

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: 675879	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Terrell Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 204 W Nash Terrell, TX 75160	
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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure dialysis services were provided consistently with professional standards of practice for 1 of 2 residents reviewed for dialysis services. (Resident #7) The facility did not provide ongoing assessments after Resident #7's dialysis treatments and did not keep ongoing communication with the dialysis facility. This failure could place residents who received dialysis at risk for complications and not receiving proper care and treatment to meet their needs. Findings included: Record review of Resident #7's face sheet indicated he was a [AGE] year-old male who re-admitted to the facility on [DATE] with the diagnoses end stage renal disease (disease in which the kidneys almost lose all function),. Record review of Resident #7's quarterly MDS dated [DATE] indicated he was able to make himself understood and he understood others. The MDS also indicated he had BIMS score of 15 which meant he was cognitively intact. The MDS also indicated he was totally dependent on staff for toileting, bathing, dressing, and required moderate assistance for bed mobility. The MDS also indicated he had dialysis while he was a resident at the facility. Record review of Resident #7's care plan dated 05/23/25 indicated he needed dialysis related to renal failure on Tuesday, Thursday, and Fridays with the goal of no signs and symptoms of complications from dialysis with interventions to interventions to monitor, document, report as needed for signs and symptoms of renal insufficiency (changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds). Record review of Resident #7's order summary report dated as of 12/01/25 indicated he had an order for 1. Resident to receive dialysis _3_ days a week on Tuesday, Thursday, and Saturday at 10:30 AM in-house dialysis by the dialysis company with a start date of 11/28/2025 and no end date. 2. Resident to receive dialysis 3 days a week on Tuesday, Thursday and Saturday in-house dialysis center under the care of Dr. _____y_____(nephrologist); phone number _____y_____. Chair Time _____y_____. With a start date of 09/25/2025 and no end date. Record review of Resident #7's medical record indicated there were no documented before and after assessments and ongoing communication with the dialysis service for Resident #7 on the following dates in which she had dialysis services provided:*10/04/25*10/11/25*10/18/25*11/13/25*11/15/25*11/18/25*11/20/25*11/22/25 Record review of the hemodialysis treatment metrics report dated 12/03/25 indicated Resident #7 did attend dialysis on the following dates:*10/04/25, *10/11/25, *10/18/25,*11/13/25, *11/15/25, *11/18/25, *11/20/25, and *11/22/25. During an interview on 12/03/2025 at 1:43 PM RN G said the dialysis nurse came on Tuesday, Thursday, and Saturdays in the morning and the charge nurse was responsible for filling out the dialysis communication form and giving it to the dialysis nurse. RN G said the dialysis communication forms were to be completed before dialysis and after to ensure communication between dialysis nurse and facility nurse. RN G said the failure of ensuring the dialysis communication forms were completed placed a risk for the charge nurse missing changes that may have occurred during dialysis or after. During an interview on 12/03/2025 at 3:10 PM the DON said she expected the charge nurses to ensure they are completing the dialysis communication forms and document the refusals. The DON said the charge nurses should have completed the communication forms for every dialysis treatment Resident #7 had. The DON said the failure of not (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675879
		If continuation sheet Page 1 of 29

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completing the dialysis communication forms placed a risk for Resident #7 having rehospitalizations, the charge nurses not knowing how much fluid that was removed during dialysis, charge nurses being unaware of Resident #7's blood pressure and vitals, and miscommunication about the plan of care or continuity of care. During an interview on 12/03/2025 at 4:23 PM the Administrator said his expectation was for the dialysis communication forms to be created by the charge nurse on Resident #7's treatment days and for the charge nurses to ensure the forms were completed after dialysis treatments were completed to be turned in and uploaded to Resident #7's medical charts. The Administrator said the failure placed a risk for Resident #7's charge nurses not having accurate information to correctly assess the resident. Record review of the facility policy Dialysis Protocols revised 07/18/18 indicated:1. Establish dialysis days and inform IDT of the same2. Implement dialysis communication regarding plan of care.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 13.33%, based on 4 errors out of 30 opportunities, which involved 2 of 5 residents (Resident #50 and Resident #52) and 1 of 1 staff (MA F) reviewed for medication administration. 1. The facility failed to ensure MA F administered Resident #50's amantadine (medication used to treat stiffness, tremors, or uncontrolled movements), escitalopram (medication used to treat depression), and aripiprazole (medication used to treat mental illnesses) on 12/02/2025. 2. The facility failed to ensure MA F administered Resident #52's carvedilol (medication used to treat heart failure and high blood pressure) with meals as ordered by the physician on 12/02/2025. These failures could place residents at risk of not receiving the therapeutic effects of their medications, possible adverse reactions, and medication errors. Findings include: 1. Record review of Resident #50's face sheet, dated 12/03/2025, indicated a [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #50 had diagnoses which included schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior) and major depressive disorder (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks). Record review of Resident #50's Quarterly MDS assessment, dated 08/23/2025, indicated she understood others and was understood by others. Resident #50 had a BIMS score of 15, which indicated her cognition was intact. Resident #50 was dependent on staff for toileting, dressing, and personal hygiene. Resident #50 received an antidepressant and an antipsychotic. Record review of Resident #50's Order Summary Report, dated 12/03/2025, indicated the following orders:escitalopram oxalate 10 mg give 1 tablet by mouth one time a day with an order date of 09/26/2025.aripiprazole oral solution 1 mg/ml give 1 ml by mouth one time a day with a start date of 12/03/2025.Amantadine syrup 50 mg/5 ml give 10 ml by mouth one time a day with a start date of 12/03/2025. Record review of Resident #50's Medication Administration Record for December 2025 indicated amantadine, aripiprazole, and escitalopram were administered on 12/02/2025 by MA F. Record review of Resident #50's care plan, with a target date of 02/07/2026, indicated she used antidepressant medication escitalopram related to depression, and to administer antidepressant medications as ordered by the physician. Resident #50's care plan indicated she used aripiprazole and amantadine related to schizophrenia to administer medications as ordered by the physician. During an observation of medication administration on 12/02/2025 at 9:45 AM, MA F administered medications to Resident #50 and did not administer amantadine, aripiprazole, and escitalopram. During an interview on 12/02/2025 at 1:14 PM, MA F said she administered Resident #50's amantadine, aripiprazole, and escitalopram prior to the medication administration the state surveyor observed. MA F said she administered them earlier because Resident #50 requested them. During an interview on 12/02/2025 at 3:25 PM, Resident #50 said when MA F administered medications with the state surveyor was the only time she received medications. Resident #50 said MA F did not go in prior to that to administer any medications. Resident #50 said she did not know the names of her medications or all the medications she received. Resident #50 said sometimes she did not get morning medications and sometimes she did. During an observation and interview on 12/03/2025 at 10:40 AM, an observation of Resident #50's amantadine 50 mg/5ml, aripiprazole 1mg/ml, and escitalopram revealed:7, 140 ml full bottles of amantadine 50 mg/5ml with instructions to give 10 ml via g-tube 1 time a day, which indicated each bottle was a 14-day supply. The bottles were dated 06/30/25, 07/11/25, 08/04/25, 08/27/25, 10/19/25, 11/05/25, 11/28/25. 4 full and 1 used 60 ml bottles of aripiprazole 1 mg/ml with instructions to give 2 ml via g-tube one time a day 60 ml, which indicated each bottle was a 30-day supply. The bottles were dated 07/27/25, 08/23/25, 09/19/25, 10/17/25, 11/14/25. Escitalopram 10 mg tablets give 1 tablet a day 1 medication card with 7 tablets left dated (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/26/2025 and 1 new medication card with 14 tablets dated 11/27/2025, which indicated a 2-week supply. MA F said she did not know why Resident #50 had an overstock of refills of her medications. MA F said Resident #50 was receiving her medications as ordered by the physician. MA F said she did not know who was re-ordering Resident #50's medications. During an interview with the facility's pharmacy on 12/03/2025 at 11:14 AM, a record of Resident #50's refills for her escitalopram, aripiprazole, and amantadine was requested. The pharmacy technician said it would be faxed over to the facility. Notified the DON and Administrator this would be faxed. The record of refills was not received upon exit of the facility. During an interview on 12/03/2025 at 11:19 AM, RN G said none of the residents complained to her about not receiving their medications. RN G said she was not aware of Resident #50's extra bottles of medications or her not receiving medications. RN G said Resident #50 did not refuse medications. RN G said if medications were administered as ordered Resident #50 would not have so many refills left. RN G said she did not re-order Resident #50's medications, the medication aides refilled them. RN G said if medications were not administered as ordered it could make it to where Resident #50's symptoms were not managed correctly. 