealed the following overstock medications on her medication cart:Buspirone 5 mg tablets dispensed on 07/20/2025 with 40 tabs remainingBuspirone 5 mg tablets dispensed on 10/02/2025 with 42 tabs remainingBuspirone 5 mg tablets dispensed on 01/25/2026 with 14 tabs remaining During an interview on 03/05/2026 at 9:35 AM, Resident #2 said sometimes he received his midday dose of buspirone and sometimes he did not. Resident #2 said he reported it to the DON, but he could not remember when he reported it to her. Resident #2 said when he remembered, he went to ask for it. Resident #2 said MA A was the only one not administering his buspirone. Resident #2 said if he did not receive multiple doses, he noticed it because he felt a little anxious. 2. Record review of a face sheet dated 03/05/3036 indicated (continued on next page)

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia (condition where the lungs cannot supply enough oxygen or remove enough carbon dioxide from the blood), bipolar disorder (a disorder associated with episodes of mood swings ranging from depression lows to manic highs), and depression (mood disorder characterized by persistent sadness and loss of interest, significantly impacting daily functioning and requiring professional diagnosis and treatment). Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated she was understood by others and understood others. The MDS assessment indicated Resident #1's BIMS score was a 15, which indicated her cognition was intact. The MDS assessment indicated Resident #1 received antidepressant medications. Record review of Resident #1's care plan initiated 06/05/2025 indicated she had depression to administer medications as ordered. Record review of Resident #1's Physician Orders dated 03/05/2026 indicated:An active order for sertraline 50 mg give one tablet by mouth one time a day with a start date of 08/13/2025.Sertraline 100 mg give 1 tablet by mouth in the morning was discontinued on 01/28/2026. During an observation of Resident #1's medications on 03/04/2026 at 11:18 AM, Resident #1 had sertraline 100 mg and sertraline 50 mg on the medication cart. During an interview on 03/05/2026 at 10:23 AM, MA A said she did not know why Resident #2 had an overstock of buspirone. MA A said she had not missed giving Resident #2 any medications. MA A said not administering medications as ordered could make the residents sick or they could end up in the hospital. MA A said when medications were discontinued, they should be removed from the medication cart, and they should be checking for medications that needed to be removed from the medication cart when they administered medications. MA A said she did not know why Resident #1's sertraline 100 mg had not been removed from the medication cart. MA A said discontinued medications should be removed from the medication cart, so they were not administered to the residents. During an interview on 03/05/2026 at 1:20 PM, the DON said Resident #2 reported he was not receiving his noon dose from MA A. The DON said she could not remember when he told her. The DON said she asked MA A if she was administering Resident #2's buspirone and she said she was administering it, but he was forgetful and did not remember she administered the medication. The DON said she looked at the buspirone medication cards and did not notice any discrepancies. The DON said she provided verbal education to MA A one on one about administering medications, but this was not documented on paper that she just spoke to MA A about it. The DON said Resident #2 did not have any complications related to not receiving the buspirone. The DON said not administering medications as ordered placed the residents at risk for negative effects. The DON said Resident #2 not receiving his buspirone as ordered placed him at risk for increased anxiety, which could lead to other complications. The DON said when a medication was discontinued the person who received the order to discontinue the medication should ensure the medication was removed from the medication cart. The DON said she tried to monitor this by checking the medication carts weekly, and she did not notice Resident #1's sertraline was not removed from the medication cart after being discontinued. The DON said not removing discontinued medications from the medication cart could lead to medication errors. During an interview on 03/05/2026 at 2:57 PM, LVN B said when a medication was discontinued, she told the medication aides to remove the medication from the medication cart. LVN B said when Resident #1's sertraline 100 mg was discontinued she thought she told MA C to remove it off the medication cart. LVN B said not removing discontinued medications from the medication cart could result in the resident receiving the medication. During an interview on 03/05/2026 at 3:01 PM, MA C said LVN B did not tell him Resident #1's sertraline 100 mg was discontinued. MA C said