

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: 676257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER Trucare Living Centers		STREET ADDRESS, CITY, STATE, ZIP CODE 2265 S Sycamore St Palestine, TX 75801	
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 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 interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 4 residents (Resident #58) reviewed for care plans. The facility failed to ensure Resident #58's care plan reflected intervention of prophylaxis antibiotic indefinitely for prevention of urinary tract infection. This failure could place residents at risk of not receiving appropriate care to meet their current needs. The findings included: Record review of a face sheet dated 12/16/2025 for Resident #58 indicated she originally admitted on [DATE] and readmitted to the facility on [DATE] and was [AGE] year-old female with diagnoses of atrial fibrillation (rapid heart rate) malnutrition, lack of coordination. Record review of a Quarterly MDS assessment dated [DATE] for Resident #58 indicated she had moderate impairment in thinking with a BIMS score of 9. Resident #58 was dependent on personal hygiene including toileting. Section N - Medications indicated Resident #58 was taking a high-risk drug classified as antibiotic during the last seven days. Record review of Resident #58's care plan for bowel- bladder incontinence initiated 5/02/2023 indicated no interventions for long term use of prophylactic antibiotic use of Macrobid 100 milligrams every hour of sleep for prevention urinary tract infection. Record Review of physician order summary dated 12/16/2025 indicated Resident #58 originally admitted to the facility 09/30/2022 and readmitted after an acute hospital stay on 08/26/2025. Record Review of an acute hospital Discharge summary dated [DATE] indicated Resident #58 was treated for a urinary tract infection and discharged with a new prescription for Macrobid 100milligram by mouth every hour of sleep indefinitely for management of urinary tract infections. During an interview on 12/16/2025 at 11:30 AM the MDS Coordinator said she was responsible for revising and updating the care plans. The MDS Nurse said that Resident #58 had been taking Macrobid every hour of sleep for urinary tract prophylaxis since 08/26/2025. She said she did include the antibiotic on her quarterly MDS dated [DATE] and failed to update the care plan with interventions appropriate to long-term use of Macrobid for prevention of urinary tract infections. The MDS Coordinator said the risk to the residents could include all members of the IDT not knowing what was going on with the residents or any needed change in interventions not being addressed. The MDS Coordinator said she would update the care plan to address possible complications of long-term antibiotic use. During an interview on 12/17/2025 at 10:00 AM, the DON said the MDS Coordinator was responsible for updating and revising the comprehensive care plans. She said other staff would update them as well, whenever needed. She said she would get communications during the morning meetings if there was something about a resident that needed to be updated on the care plan. She said the MDS Coordinator also does reviews quarterly and after each MDS assessment such as a change of condition. She said if interventions were not included in the care plan, staff may not know resident needs and changes in care provided. During an interview on 12/16/2025 at 4:30 pm the Administrator said she was aware that Resident #58 had a problem with her care plan and interventions for long term antibiotic use had not been addressed. She said MDS Coordinator was responsible for updating and revising the comprehensive care plans and the care plan had already been updated. She said if interventions were not included in the care plan, staff may not know (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident needs and changes in care provided. Record review of a facility policy titled Comprehensive Care Plan Revision dated 03/01/2022 reflected Policy Statement: An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. The Interdisciplinary Team documents in the CAT (Care Area Triggers) summary sheet and/or records in the clinical record: a. The residents' status in triggered CAT areas; b. The team's rationale for deciding whether to proceed with care planning; and c. Evidence that the team considered the development of care planning interventions for all CAT's triggered by the MDS. 3. Each resident's Comprehensive Care Plan has been designed to: a. Incorporate identified problem areas, b. Incorporate risk factors associated with identified problems; c. Build on the resident's strengths; d. Reflect treatment goals and objectives in measurable outcomes; e. Identify the professional services that are responsible for each element of care; f. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; and g. Enhance the optimal functioning of the resident by focusing on a rehabilitative program. 4. The resident's Comprehensive Care Plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MOS). 5. Care plans are revised as changes in the residents' condition dictate. Care plans are reviewed at least quarterly and any significant change in status. 6. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies.		