2. Record review of Resident #52's face sheet, dated 12/03/2025, indicated a [AGE] year-old male initially admitted to the facility on [DATE]. Resident #52 had diagnoses which included cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery (stroke caused by a blocked or narrowed artery in the brain), essential hypertension (high blood pressure), and dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #52's Quarterly MDS assessment, dated 10/07/2025, indicated he rarely/never understood others and was rarely/never understood by others. Resident #52's BIMS score was a 00, which indicated his cognition was severely impaired. Resident #52 required partial/moderate assistance with dressing and toileting and was dependent on staff for showering/bathing. Record review of Resident #52's Order Summary Report, dated 12/03/2025, indicated an order for carvedilol 25 mg give 1 tablet by mouth two times a day give with meals with a start date of 1/16/2025. Record review of Resident #52's December 2025 MAR indicated carvedilol 25 mg give 1 tablet by mouth two times a day, give with meals, was administered by MA F. Record review of Resident #52's care plan, with a target date of 12/31/2025, indicated he had hypertension and had carvedilol prescribed to give medications as ordered. During an observation of medication administration on 12/02/2025 at 9:58 AM, MA F administered medications to Resident #52. MA F administered Resident #52's carvedilol 25 mg. The order for Resident #52's carvedilol 25 mg indicated to administer it with meals. Resident #52 was not having a meal or eating anything. During an interview on 12/02/2025 at 10:06 AM, MA F said she administered Resident #52's carvedilol 25 mg correctly because he had already eaten breakfast. During an interview on 12/03/2025 at 3:21 PM, the DON said medications should be administered as ordered by the doctor. The DON said none of the residents reported to her they were not receiving their medications. The DON said if a medication order indicated to give with meals, it should be given whenever the residents were eating or with a snack. The DON said Resident #50 was on a program where her medications had to be ordered every two weeks. The DON said if medications were administered as ordered she would not have so many refills left. The DON said it was important for the residents to receive all of their medications as ordered so the medications could treat the residents' conditions, and they could keep them as healthy as possible. During an interview on 12/03/2025 at 4:38 PM, the Administrator said he expected for medications to be administered as ordered, and for them to be signed off as administered only if they were administered. The Administrator said the DON checked to see if there were any holes in the MAR to ensure medications were administered as ordered. The Administrator said management should be asking the residents if they were receiving their medications. The Administrator said if medications were not administered as ordered the residents would not receive the medications they needed. Record review of the facility's policy titled, Medication Administration, revised June 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.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 3 of 6 residents (Resident #7, Resident #50 and Resident #52) reviewed for drugs and biologicals. 1. The facility failed to ensure Resident #50's medication labels for her famotidine, aripiprazole (medication used to treat mental illnesses), and amantadine (medication used to treat stiffness, tremors, or uncontrolled movements) matched her physician order. 2. The facility failed to ensure Resident #52's medication label for his tamsulosin (medication used to treat enlarged prostate) matched his physician order. 3. The facility failed to ensure Resident #7 did not have 2 bottles of wound cleanser, 2 enemas, and medi honey (wound care medication) on his dresser. These failures could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse and drug diversion. Findings included: 1. Record review of Resident #50's face sheet, dated 12/03/2025, indicated a [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #50 had diagnoses which included schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior) and major depressive disorder (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks). Record review of Resident #50's Quarterly MDS assessment, dated 08/23/2025, indicated she understood others and was understood by others. Resident #50's MDS assessment indicated she had a BIMS score of 15, which indicated her cognition was intact. Resident #50 was dependent on staff for toileting, dressing, and personal hygiene. Resident #50 received an antipsychotic. Record review of Resident #50's Order Summary Report, dated 12/03/2025, indicated the following orders: Famotidine give 1 tablet by mouth two times a day with a start date of 12/02/2025. Aripiprazole oral solution 1 mg/ml give 1 ml by mouth one time a day with a start date of 12/03/2025. Amantadine syrup 50 mg/5 ml give 10 ml by mouth one time a day with a start date of 12/03/2025. Record review of Resident #50's care plan, with a target date of 02/07/2026, indicated Resident #50 had GERD (acid reflux) and was prescribed Pepcid (famotidine) to give medications as ordered. Resident #50's care plan indicated she used aripiprazole and amantadine related to schizophrenia to administer medications as ordered by the physician. During an observation of medication administration on 12/02/2025 at 9:45 AM, MA F administered (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #50's famotidine by mouth and the medication label on Resident #50's famotidine instructed to give 1 tablet via gastrostomy tube two times a day. There was no label to indicate there was a change in the order. During an observation and interview on 12/02/2025 at 1:14 PM, an observation was made of Resident #50's aripiprazole and amantadine the medication labels instructed: aripiprazole 1 mg/ml, give 2 ml via g-tube one time a day amantadine 50 mg/ml 7/11/25 give 10 ml via g-tube one time a day MA F said Resident #50 received all of her medications by mouth. MA F said Resident #50 used to have a g-tube, but it was removed. She could not remember when it was removed. MA F said the medication labels should match the order for the medications. MA F said when there was a medication order change there should be a sticker placed on the medication to alert staff there was a change in the order for the medication. MA F said she did not know why there was not a sticker to indicate the order changed. MA F said this was important, so staff knew how to administer the medication correctly. 2. Record review of Resident #52's face sheet, dated 12/03/2025, indicated a [AGE] year-old male initially admitted to the facility on [DATE]. Resident #52 had diagnoses which included cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery (stroke caused by a blocked or narrowed artery in the brain), essential hypertension (high blood pressure), and dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #52's Quarterly MDS assessment, dated 10/07/2025, indicated he rarely/never understood others and was rarely/never understood by others. Resident #52's BIMS score was a 00, which indicated his cognition was severely impaired. Resident #52 required partial/moderate assistance with dressing and toileting and was dependent on staff for showering/bathing. Record review of Resident #52's Order Summary Report, dated 12/03/2025, indicated: Tamsulosin 0.4 mg give 1 capsule by mouth one time a day with a start date of 12/03/2025. During an observation of medication administration on 12/02/2025 at 9:58 AM, MA F administered Tamsulosin 0.4 mg 1 capsule to Resident #52. The medication label instructed to give 1 capsule by mouth at bedtime. During an interview on 12/02/2025 at 10:06 AM, MA F said Resident #52 was getting his Tamsulosin at bedtime before, but the order changed, and they were giving it in the morning now. MA F said the order was changed a few months ago. MA F said the DON was responsible for making sure the medication label matched when the medications were administered. MA F said a change of the order label should be placed on the medication card, but she did not know why one was not on there. MA F said it was important for the medication label to match so they knew how to administer the medication, and so they would not give the wrong medication or dose and for them to give it at the right time. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/03/2025 at 11:27 AM, RN G said the medication label should match the residents' medication order. RN G said when there was a change in an order for a medication, they should apply the medication change label. RN G said usually the ADON and DON were the ones responsible for ensuring this happened. RN G said she did not remember when Resident #50's g-tube was removed, but Resident #50 was receiving all of her medications by mouth. RN G said she did not know when Resident #52's tamsulosin was changed from being administered at bedtime to in the morning time. RN G said it was important for the medication labels to match the orders to have the correct route of administration and to ensure medications were administered at the right time. RN G said if the order did not match the medication label it could cause the medication to be administered incorrectly. During an interview on 12/03/2025 at 3:26 PM, the DON said when the order changed for a resident's medication the nurse should place a sticker to indicate the order was changed on the medication card, reorder the medication, and then discard the old one so there was no confusion. The DON said the pharmacy did an audit on the medication carts once a month and she believed they monitored this. The DON said if the medication label was not matching the order there could be harm to the residents because it would not have the right dose, time, and route. During an interview on 12/03/2025 at 4:35 PM, the Administrator said when a residents medication order changed the nurses should correct the medication label or they could notify the ADON/DON. The Administrator said he expected the medication card to match the order. The Administrator said the nurses should place a change of order label on the medication card. The Administrator said the medication label not matching the order could result in the medication given at the wrong time or confusion on when to give it. 3. Record review of Resident #7's face sheet indicated a [AGE] year-old male who re-admitted to the facility on [DATE]. Resident #7 had diagnoses which included end stage renal disease (disease in which the kidneys almost lose all function), chronic systolic heart failure (when the hearts main pumping chamber weakens and cannot pump enough oxygen-rich blood to the body), respiratory failure (inadequate gas exchange by the respiratory system), and bipolar disorder (brain disorder causing extreme shifts in mood, energy, activity levels, and focus). Record review of Resident #7's care plan, dated 05/23/25, indicated he had congestive heart Failure related to fluid overload with interventions for staff to give cardiac medications as ordered. Resident #7 had a pressure ulcer with interventions to administer medications as ordered and monitor and document for side effects and effectiveness, and to follow facility policies and protocols for the prevention and treatment of skin breakdown. Record review of Resident #7's quarterly MDS, dated [DATE], indicated he was able to make himself understood and he understood others. Resident #7 had BIMS score of 15, which meant he was cognitively intact. Resident #7 was totally dependent on staff for toileting, bathing, dressing, and required moderate assistance for bed mobility. Resident #7 had dialysis while he was a resident at the facility. Record review of Resident #7's order summary report, dated 12/01/25, indicated he had orders for: 1.wound #1: Clean coccyx with wound cleanser, skin prep surrounding tissue or peri wound, Apply Dakins moistened Fluffed gauze, Cover with superabsorbent everyday shift with a start date of 11/22/2025 and no end date. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The order summary report did not indicate an order for medi honey wound care medication nor the fleets enema. During an observation on 12/01/2025 at 3:06 PM, Resident #7 was lying in bed and he had 2 bottles of wound cleanser spray, 1 container of Medi honey wound care medication and a fleets enema on his dresser. During an observation on 12/02/2025 at 8:04 AM, Resident #7 was lying in bed with his dialysis running. He continued to have 2 bottles of wound cleanser, medi honey, and a fleets enema in the room on his dresser. During an observation and interview on 12/03/2025 at 1:47 PM, RN G entered Resident #7's room with the state surveyor and noted 2 bottles of wound cleanser, a container of medi honey, and 2 fleets enemas on Resident #7's dresser. RN G said the wound cleanser, enemas, nor the medi honey should not have been in the resident's room. She said she guessed the other nurse left it in there. RN G said when she provided care, she would remove all the items. RN G said she was aware of residents wandering around the facility and she said the failure placed a risk for other residents getting the medication and using it improperly or ingesting it. During an interview on 12/03/2025 at 3:12 PM, the DON said she expected the prescription medication not to be in the residents' rooms. The DON said all medications should be locked in the medication carts or in the medication rooms. The DON said the failure of leaving prescribed medications in Resident #7's room placed a risk for those medications being in reach of Resident #7, the roommate, or other residents in the facility to use the medications incorrectly, ingest them, or place the medications where they did not need to be. The DON said ultimately the DON was responsible for ensuring there were no medications left in residents' rooms as well as the charge nurse on the hallway[TF4] . During an interview on 12/03/2025 at 4:28 PM, the Administrator said anything that was for medical use should be put away in the medication carts or the medication rooms where only the charge nurses or medication aides had access. The Administrator said the failure placed a risk for any residents to get into the medications and use the medications for something they were not designed for. The Administrator said the facility also had residents who wandered who could get access to the medications that were left in Resident #7's room. The Administrator said the charge nurses were responsible for ensuring no medications were left in resident rooms as well as staff who made rounds in the facility. 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. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature , light and humidity controls. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing.		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on interview and record review the facility failed to employ sufficient staff with appropriate competencies and skills to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for 3 of 8 dietary staff (Cook N, [NAME] O, and Kitchen Aide P) reviewed for food and nutrition services. The facility failed to ensure dietary staff (Cook N, [NAME] O, and Kitchen Aide P) serving in the kitchen maintained a current Food Handler Certificate. This failure could place residents at risk of causing foodborne illnesses or infection. Findings include: Record review of [NAME] N's employee file indicated her date of hire was 08/05/2025, and her Texas Food Handler Certificate was issued 12/02/2025, after state surveyor intervention. [NAME] N had no other food handler certificate on file. Record review of [NAME] O's employee file indicated her date of hire was 04/25/2000, and her Texas Food Handler Certificate was issued 12/02/2025, after state surveyor intervention. [NAME] O's Texas Food Handler Certificate that was on file prior to state surveyor intervention was issued 08/23/23 and expired 08/23/25. Record review of Kitchen Aide P's employee file indicated her date of hire was 07/18/2006, and her Texas Food Handler Certificate was issued 12/02/2025, after state surveyor intervention. Kitchen Aide P's Texas Food Handler Certificate that was on file prior to state surveyor intervention was issued 11/10/23 and expired 11/10/25. During an interview on 12/03/2025 at 2:55 PM, the Dietary Manager said the food handler's certificates should have been completed prior to employees starting in the kitchen, but he worked at the hospital prior to starting to work at the facility in October, and he was unaware he was responsible for getting the food handler's certificates completed. The Dietary Manager said he thought the staff had already completed the certificates when he started in his position. The Dietary Manager said the failure of staff not having the food handler's certificates placed a risk was for the kitchen staff not knowing the procedures but most importantly the staff not knowing the handwashing procedures. The Dietary Manager said the failure also placed a risk for cross contamination and infection. During an interview on 12/03/2025 at 3:06 PM, the DON said she expected the kitchen staff to follow policies and the dietician to notify her of any issues. During an interview on 12/03/2025 at 3:50 PM, the Administrator said the facility did not have a policy regarding food handler certificates. During an interview on 12/03/2025 at 4:18 PM, the Administrator said his expectation was that all staff in the kitchen had the food handler's certificate before it expired and before beginning to work. The Administrator said the failure placed a potential risk for incorrect portions being served and staff passing germs on to the residents.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview [TF1] the facility failed to ensure each resident received and the facility provided food and drink that was palatable, attractive, and at a safe and appetizing temperature for 1 of 1 kitchen [TF2] meal (lunch) [TF3] and 3 of 22 residents (Resident #35, Resident #4, and Resident #40) reviewed for food and nutrition services. The facility failed to ensure dietary staff provided food that was palatable and had an appetizing temperature on 12/01/25 at lunch. This failure could place residents at risk of decreased food intake, hunger, and unwanted weight loss. Findings included: During an interview on 12/01/2025 at 11:38 AM, Resident #35 said the food was not very good, it tasted bad, and about half the time the food was cold. During an interview on 12/01/2025 at 11:51 AM, Resident #4 said the food did not taste good and the food was not warm enough. During an interview on 12/02/2025 at 11:06 AM, Resident #40 said she wished the food tasted better; she said it was bland. During an onservation on 12/02/2025 at 12:38 PM the last hall trays that included the sample tray exited the kitchen to be delivered on the halls and was delivered to the 5 state surveyors with the Dietary Manager present at 12:53 PM. During an observation and interview on 12/02/2025 at 12:53 PM the sample tray was received by 5 surveyors and the Dietary Manager and 5 state surveyors sampled a test tray. The sample tray consisted of rotisserie chicken, fried okra, baked beans, corn bread, and pudding. The Dietary Manager said the overall tray was luke warm and if he had received it on the halls, he would not want to eat it. He said the kitchen was responsible for preparing the food and the aides were responsible for ensuring the food out to the residents in a timely manner so that it was hot. He said it took too long to get the trays out. The Dietary Manager said the failure placed a risk for residents not wanting to eat the food and possible weight loss. The 5 state surveyors tested the tray as well. The 5 state surveyors and the Dietary Manager agreed that the rotisserie chicken was warm and bland, but could have been hotter, the fried okra was warm and could have been hotter, the baked beans were warm and bland and could have been hotter, and the corn bread was warm and not completely done in the middle as witnessed by a gooey texture. During an interview on 12/03/25 at 3:08 PM, the DON said she expected the food to be delivered in a timely manner and the food should have been hot when the residents received the food. The DON said the staff should not have to warm up the food at all. The DON said the CNAs were responsible for passing the trays after they were checked by the nurse. The DON said the failure of not serving a hot palatable tray placed a risk for weight loss for all residents. Record review of the facility's Food and Nutrition Services Staff policy, dated October 2022, indicated: Policy Statement .3. The food and nutrition services department will not depend on nurses, nurse aides or feeding assistants to safely carry out the functions of the department but instead will use support personnel to enhance the meal service experience for the residents.4. Food will be palatable, attractive, and served in a timely manner at proper temperatures.		