when a medication was discontinued, the nurses let him know, and he removed it from the medication cart. MA C said it was important to remove discontinued medications from the medication cart so they would not mistakenly administer the medication to the resident. During an interview on 03/05/2026 at 3:18 PM, the Administrator said his expectations were for the medications to be administered as ordered, and for discontinued medications to be removed from the medication cart. The Administrator (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said the DON was responsible for providing oversight to ensure this happened. The Administrator said not administering medications as ordered placed the residents at risk for adverse reactions, and not removing discontinued medications from the medication cart could result in the residents receiving medications they were not supposed to receive. Record review of the facility's policy titled, Medication Administration, reviewed 06/24/2025, indicated, Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber orders, including any required time frame. Record review of the facility's policy titled, Storage of Medications, reviewed 06/24/2025, indicated, .Discontinued, outdated or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 all drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable and failed to ensure, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 2 of 4 medication carts (200 hall Nurse Medication Cart and 200 hall Medication Aide Medication Cart) reviewed for drugs and biologicals. The facility failed to ensure MA A properly stored a medication card of gabapentin 300 mg capsules, when she left it on top of the medication cart unattended on 03/04/2026. The facility failed to ensure LVN B properly stored a vial of insulin when she left the vial of insulin on top of the 200 hall Nurse Medication Cart and failed to secure the 200 hall Nurse Medication Cart, when she left the cart unlocked and unattended on 03/04/2026. These failures could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion.Findings included:During an observation and interview starting on 03/04/2026 at 11:13 AM, MA A was administering medications. MA A left a medication card with gabapentin 300 mg capsules on top of the 200-hall medication aide cart in a hallway with residents around. MA A went inside the resident's room to administer medications. The gabapentin was out of MA A's view. MA A said medications should not be left on top of the medication cart unattended. She said she should have put the gabapentin back inside the medication cart before going to administer medications. MA A said unattended medications could be picked up by the residents or staff. During an observation and interview starting on 03/04/2026 at 5:10 PM, there was an unlocked and unattended medication cart with insulin lispro 100 units/ml on top of the unattended, unlocked medication cart on the 200-hall in front of a resident's room. Staff and residents were observed. The door to the resident's room was closed. LVN B exited the room. LVN B said it was the 200-hall nurse medication cart, and she was responsible for it. LVN B said she forgot to put the insulin back inside the medication cart and lock it prior to entering the resident's room. LVN B said people could pick up the medications when they were left on top of the medication cart unattended, and people could take medications from inside the medication cart when it was left unlocked and unattended. During an interview on 03/06/2026 at 1:28 PM, the DON said medications should not be left on top of the medication cart. The DON said medications should be placed inside the medication cart, and the medication cart should be locked every time they walked away from it or their backs were turned. The DON said unattended medications on top of a medication cart and an unlocked medication cart could result in the residents or employees taking the medications or the residents could ingest the medications and this could result in adverse effects. The DON said she monitored to ensure the staff were properly storing the medications and locking the medication carts when she was walking through the hallways daily. During an interview on 03/06/2026 at 3:26 PM, the Administrator said he expected medication carts to be locked when not under the staff's supervision, and he expected medications not to be left on top of the medication carts. The Administrator said the DON was responsible for monitoring to ensure the staff were locking medication carts and storing medications properly. The Administrator said if medications or an unlocked medication cart were not within the staff's sight someone could grab the medications. Record review of the facility's policy titled, Storage of Medications, reviewed 06/24/2025, indicated, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls.9. Unlocked medication carts are not left unattended.