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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** 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 3 of 4 residents (Resident #7, Resident #27 and Resident #45) reviewed for infection control. 1. The facility failed to ensure Resident #45 had proper signage for contact isolation precautions posted and her order specified the type of isolation precaution she required. 2. The facility failed to ensure CNA B and CNA L provided proper incontinent care to Resident #27 and failed to ensure CNA B performed hand hygiene during the incontinent care on 12/02/2025. 3. The facility failed to ensure CNA M and CNA L used the proper PPE (Gown and Gloves) while transferring Resident #7 with a mechanical lift on 12/1/2025. These failures could place residents at risk for cross contamination and the spread of infection. Findings include: 1. Record review of Resident #45's face sheet, dated 12/03/2025, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #45 had diagnoses which included cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery (stroke caused by a blocked or narrowed artery in the brain) and hemiplegia unspecified affecting the left nondominant side (paralysis or severe weakness on the left side of the body). Record review of Resident #45's Comprehensive MDS assessment, dated 11/05/2025, indicated she was understood by others and understood others. Resident #45's MDS assessment indicated she had a BIMS score of 14, which indicated her cognition was intact. Resident #45 was dependent on staff for toileting, bathing, dressing and personal hygiene, and required partial/moderate assistance with eating. The MDS assessment did not indicate if Resident #45 required isolation or quarantine for active infectious disease. Record review of Resident #45's Order Summary Report, dated 12/01/2025, indicated: Isolation Precautions: (pick all that apply) ____ standard, ____ droplet, ____ airborne related to specify diagnosis i.e. COVID (coronavirus) every shift initials acknowledge the following: resident resided in room alone, and received all medications, participated in activities, received all meals, when applicable received all rehab services, and received all ADL care, in room the entire shift with a start date of 11/30/2025. Acyclovir (medication used to treat shingles) 800 mg give 1 tablet by mouth five times a day for shingles for 7 days with at start date of 11/30/2025. Resident #45's Order Summary Report did not specify what type of isolation precaution she required. Record review of Resident #45's care plan, revised 12/01/2025, indicated she required enhanced barrier precautions (Contact Isolation) related to shingles. Interventions included apply signage outside of the resident's room. During an observation and interview on 12/01/2025 at 2:29 PM, there was a sign on Resident #45's door which indicated, Stop Please See Nurse Before Entering. There was another sign which indicated to apply gown, mask, goggles, gloves. The signs did not indicate what type of isolation precautions Resident #45 required. Resident #45 said she had shingles. (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 observation on 12/03/2025 at 8:19 PM, Resident #45's door had one sign that said, Stop Please See Nurse Before Entering. There was no sign to indicate the type of isolation precautions required or what PPE to put on. During an observation and interview on 12/03/2025 at 2:26 PM, Resident #45's door had one sign that said, Stop Please See Nurse Before Entering. There was no sign to indicate the type of isolation precautions required or what PPE to put on. CNA K said he did not know what type of precautions Resident #45 required. He said he just put on the PPE in the isolation cart which was gloves, gown, a face mask, and shoe covers. CNA K said the nurse usually told them what type of isolation precautions the residents required, but he was not told. CNA K said it was important to know what type of isolation precautions were required for his own safety, so he knew the approach required, and so whatever she had did not spread. During an interview on 12/03/2025 at 2:30 PM, RN H said Resident #45 required contact precautions. RN H said when a resident required isolation precautions the nurse should put an order in, put a sign on the door, and let the CNAs know the type of precaution required. RN H said he was not aware Resident #45's order did not specify the type of precaution she required, and that there was no sign on her door to specify she required contact precautions. RN H said it was important to have an order and place a sign to indicate the type of precautions required so all the staff knew what was going on with the patient and what PPE was required. RN H said not having these things in place, placed the residents at risk for transmission of the disease. During an interview on 12/03/2025 at 3:16 PM, the DON said the nurse was responsible for ensuring the resident's order specified the type of isolation precaution required, placing a sign specific to the isolation requirements on the door, and placing the proper PPE outside of the room. The DON said she was responsible for ensuring this happened. The DON said Resident #45 required contact precautions. She said she was not aware Resident #45 did not have these things in place. The DON said it was important for the proper steps to be put in place because they did not want anyone else to get the infection. The DON said this was an infection control issue, and they needed to be mindful to catch these things, so they did not cause harm to the patients. During an interview on 12/03/2025 at 4:31 PM, the Administrator said the order for isolation precaution should indicate the type of precaution Resident #45 required. The Administrator said a sign which indicated she required contact precautions should be up on the door with the proper PPE readily accessible. The Administrator said the nurses should ensure these steps were taken, and nurse management should provide oversight. The Administrator said not specifying the type of precautions Resident #45 required could result in the wrong type of precautions and the potential to infect others. 2. Record review of Resident #27's face sheet, dated 12/03/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #27 had diagnoses which included neuromuscular dysfunction of bladder (occurs when nerve damage interferes with the bladder's ability to store and release urine properly), quadriplegia (the dysfunction or loss of motor and/or sensory function in the cervical area of the spinal cord), seizures, (abnormal electrical activity in your brain that causes changes in awareness and muscle control), and muscle weakness. Record review of Resident #27's significant change in condition, MDS assessment, dated 10/02/25, indicated Resident #27 understood and was understood by others. Resident #27's BIMS score was 15, which indicated his cognition was intact. Resident #27 required total assistance with toileting, bed (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mobility, dressing, personal hygiene, transfers, and eating. Resident #27 was frequently incontinent of bowel and bladder. Record review of Resident #27's comprehensive care plan, revised on 07/27/23, indicated Resident #27 had an ADL Self Care Performance Deficit. The care plan interventions were for 2 staff to provide toileting. Record review of Resident #27's comprehensive care plan, revised on 11/21/24, indicated Resident #27 was incontinent of bowel. The interventions were for staff to provide pericare after each incontinence episode and check the resident every two hours, and assist with toileting as needed. During an observation on 12/02/25 at 11:40 AM, CNA L and CNA B provided incontinent care for Resident #27, who had a bowel movement. CNA L wiped his front area using side-to-side motion and wiped front to back and back to front with the same wipe. CNA L and CNA B turned Resident #27 to his right side. CNA B wiped his buttocks using back-to-front and front-to-back motions, smearing bowel on his buttocks. CNA B changed her gloves several times throughout pericare to his buttocks but did not perform hand hygiene with every glove change. During an interview on 12/02/25 at 12:03 PM, CNA B said she did not realize she did not perform hand hygiene before changing her gloves each time while providing incontinent care. She said after she completed peri care to Resident #27's buttock, she realized she wiped front to back and back to front several times. She said she was supposed to wipe front to back to prevent bacteria. She said she knew that without hand hygiene or removing dirty gloves, she could cause cross-contamination. During an interview on 12/03/25 at 3:26 AM, LVN A said she was Resident #27's nurse. She said she expected the CNAs to perform incontinent care the correct way. She said she expected them to change their gloves between clean and dirty and wipe front to back to prevent cross-contamination and infection. During an interview on 12/03/25 at 3:38 PM, the DON said she expected the CNAs to perform incontinent care correctly. She said she expected staff to change their gloves between dirty to clean and use hand hygiene between glove changes. The DON said they went over incontinence care and hand washing during skill check off annually, and as needed. She said nurse management oversaw infection control and cross-contamination. She said she randomly selected a staff member and watched them perform incontinent care. She said staff should wipe front to back, change gloves, and practice hand hygiene to prevent infection. During an interview on 12/03/25 at 4:44 PM, the Administrator said he expected all staff to perform incontinent care as they were taught and use proper hand hygiene techniques. The Administrator said he was not clinical but expected the DON to ensure staff were trained on incontinent care and infection control. He said improper hand hygiene or incontinence care could place residents at risk of infection. Record review of the facility's undated policy titled, Handwashing-Hand Hygiene Policy and Procedures, indicated, Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Applying and Removing Gloves: 1. Perform hand hygiene before and after applying non-sterile gloves. Record review of the facility's undated policy titled, Perineal Care, indicated, Purpose: The purposes (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 3. Record review of Resident #7's face sheet indicated a [AGE] year-old male who re-admitted to the facility on [DATE]. Resident #7 had diagnoses which included end stage renal disease (disease in which the kidneys almost lose all function), chronic systolic heart failure (when the hearts main pumping chamber weakens and cannot pump enough oxygen-rich blood to the body), respiratory failure (inadequate gas exchange by the respiratory system), and bipolar disorder (brain disorder causing extreme shifts in mood, energy, activity levels, and focus). Record review of Resident #7's quarterly MDS, dated [DATE], indicated he was able to make himself understood and he understood others. Resident #7 had a BIMS score of 15, which meant he was cognitively intact. Resident #7 was totally dependent on staff for toileting, bathing, dressing, and required moderate assistance for bed mobility. Resident #7 had dialysis while he was a resident at the facility. Record review of Resident #7's care plan, revised on 06/10/25, indicated he required enhanced barrier precautions related to wounds and dialysis with interventions in place to use enhanced barrier precautions during high-contact resident care which included transferring. During an observation and interview on 12/01/2025 at 2:58 PM, revealed CNA M was seen in the room transferring Resident #7 alone with the mechanical by applying the lift pad and raising him in the air without using PPE. After CNA M had Resident #7 in the air and moved over to Resident #7's bed, CNA L entered Resident #7's room with no PPE on and assisted CNA M in completing the mechanical lift transfer by placing Resident #7 on his bed. CNA M said the staff should have been using PPE to complete the transfer for Resident #7 because Resident #7 was a dialysis resident. CNA M said the failure placed a risk for infection. Resident #7 had the enhanced barrier precaution sign on his door and the PPE was in a cart outside of the room. During an interview on 12/03/2025 at 1:47 PM, RN G said the CNAs should have used PPE while transferring Resident #7. RN G said CNA M complained about the size of the gowns, so she thought that may be a reason he failed to use the gown. RN G said the failure placed a risk of the spread of infection from staff to residents and from residents to staff. During an interview on 12/03/2025 at 3:15 PM, the DON said she expected the CNAs to use the proper PPE for residents who required enhanced barrier precautions. The DON said the CNAs should have used enhanced barrier precautions while transferring Resident #7, because it was considered close contact. The DON said the failure placed a risk for infection. During an interview on 12/03/2025 at 4:25 PM, the Administrator said the CNAs should have used the proper PPE to provide the transfer assistance for Resident #7. The Administrator said the failure of not wearing the PPE placed a risk for the staff and residents not having the extra layer of protection to prevent infection. Record review of the facility's policy titled, Infection Prevention and Control Program, revised 06/30/2025, did not address the use of contact precautions or enhanced barrier precautions.