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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 prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 3 residents (Resident #1) reviewed for infection control. The facility failed to ensure CNA D used the proper PPE for droplet precautions (face shield and face mask) while in Resident #1's room and removed it prior to exiting Resident #1's room on 03/04/2026. The facility failed to ensure MA A used the proper PPE for droplet precautions (face shield) when administering medications to Resident #1 and removed it prior to exiting Resident #1's room on 03/04/2026 and 03/05/2026. This failure could place residents at risk for cross contamination and the spread of infection. Findings included: Record review of a face sheet dated 03/05/3036 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia (condition where the lungs cannot supply enough oxygen or remove enough carbon dioxide from the blood), bipolar disorder (a disorder associated with episodes of mood swings ranging from depression lows to manic highs), and tracheostomy status (surgically created opening in the trachea, which may be temporary or permanent which allows are to pass directly into the lungs). Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated she was understood by others and understood others. The MDS assessment indicated Resident #1's BIMS score was a 15, which indicated her cognition was intact. The MDS assessment indicated Resident #1 received antidepressant medications. Record review of Resident #1's Physician Orders dated 03/05/2026 indicated:Isolation precautions droplet related to flu/pneumonia with a start date of 03/04/2026. Record review of Resident #1's care plan with a date initiated of 03/04/2026 indicated she had pneumonia. Resident #1's care plan did not address the use of droplet precautions. During an observation on 03/04/2026 starting at 10:31 AM, on the wall beside Resident #1's doorframe was a sign that indicated droplet precautions, and outside of Resident #1's doorway was a plastic cart with face shields, face masks, gowns, gloves, and shoe covers inside. CNA D was observed inside Resident #1's with no PPE. After CNA D saw surveyor, she exited the room, and applied a face mask, shield, and gown, and re-entered Resident #1's room. When CNA D exited the room, she removed her PPE outside Resident #1's room in the hallway. During an observation and interview on 03/04/2026 at 11:13 AM, MA A put on a face mask, gown, and gloves, and entered Resident #1's room to administer medications. MA A exited Resident #1's room and disposed of her PPE in the biohazard box in the hallway. MA A said she did not need to put on a face shield because she was not in Resident #1's room for a long time. MA A said removing her PPE outside of Resident #1's room in the hallway was appropriate. During an interview on 03/04/2026 at 3:13 PM, CNA D said she was not aware Resident #1 required droplet precautions. CNA D said she was in a rush and did not pay attention to the sign on the wall outside of Resident #1's door which indicated droplet precautions were required. CNA D said she was preparing to provide care to Resident #1 when she was observed inside Resident #1's room without PPE. CNA D said PPE should be removed before leaving the residents' rooms. CNA D said putting on PPE and removing it as required was important for infection control. During an observation and interview on 03/05/2026 at 8:21 AM, MA A put on a face mask, gown, and gloves and entered Resident #1's room to check her blood pressure. MA A exited Resident #1's room into the hallway wearing the same PPE. MA A removed her gloves and performed hand hygiene, put on new gloves, but did not remove her gown and face mask. MA A prepared Resident #1's medications in the hallway outside of Resident #1's room and administered them to Resident #1. MA A said she had worn her PPE properly. During an interview on 03/05/2026 at 1:49 PM, the DON said Resident #1 required droplet precautions because she had pneumonia. The DON said for droplet precautions the staff should put on a face mask, face shield, gown and gloves prior to entering the resident's room. The DON said PPE should be removed and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disposed of prior to exiting the resident's room. The DON said everybody should be making sure staff were wearing the proper PPE when they were walking down the halls. The DON said PPE should be worn and disposed of properly to decrease infections and cross contamination. During an interview on 03/05/2026 at 3:31 PM, the Administrator said he expected the staff to follow the facility protocol for droplet precautions. The Administrator said the staff should put on the proper PPE prior to entering the resident's room and remove the PPE prior to exiting the resident's room. The Administrator said the DON was responsible for ensuring the staff were putting on and disposing of PPE properly. The Administrator said this was important for infection control and placed the residents at risk of infection. Record review of the facility's Infection Prevention and Control Program reviewed 03/03/2026 indicated An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.Prevention of infection.Important facets of infection prevention include: educating staff and ensuring that they adhere to proper techniques and procedures. The policy did not specifically address the PPE required for droplet precautions. The policy specific to droplet precautions was requested and not provided prior to exit of the facility.