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs for 3 of 6 (Resident #2, Resident #55, and Resident #40) residents reviewed for care plans. 1. The facility failed to care plan for Resident #2's hydroxyzine (medication used to treat anxiety), which started on 08/01/25. 2. The facility failed to care plan the removal of Resident #55's supervised smoking to unsupervised smoking on 3/3/25. 3. The facility failed to care plan the removal of Resident #40's tracheostomy size 7.0 trach to size 6.0. This failure could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. The findings included: 1. Record review of Resident #2's face sheet, dated 12/03/25, indicated Resident #2 was a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included anxiety (a normal feeling of worry or fear in response to stress). Record review of Resident #2's quarterly MDS assessment, dated 11/16/25, indicated Resident #2 was understood and was understood by others. Resident #2's BIMs score was 15, which indicated he was cognitively intact. Resident #2 was dependent with his ADLs. The MDS indicated he received an antianxiety medication during the 7-day look-back period. Record review of Resident #2's comprehensive care plan, dated 09/02/25, did not address medication, Hydroxyzine for anxiety. Record review of Resident #2's physician orders dated 08/01/25 indicated Hydroxyzine HCl Oral Tablet (Hydroxyzine HCl), give 25 mg by mouth two times a day for anxiety. Record review of Resident #2's medication administration record dated 11/01/25 through 11/30/25 revealed Resident #2 received Hydroxyzine HCl Oral Tablet (Hydroxyzine HCl), give 25 mg by mouth two times a day for anxiety. 2. Record review of Resident #55's face sheet, dated 12/03/25, indicated Resident #55 was a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included dementia (a general term for a decline in mental ability that interferes with daily life, affecting memory, thinking, and problem-solving), traumatic brain injury also known as TBI (an injury to the brain caused by an external force, such as a blow, bump, or jolt to the head, which can lead to physical and mental challenges), and seizures (abnormal electrical activity in your brain. It causes changes in awareness and muscle control). Record review of Resident #55's quarterly MDS assessment, dated 09/18/25, indicated Resident #55 understood and was understood by others. Resident #55's BIMs score was 07, which indicated she was severely impaired. Resident #55 required assistance with bathing, transfers, and toileting, and was independent with personal hygiene, eating, and bed mobility. Record review of Resident #55's comprehensive care plan, dated 02/11/25, indicated Resident #55 was a smoker and was at risk for injury due to her smoking preference. The interventions of the care plan were for staff to evaluate her smoking safety abilities and provide appropriate interventions as indicated. Provide 1:1 education with staff and resident on compliance concerns, notify RP that the resident must be a supervised smoker, and that staff would keep her smoking supplies. Record review of Resident #55's Smoking Screen Assessment, which was last dated 03/03/25, revealed she was a safe smoker. During an observation and interview on 12/01/25 at 1:12 p.m., Resident #55 was seen going outside with a cigarette in her mouth. Resident #55 took a lighter out of her pocket and lit her cigarette. Resident #55 said she kept her own smoking supplies. 3. Record review of Resident #40's face sheet, dated 12/03/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included Respiratory failure (a serious condition where the lungs can't adequately supply oxygen or remove carbon dioxide, leading to low blood oxygen (hypoxemia) or high CO2 (hypercapnia), Tracheostomy status (a patient having a surgically created opening (tracheostomy) in their windpipe (trachea) for breathing, often for long-term ventilator use, (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	airway obstruction (like from injury, swelling, or cancer), or poor secretion management), sleep apnea (a serious sleep disorder where breathing repeatedly stops and starts, most commonly due to airway blockage), and heart failure (a condition in which the heart can't pump enough blood throughout the body). Record review of Resident #40's quarterly MDS assessment, dated 10/01/25, indicated Resident #40 understood and was understood by others. Resident #40's BIMS score was 15, indicating she was cognitively intact. The MDS indicated she requires assistance with ADLs and was set up for eating. The MDS indicated she required tracheostomy care over the 7-day look-back period. Record review of Resident #40's comprehensive care plan, revised on 07/30/25, indicated she had a tracheostomy related to impaired breathing mechanics and used a 7.0 ID (inner diameter) tracheostomy. The intervention was for staff to monitor/document respiratory rate, depth, and quality. Check and document every shift/as ordered. Provide good oral care daily and as needed. Tube out procedure: Keep an extra trach tube and obturator at bedside. If the tube was coughed out, open the stoma with a hemostat. If the tube cannot be reinserted, monitor/document for signs of respiratory distress. If able to breathe spontaneously, elevate the head of the bed to 45 degrees and stay with the resident. Obtain medical help immediately. Record review of Resident #40's physician's orders dated 09/29/25, indicated tracheostomy care every shift and as needed using aseptic technique. Remove the inner cannula, clean with sterile water, and dry with sterile gauze and a cotton swab. Re-insert the inner cannula, turn to lock. Clean and rinse the outer cannula/stoma with sterile water, pat dry with sterile gauze. May use split sterile gauze as needed related to tracheostomy status. The size was not indicated in the orders. During an observation and interview on 12/03/25 at 3:11 p.m., the MDS Coordinator said she was responsible for the care plan, but each team member does their part. She said she had been in the MDS position for 1 month. She said care plans should be updated if something changes in the resident's condition, quarterly and annually. She looked at Resident 55's last smoking assessment and said that since it deemed her safe to smoke, her care plan should have been updated. She said Resident #40's tracheostomy size was a 6.0, and her care plan should have been updated to reflect the correct size. She said it was important to care plan the residents' care so they would receive quality care. During an observation and interview on 12/03/25 at 3:11 p.m., the MDS Coordinator said she was responsible for the care plan, but each team member does their part. She said she had been in the MDS position for 1 month. She said care plans should be done or updated if something was new or changed in the resident's condition. She looked in Resident #2's medical records and did not see a care plan for his hydroxyzine. She looked at Resident 55's last smoking assessment and said that since it deemed her safe to smoke, her care plan should have been updated. She said Resident #40's tracheostomy size was a 6.0, and her care plan should have been updated to reflect the correct size. She said it was important to care plan the residents' care so they would receive quality care. During an interview on 12/03/25 at 4:31 p.m., the DON said care plans were a team effort with the IDT. She said the MDS nurse was the overseer of care plans. She said they were made aware of any new orders or changes in the morning meetings and the Electronic Health Records dashboard. She said she randomly monitored care plans for completion. She said if care plans were not done properly, care could be missed. During an interview on 12/03/25 at 4:44 p.m., the Administrator said all disciplines should work together to complete a resident's care plan, but the MDS Coordinator was the overseer. He said care plans were the blueprint of residents' care. He said it was used so staff would know the care the residents needed. Record review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, undated, indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Terrell Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 204 W Nash Terrell, TX 75160	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment.12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). 13. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition.d. At least quarterly, in conjunction with the required quarterly MDS assessment.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide an ongoing program of activities in accordance with the comprehensive assessment to meet the interests and the physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #10) reviewed for activities. The facility failed to ensure quarterly activity assessments were completed for Resident #10 and to provide activities to meet their low-functioning needs. This failure could place residents at risk for not having activities to meet their interests or needs and a decline in their physical, mental, and psychosocial well-being. Findings included: Record review of Resident #10's face sheet dated 12/03/2025 revealed a [AGE] year old male initially admitted [DATE] and re-admitted [DATE] with diagnoses which included cerebral palsy (a group of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination), unspecified convulsions (a medical event in which nerve cell activity in the brain is disrupted, causing muscles to involuntarily contract and spasm), and shaken infant syndrome (type of brain injury that happens when a baby or young child is shaken violently). Record review of Resident #10's Quarterly MDS assessment dated [DATE] revealed Section F, Preferences for Customary Routine and Activities was not completed due to the resident was rarely/never understood and a family interview was not completed. Resident #10 was totally dependent in all areas of activities of daily living to include eating, dressing, toileting, bathing, transfers and mobility. Record review of the care plan with target date 01/18/2026 revealed Resident #10 had little, or no activity involvement related to physical limitations with a goal for him to participate in activities of choice 3 times per week. Interventions included Resident #10 required assistance/escort to activity functions, and the resident's preferred activities were in his room and enjoyed being read to. Record review of Resident #8's electronic health record from 12/01/2025-12/03/2025 indicated Resident #8 had no completed activity assessments. During observations and attempted interviews on 12/01/2025 at 11:39 a.m., 12/01/2025 at 3:49 p.m., 12/02/2025 at 9:10 a.m., 12/02/2025 at 3:13 p.m., 12/03/2025 at 7:45 a.m., and 12/03/2025 at 1:55 p.m., Resident #10 was sitting in front of his TV, with it playing cartoons, in his specialized wheelchair alone in his room. Resident #10 was non-interviewable. During a telephone interview on 12/03/2025 at 2:25 p.m. Resident #10's foster mother stated she was aware that the television was on most of the time in Resident #10's room and was not aware of out of room activities that were available to him. During an interview on 12/02/2025 at 4:21 p.m., CNA A stated that Resident #10 will sometimes go to music events or the TV room. During an interview on 12/02/2025 at 4:51 p.m., CNA B stated that she will sing to Resident #10 when she was working with him and stated on the evening shift, he tends to remain in his room with the TV on. During an interview on 12/03/2025 at 3:00 p.m. the Activity Director stated there isn't much [I] can do with him because he doesn't do anything. The Activity Director stated that since Resident #10 has received the large screen TV, that the staff pretty much just turn on the cartoons because he likes them. The Activity Director stated she was aware of the care plan indicating resident likes to be read to but that he does not have any books. The Activity Director stated she will review with the IDT members to identify alternate resources she could implement for this resident to meet his needs. The Activity Director stated she documents in the EMR under the progress note section but does not complete a quarterly activity assessment. The Activity Director stated it was important to complete the activity assessments to ensure resident's preferences or identified activity needs are met. During an interview on 12/03/2025 at 3:20 p.m., the DON stated that she felt the current facility activity calendar was lacking in activity events for low-functioning residents. The DON stated that she expected the AD and IDT members to identify activities and resources appropriate for low-functioning residents to ensure their activity needs are met. The DON stated she expected the AD to complete activity assessments quarterly and as needed for all residents and that she would complete spot checks to ensure activities are in place. The DON (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that it may be necessary to assign specific staff members to low-functioning residents to ensure activity needs are met. During an interview on 12/03/2025 at 4:08 p.m., the Administrator stated that low functioning residents should be reviewed by the IDT members to determine what types of interactions and activities are appropriate. The Administrator stated that residents who have been identified as low functioning should be assessed for appropriate activities. The Administrator stated it was important for the activity assessments to be completed to personalize the activities for the residents and to prevent decline in psychosocial well-being. Record review of the facility's policy titled, Activity Evaluation, revised February 2023, indicated, In order to promote the physical, mental and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident at least quarterly and with any change of condition that could affect his/her participation in planned activities .3. The activities director is responsible for completing, directing and/or delegating the completion of the activities component of the comprehensive assessment .The completed activity evaluation is part of the resident's medical record and is updated as necessary, but at least quarterly .		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for 1 of 2 (Resident #10) residents reviewed for range of motion. The facility failed to ensure Resident #10's wrist roll (medical device used to treat hand contractures, permanent tightening of the muscles, tendons, skin and surrounding tissues that cause stiffness, placed in the hands to help improve range of motion) was in place to his left hand. The facility failed to implement a medical device for Resident #10's left hand to help improve range of motion. The failures could place residents at increased risk for decrease in mobility and range of motion and contribute to worsening of contractures. Findings included: Record review of Resident #10's face sheet dated 12/03/2025 revealed a [AGE] year old male initially admitted [DATE] and re-admitted [DATE] with diagnoses which included cerebral palsy (a group of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination), muscle contracture (a permanent shortening or tightening of muscle fibers), unspecified convulsions (a medical event in which nerve cell activity in the brain is disrupted, causing muscles to involuntarily contract and spasm), and shaken infant syndrome (type of brain injury that happens when a baby or young child is shaken violently). Record review of the Quarterly MDS assessment dated [DATE] revealed Resident #10 was severely impaired in cognitive skills for daily decision making, was rarely understood and rarely understood by others with short-term and long-term memory deficits. Resident had functional limitations in range of motion to upper and lower extremity, utilized a wheelchair for mobility and was totally dependent in all areas of ADL concern; was receiving OT services and did not receive passive or active range of motion or splint or brace assistance. Record review of Resident #10's care plan focus problem with target date 01/18/2026 revealed limited physical mobility related to shaken infant syndrome and contractures with goal to maintain current level of mobility. Interventions/Tasks reveals resident to wear left wrist roll daily or as tolerated for contracture prevention/management and provide gentle range of motion as tolerated with daily care. Record review of Resident #10's care plan, viewed 12/02/2023 had a focus problem dated 1/10/25, revised 1/24/25 revealed impaired physical mobility related to contractures to bilateral lower extremities, left upper extremity, left hand, right ankle secondary to Cerebral Palsy. Interventions/Tasks revealed splints may be applied per physicians' orders dated 1/10/25. Focus problem dated 3/14/25 revealed resident will wear left palm protector. Record review of Resident #10's physician's order dated 08/22/2025 revealed Resident to wear left wrist roll daily or as tolerated for contracture prevention/management. Record review of Resident #10's November and December 2025 TAR revealed that nursing documented that left wrist roll was in place at twice per day at 8:00 a.m. and 9:00 p.m. from November 1 thru November 30 and December 1 thru December 3. Record review of occupation therapy rehabilitative program revealed Resident #10 was seen one time per week to provide gentle passive range of motion to upper and lower extremity contractures. An observation and attempted interview of Resident #10 on 12/01/2025 at 11:39 a.m., 12/01/2025 at 3:49 p.m., 12/02/2025 at 9:10 a.m., 12/02/2025 at 3:13 p.m., 12/03/2025 at 7:45 a.m., and 12/03/2025 at 1:55 p.m. revealed no left wrist roll in place. During an interview on 12/02/2025 at 4:21 p.m., CNA A stated that she was not aware of a left wrist roll for Resident #10, but that if a roll was needed, the nurses would apply. During an interview on 12/02/2025 at 4:34 p.m., CNA C stated that he does not usually work 100 hall but has not seen a hand roll to Resident #10's left hand and that he has never applied a hand roll to this resident. During an interview on 12/02/2025 at 4:45 p.m., LVN E stated that this was her first day at the facility, that she was not aware of a left wrist roll for Resident #10 but that she would apply when it popped up on the TAR. During an interview on 12/02/2025 at 4:51 p.m., CNA B (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that she does not recall seeing a hand roll for Resident #10 but that it would be good for him. During an interview on 12/03/2025 at 8:17 a.m., RN D stated she applied a left-hand roll for Resident #10 on 12/02/25 and has not yet applied a hand roll today. RN D stated that it was important to apply the hand roll to prevent further contractures for this resident. RN D stated she would ensure there was no skin breakdown and assess for and medicate for pain if necessary, when applying hand roll. During an interview on 12/03/2025 at 8:51 a.m., the DOR stated Resident #10 was followed one time per week for habilitative services under PASRR program. The DOR stated that OT staff focus on passive range of motion during visit and that nursing staff are responsible for applying the hand roll daily. The DOR stated that resident is very contracted due to his diagnosis and failure to utilize preventative measures could cause increase in contractures and associated pain. During an interview on 12/03/2025 at 3:20 p.m., the DON stated that she expects nursing and therapy to implement splinting or contracture management devices per physicians' orders. The DON stated that failure to implement the identified devices for contractures could result in increased contractures as well as increased pain for the resident. The DON stated that the therapy department are responsible for identifying residents who have contractures and assisting the nursing department in implementing appropriate devices based on therapy recommendations and physician orders and that ultimately, she was responsible for ensuring devices are properly utilized. During an interview on 12/03/2025 at 4:08 p.m., the Administrator stated that he expects therapy to be on top of the contracture management program and for the nursing staff to implement the program. The Administrator stated that failure to implement the identified device for contractures could result in increased contractures and put resident at risk for pain. Record review of the policy for contractures titled Contracture Management Program, reviewed 06/24/2025 revealed the Intent is to have a program within the facility geared towards the prevention of new contractures and maintenance or improvement of Range of Motion and Resident's identified as at risk will be seen by Restorative Nursing indefinitely to manage splinting.assessed quarterly and reviewed in the clinical standards weekly.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the residents' environment remained free of accident hazards for 1 of 22 residents (Resident #7) reviewed for accident hazards. The facility failed to ensure Resident #7's was transferred with the mechanical lift using 2 staff members throughout the entire transfer. This failure could place residents at risk for injuries. Findings included: Record review of Resident #7's face sheet indicated he was a [AGE] year-old male who re-admitted to the facility on [DATE] with the diagnoses end stage renal disease (disease in which the kidneys almost lose all function), chronic systolic heart failure (when the hearts main pumping chamber weakens and cannot pump enough oxygen-rich blood to the body), respiratory failure (inadequate gas exchange by the respiratory system), and bipolar disorder (brain disorder causing extreme shifts in mood, energy, activity levels, and focus). Record review of Resident #7's quarterly MDS dated [DATE] indicated he was able to make himself understood and he understood others. The MDS also indicated he had BIMS score of 15 which meant he was cognitively intact. The MDS also indicated he was totally dependent on staff for toileting, bathing, dressing, and required moderate assistance for bed mobility. The MDS also indicated he had dialysis while he was a resident at the facility. Record review of Resident #7's care plan dated 05/23/25 indicated he had an ADL self-care performance deficit related to limited mobility, limited ROM, and musculoskeletal impairment with interventions for Resident #7 being totally dependent and requiring 2 staff for transferring. During an observation and interview on 12/01/2025 at 2:58 PM CNA M was seen in the room transferring Resident #7 alone with the mechanical by applying the lift pad and raising him in the air. After CNA M had Resident #7 in the air and moved over to Resident #7's bed, CNA L entered Resident #7's room and assisted CNA M in completing the mechanical lift transfer by placing Resident #7 on his bed. CNA M said CNA L was in Resident #7's room with him a couple of minutes prior to him coming into the room when the surveyor noted CNA L entering Resident #7's room, CNA M walked off from the surveyor. During an interview on 12/01/2025 at 3:03 PM CNA L said he was not in Resident #7's room prior to surveyor seeing him enter the room. CNA L said the nurse told him to go Resident #7's room because the other CNA M was completing a transfer and when he entered while surveyor standing at Resident #7's door, CNA M had Resident #7 in the mechanical lift and CNA L said he assisted CNA M to lay Resident #7 down from the mechanical lift. CNA L said the CNAs were all supposed to use 2 people to assist any residents using a mechanical lift. During an interview on 12/01/2025 at 3:06 PM Resident #7 said he did not remember if the CNA M had someone with him when CNA M got him up from the wheelchair with the mechanical lift but he knew CNA L came in to help lay him down from the mechanical lift. Resident #7 said he was worried about falling during the transfer as well. During an interview on 12/03/2025 at 1:47 PM RN G said she was not aware CNA M was completing a mechanical lift transfer alone. RN G said she expected the CNAs to always transfer residents with 2 people assist when using a mechanical lift. RN G said the failure placed a risk for falls or injury when you only have 1 person. During an interview on 12/03/2025 at 3:15 PM the DON said that every resident that required a mechanical lift for transfers should have 2 people assisting and she expected the CNAs to always follow the protocol. The DON said the failure of CNA M not having a second person during the entire transfer placed a risk for accidents or injury to Resident #7. During an interview on 12/03/2025 at 4:27 PM the Administrator said that there should always be 2 staff assisting with a mechanical lift transfer for safety. She said the failure placed a risk of injury to Resident #7 as well as the potential for accidents and safety hazards. Record review of the facility policy Activities of Daily Living, Supporting dated March 2018 did not indicate how many staff were needed for a mechanical lift transfer.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 3 residents (Resident #40) reviewed for respiratory care. 1. The facility failed to have an extra tracheostomy in Resident #40's room. 2. The facility failed to ensure Resident #40's oxygen was set at 4 liters per nasal cannula as ordered on 12/01/25 and 12/02/25. These failures could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care. Findings included: Record review of Resident #40's face sheet, dated 12/03/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included Respiratory failure (a serious condition where the lungs can't adequately supply oxygen or remove carbon dioxide, leading to low blood oxygen (hypoxemia) or high CO2 (hypercapnia), Tracheostomy status (a patient having a surgically created opening (tracheostomy) in their windpipe (trachea) for breathing, often for long-term ventilator use, airway obstruction (like from injury, swelling, or cancer), or poor secretion management), sleep apnea (a serious sleep disorder where breathing repeatedly stops and starts, most commonly due to airway blockage), and heart failure (a condition in which the heart can't pump enough blood throughout the body). Record review of Resident #40's quarterly MDS assessment, dated 10/01/25, indicated Resident #40 understood and was understood by others. Resident #40's BIMS score was 15, indicating she was cognitively intact. The MDS indicated she required assistance with ADLs and set up assistance for eating. The MDS during the 7-day look-back period indicated Resident #40 was receiving oxygen and tracheostomy care. Record review of Resident #40's comprehensive care plan, revised on 06/05/25, indicated she had respiratory status, difficulty breathing related to chronic respiratory failure, sleep apnea, and tracheostomy. The intervention was for staff to have oxygen set at 4 liters per nasal cannula. Record review of Resident #40's comprehensive care plan, revised on 07/30/25, indicated she had a tracheostomy related to impaired breathing mechanics and used a 7.0 ID (inner diameter) tracheostomy. It indicated she did her own suctioning. The intervention was for staff to monitor/document respiratory rate, depth, and quality. Provide good oral care daily and as needed. Tube out procedure: Keep an extra tracheostomy tube and obturator at bedside. If the tube was coughed out, open the stoma with a hemostat. If the tube cannot be reinserted, monitor/document for signs of respiratory distress. If able to breathe spontaneously, elevate the head of the bed to 45 degrees and stay with the resident and obtain medical help immediately. Record review of Resident #40's physician's orders dated 08/12/25, indicated oxygen at 4 liters per minute via tracheostomy continuously every shift related to chronic respiratory failure. Record review of Resident #40's physician's orders dated 09/29/25, indicated tracheostomy care every shift and as needed using aseptic technique. Remove the inner cannula, clean with sterile water, and dry with sterile gauze and a cotton swab. Re-insert the inner cannula, turn to lock. Clean and rinse the outer cannula/stoma with sterile water, pat dry with sterile gauze. May use split sterile gauze as needed related to tracheostomy status. The size was not indicated in the orders. Record review of Resident #40's respiratory note dated 10/13/25 indicated, Resident #40 had a 6.0 tracheostomy and wore oxygen at 4 liters per minute. During an observation and interview on 12/01/25 at 3:35 p.m., Resident #40 was lying in bed on her phone. Resident #40 was wearing oxygen at 5 liters per nasal cannula. Resident #40 said her oxygen should be set at 4 liters. Resident #40 did not have her extra tracheostomy in the room. Resident #40 said she did have the Ambu bag with her extra tracheostomy in it in the closet. She said she does her own suctioning and said she knew when she was having respiratory distress to notify staff. During an observation and interview on 12/01/25 at 6:04 p.m., LVN B verified that Resident #40 did not have her Ambu bag or a smaller size extra tracheostomy visible in (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her room. She looked in the closet and did not see the Ambu bag or extra tracheostomy. She went about ten feet away and obtained an Ambu bag. She looked in the supply closet and could not locate a tracheostomy size 5.0. She said it was her responsibility to ensure the emergency setup was in Resident #40's room. She said the emergency set-up should contain an Ambu bag, hemostats, and a smaller extra tracheostomy. She said it was important to ensure the emergency set-up was in the room to prevent respiratory distress, such as shortness of breath. During an interview on 12/01/25 at 6:43 p.m., the DON said Resident #40 should have an Ambu bag on the wall and an extra smaller tracheostomy inside the bag. She said the extra tracheostomy should be a size 5.0. She said she had been made aware that they could not find the size 5.0 tracheostomy and were looking for it. She said she thought she last saw the Ambu bag taped on the wall about a week ago. She said nurse management rounds daily, and it should have been checked. She said the ADON does daily rounding for Resident #40. She said that without the Ambu bag or extra tracheostomy in her room, it could cause respiratory distress or hospitalization. During an interview on 12/01/25 at 6:47 p.m., the ADON said she did not make a daily round for Resident #40. She said she was over Resident #40's hall to ensure orders were correct, nurses were documenting, etc. She said each resident had a neighbor program, and they were responsible for ensuring the Ambu bag was in place, along with the charge nurses. She said Resident #40 should have oxygen, Ambu bag, a suction machine, a trach collar, a 5.0 tracheostomy, and a tracheostomy kit at bedside. She said the risk of not having it at the bedside could cause a delay in care. During an observation on 12/02/25 at 7:51 a.m., Resident #40 had an Ambu bag, extra tracheostomy ties, tracheostomy size 6.0, and 5.0 in the bag hanging in front of her bed. During an interview on 12/02/2025 9:23 a.m., the DON said she searched the facility yesterday (12/01/25) and found the 5.0 tracheostomy in an isolation cart. She showed the surveyor the box, which was half full. During an observation and interview on 12/02/25 at 10:30 a.m., LVN C verified Resident #40 was receiving oxygen at 5 liters per nasal cannula. She said it was her responsibility to ensure the oxygen was set at the correct rate. She said she had not checked Resident #40's oxygen before the state surveyor's intervention. She said it was important to ensure the oxygen was at the correct rate ordered to help maintain an effective airway and decrease the risk of hypercapnia. During an attempted phone interview on 12/03/2025 at 10:10 a.m., Respiratory Therapist did not answer, and a message was left. During an interview on 12/03/25 at 10:50 a.m., the SW said she was Resident #40's neighbor program. She said daily rounds were done for extra support or concerns. She said if she saw that things were not in place, she or someone could fix them. She said she was not clinical and did not know she needed to look for an Ambu bag or extra tracheostomy for Resident #40. During an interview on 12/03/25 at 3:54 p.m., the DON said the charge Nurses were responsible for making sure the oxygen was set at the ordered rate. She said the nurse managers made random rounds to ensure oxygen was set at the ordered rate. She said if the oxygen rate were not set to the ordered rate, it could cause respiratory distress. The DON said residents who had a tracheostomy should have an obturator, tracheostomy ties, lubricants (if needed), an Ambu bag, an extra tracheostomy of the current size, and one smaller size. She said extra supplies should be centrally located in the room. She said the nurses were responsible for making sure the extra supplies were in the room, and the nurse managers were supposed to ensure they were. She said failure to have extra supplies could cause respiratory distress. During an interview on 12/03/25 at 4:44 p.m., the Administrator said if a resident had an order for oxygen, it should be applied. He said the nurses were responsible for ensuring the oxygen was set at the ordered rate, and nurse managers were the overseers. He said he was not clinical and not sure what the risk could be for not having the oxygen set at the correct rate. He said if a resident had a tracheostomy, then they should have an extra tracheostomy and a size smaller in the room in case the tracheostomy becomes dislodged or the hole closes. He said again he was not clinical and did not know everything required, but he expected the nurses to have what the residents needed in place, and the nurse managers to ensure those things were in place. He said failure to have these things in place could cause the resident to go to the hospital. Record review of (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Terrell Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 204 W Nash Terrell, TX 75160	
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility policy titled, Oxygen Administration, undated, indicated, Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration and oxygen safety guidelines. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Steps in procedure: .6. Check the tubing connected to the oxygen cylinder to ensure that it is free of kinks. 7. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute. 8. Place appropriate oxygen device on the resident (i.e., mask, nasal cannula, and/or nasal catheter). Record review of facility policy titled, Tracheostomy Care, undated, indicated, Purpose: The purpose of this procedure is to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas. General guidelines: .7. A replacement tracheostomy tube must be available at the bedside at all times. 8. A suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at the bedside at all times.		

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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 assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 5 residents (Resident #50) reviewed for pharmacy services. The facility failed to ensure Resident #50's escitalopram oxalate 5 mg (medication used to treat depression) was removed from the medication cart after it was discontinued on 09/26/2025. This failure could place residents at risk of receiving medications that were not ordered and medication errors. Findings include: Record review of Resident #50's face sheet, dated 12/03/2025, indicated a [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #50 had diagnoses which included schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior) and major depressive disorder (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks). Record review of Resident #50's Quarterly MDS assessment, dated 08/23/2025, indicated she understood others and was understood by others. Resident #50 had a BIMS score of 15, which indicated her cognition was intact. Resident #50 was dependent on staff for toileting, dressing, and personal hygiene. Resident #50 received an antidepressant. Record review of Resident #50's Order Summary Report, dated 12/03/2025, indicated an order for escitalopram oxalate 10 mg, give 1 tablet by mouth one time a day with an order date of 09/26/2025. There was no order for escitalopram oxalate 5 mg. Record review of Resident #50's progress note, dated 09/26/2025, indicated resident seen by psychiatric services. NP new order received to increase escitalopram to 10 mg PO QD. Family notified. Signed by RN H. Record review of Resident #50's care plan, with a target date of 02/07/2026, indicated she used antidepressant medication escitalopram related to depression, and to administer antidepressant medications as ordered by the physician. During an observation and interview with RN G on 12/02/2025 at 3:40 PM, Resident #50 had escitalopram 5 mg and escitalopram 10 mg on the medication cart. RN G said she did not know why they were both on the medication cart. RN G said Resident #50 was no longer supposed to receive escitalopram 5 mg. RN G said when a new medication order was received, the old medication should be removed from the medication cart, and when the new medication should be ordered. RN G said it was important to remove the discontinued medication, so they did not administer the wrong medication to the residents. During an interview on 12/03/2025 at 8:29 AM, RN H said he did not remember receiving the order for Resident #50's escitalopram to be changed from 5 mg to 10 mg. RN H said the process when they received an order to change the residents' medications was for them to do the medication change in the resident's electronic health record, notify the pharmacy of the dose change, and take the discontinued medication off of the medication cart. RN H said he did not remember if this was completed when Resident #50's escitalopram 5 mg was discontinued. RN H said it was important for discontinued medications to be removed from the medication carts to avoid medication errors. During an interview on 12/03/2025 at 3:19 PM, the DON said when a medication was changed it should be removed from the medication cart when the new medication arrived. The DON said the nurses were responsible for ensuring this happened. The DON said she was not aware Resident #50's escitalopram 5 mg was still on the medication cart. The DON said discontinued medications should be removed from the medication carts because the residents could receive the wrong dose and it could result in a medication error, which could cause patient harm. During an interview on 12/03/2025 at 4:34 PM, the Administrator said when medications were discontinued, he expected the nurses to remove them from the medication cart. The Administrator said not removing discontinued medications from the medication cart could result in the residents getting the wrong medication. Record review of the (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish policies in accordance with applicable Federal, State and local and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents for 2 of 4 residents (Resident #2 and Resident #55) reviewed for smoking. The facility failed to follow the policy on smoking by not completing a smoking screen assessment quarterly on Resident #2 and Resident #55. This failure could place residents at risk of unsafe smoking and injury. Findings included: Record review of Resident #2's face sheet, dated 12/03/25, indicated Resident #2 was a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #2 had diagnoses which included dementia (a general term for a decline in mental ability that interferes with daily life, affecting memory, thinking, and problem-solving), diabetes (high blood sugar), and high blood pressure. Record review of Resident #2's quarterly MDS assessment, dated 11/16/25, indicated Resident #2 was understood and was understood by others. Resident #2's BIMs score was 15, which indicated he was cognitively intact. Resident #2 was dependent with his ADLs. Record review of Resident #2's comprehensive care plan, dated 06/05/24, indicated Resident #9 was a smoker and was at risk of injury due to his smoking preference. The interventions of the care plan were for staff to provide education on the risk of smoking and encourage him to follow the smoking times and policy. Record review of Resident #2's Smoking Screen Assessment, which was last dated 4/25/25, revealed he was a safe smoker. During an observation on 12/01/25 at 1:13 p.m., Resident #2 was outside smoking with other residents. Resident #2 said he always kept his own smoking supplies with him. 2. Record review of Resident #55's face sheet, dated 12/03/25, indicated Resident #55 was a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #55 had diagnoses which included dementia (a general term for a decline in mental ability that interferes with daily life, affecting memory, thinking, and problem-solving), traumatic brain injury also known as TBI (an injury to the brain caused by an external force, such as a blow, bump, or jolt to the head, which can lead to physical and mental challenges), and seizures (abnormal electrical activity in your brain. It causes changes in awareness and muscle control). Record review of Resident #55's quarterly MDS assessment, dated 09/18/25, indicated Resident #55 understood and was understood by others. Resident #9's BIMs score was 07, which indicated she was severely impaired. Resident #9 required assistance with bathing, transfers, and toileting, and was independent with personal hygiene, eating, and bed mobility. Record review of Resident #55's comprehensive care plan, dated 02/11/25, indicated Resident #9 was a smoker and was at risk for injury due to her smoking preference. The interventions of the care plan were for staff to evaluate her smoking safety abilities and provide appropriate interventions as indicated. Provide 1:1 education with staff and resident on compliance concerns, notify the responsible party that the resident must be a supervised smoker, and staff would keep her smoking supplies. Record review of Resident #9's Smoking Screen Assessment, which was last dated 03/03/25, revealed she was a safe smoker. During an observation and interview on 12/01/25 at 1:12 p.m., Resident #55 was seen going outside with an unlit cigarette in her mouth. Resident #55 took a lighter out of her pocket and lit her cigarette outside. Resident #55 said she always kept her own smoking supplies with her. During an interview on 12/03/25 at 3:00 p.m., the Social Worker said she was responsible for completing the smoking assessments. She said she was not aware of what the smoking policy said about how often smoking assessments needed to be completed, but she completed them yearly. She said the smoking assessment was to assess the resident for safety while smoking. She said if the smoking assessments were not done, then a resident might not be safe to smoke, which could place them at risk for burns or injuries. During an interview on 12/03/25 at 2:20 p.m., the DON said she had been the DON for about 2 months at the facility and was not sure about the time frame of the smoking assessments. She said the Social (continued on next page)		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Worker was responsible for doing the smoking assessments. She said she would have to look further at the process and monitoring of the smoking assessments. She said she knew the smoking assessments were done to ensure the residents were safe to smoke. She said that since the smoking assessment was not being done, it could place the residents at risk for burns or injuries. During an interview on 12/03/25 at 3:00 p.m., the Administrator said the Social Worker was responsible for completing the smoking assessment. He said he had only been at the facility for about a month and was told the smoking assessments were supposed to be done yearly. He said he had not looked at the policy until after the state surveyor had interviewed the Social Worker, and she informed him of the assessment dates. He said if the policy changed, then all residents who smoked, assessments should have been updated to reflect the change in policy. He said if the smoking assessments were not done, then it could potentially place a resident at risk for injury. Record review of the facility's Policy titled Facility Smoking Policy-Supervised and Unsupervised, revised date of 07/01/25, indicated, Safe smoking environment: It is the responsibility of the facility to provide a safe and hazard-free environment for those residents who have been assessed as being safe for the facility privileges. The facility is responsible for informing residents, staff, and other affected parties of the facility's smoking policies through verbal means. The policy is intended to minimize the risk to: Residents who smoke, passive smoke to others, and fire. Residents wishing to smoke while at the facility will have a Smoking Safety Evaluation completed by the interdisciplinary team to determine the resident's ability to follow smoking policies safely. Resident smoking evaluations will be conducted: on Admit/Readmit, Quarterly, and Change in Condition.		