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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 12 residents and 1 of 1 medication rooms (Resident #26 and medication room B) reviewed for pharmacy services. 1. The facility failed to remove Resident #26's insulin that had expired on [DATE] from the nurse medication cart. 2. The facility failed to date when tuberculin PPD was opened. These failures could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications, decreased quality of life, and hospitalization. Findings: 1. Record review of Resident #26's facility face sheet revealed Resident #26 was a [AGE] year-old female that was admitted on [DATE] with a diagnosis of senile degeneration of the brain (impaired memory). Record review of Resident #26's comprehensive care plan dated [DATE] indicated Resident #26 had diabetes mellitus and was on insulin, to give diabetes medication as ordered by doctor and monitor for side effects and effectiveness. Record review of Resident #26's quarterly MDS assessment dated [DATE] revealed Resident #26 had a BIMS of 09 indicating moderately impaired cognition and had received insulin. Record review of Resident #26's order summary report dated [DATE] revealed Resident #26 had an order for Admelog SoloStar 100 unit/ml Solution pen-injector, and to inject as per sliding scale before meals and at bedtime. During an observation of station A's nurse medication cart on [DATE] at 8:15 am Resident #26 had a syringe of Admelog Solostar insulin that was in use on the cart and dated [DATE]. During an interview on [DATE] at 8:16 am LVN B said all insulin should be dated when opened and the nurses should use the insulin storage policy to ensure the insulin was replaced appropriately. She said that Admelog insulin was to be discarded after 28 days and was not sure how it was missed on the cart. She said that medications that were past the use by date could have decreased potency or adverse effects. During an interview on [DATE] at 9:55 am the DON said that when insulin was removed from the refrigerator and placed on the medication cart the nurses should date the syringe and use the insulin storage requirement tool to know how long the medication was good for. She said the nurses should be checking their medication carts regularly and before administering any medication to ensure that it was within date. She said she expected the nurses to follow the storage requirements for medications to prevent adverse reactions. Record review of an undated nurse tool titled Insulin Storage Requirements revealed Admelog Solostar was good for 28 days after opening at room temperature. 2. During an observation of the medication room located at station B with the DON on [DATE] at 8:00 am there was an opened undated bottle of tuberculin PPD (used to detect tuberculosis infection) (Aplisol) in the refrigerator. During an interview on [DATE] at 8:02 am the DON said that the charge nurses were responsible for the administration of TB, and the vial should be dated when opened because it was only good for 30 days. She said that using TB that was past the administration date could cause false readings or adverse reactions. During an interview on [DATE] at 8:11 am LVN B said that when a resident was admitted the nurse administered the TB to the resident. She said the nurse should check the dates before administering. She said the vial was good for 28 days after opening and should be dated when opened and disposed of after 28 days to avoid inaccurate results. During an interview on [DATE] at 10:13 am the Administrator said that the nurses were responsible for proper labeling and storage of multiuse vials and insulin. She said that all nurses were trained on hire and as needed on proper medication storage and labeling. She said that TB should be dated when it was opened and discarded by the directions and if used past the date could cause false readings or medication ineffectiveness. She said Insulin should be checked by the nurses before administering and not given if it was expired. She said insulin should be discarded per the medication guidelines to prevent any possible complications. Record review of an untitled nurse (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tool dated [DATE] indicated, .tuberculin purified protein derivative (Aplisol) keep refrigerated and discard opened product after 30 days. Record review of a facility policy titled Storage of Medications dated [DATE] revealed, .The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, 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 2 of 8 residents (Residents #49 and #53) reviewed for infection control. 1. The facility failed to ensure CNA C performed hand hygiene between glove changes during peri-care on 12/15/25 with Resident #49. 2. The facility failed to ensure CNA A and LVN B followed enhanced barrier precautions and wore a gown and gloves when providing direct care to Resident #53 on 12/15/2025. These failures could place residents at risk for cross contamination and infection. Findings: 1. Record review of a facility face sheet dated 12/16/25 for Resident #49 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including dementia and arthritis. Record review of a Quarterly MDS dated [DATE] for Resident #49 indicated a BIMS score of 10, which indicated he had moderately impaired cognition. He required total assistance with toileting hygiene. He was always incontinent of bowel and bladder. Record review of a comprehensive care plan dated 9/15/25 for Resident #49 indicated he was incontinent of bowel and bladder with an intervention to check every 2 hours and provide incontinent care as needed. During an observation on 12/15/25 at 10:41 am CNA A and CNA C were observed performing incontinent care on Resident #49. CNA C was observed to remove her gloves after completing incontinent care and proceeded to put on a clean pair of gloves before applying a clean brief without performing hand hygiene. During an interview on 12/15/2025 at 10:52 am, CNA C said she had been working here for about 6 years. She said she realized she had not sanitized between the last glove change, and she knew she should have. She said it was to prevent infections in residents. During an interview on 12/17/2025 at 9:06 am IP said she expected her staff to perform hand hygiene before and after care and with each glove change to help prevent an increased risk of infections in the residents. During an interview on 12/17/2025 at 9:56 am DON said she and IP were responsible for infection control. She said she expected her staff to properly perform hand hygiene by washing or sanitizing their hands between glove changes. She said the residents could be at an increased risk of infection if proper hand hygiene procedures were not followed. She said she would be educating staff on handwashing and monitoring closer for compliance going forward. During an interview on 12/17/2025 at 10:14 am Administrator said she expected staff to follow policy and procedures regarding hand hygiene before and after care, and between glove changes. She said residents could be exposed to infections if they are not followed. Record review of a Personnel Competency Review dated 12/17/25 for Fourth Quarter 2025 for CNA C, indicated she had been successfully checked off on perineal care and PPE. Record review of a facility policy titled Handwashing/Hand Hygiene dated 7/17/2012 read: .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternately, soap (antimicrobial or non-antimicrobial) and water for the following situations: .m. after removing gloves . and .perform hand hygiene before applying non-sterile gloves . 2. Record review of Resident #53's facility face sheet revealed Resident #53 was a [AGE] year-old male that admitted to the facility on [DATE] with a diagnosis of pneumonia. Record review of Resident #53's comprehensive care plan dated 12/05/2025 revealed Resident #53 was on enhanced barrier precautions due to pressure ulcers and proper use of PPE to be observed, use of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDRO. Record review of Resident #53's admission MDS assessment dated [DATE] revealed Resident #53 had a BIMS of 12 indicating moderately impaired cognition, was dependent on staff for all activities of daily living and had a pressure ulcer. Record review of Resident #53's order summary report dated 12/17/2025 did not reveal an order for EBP. During an observation on 12/15/2025 at 10:14 AM Resident #53 had a sign on his door indicating EBP, and there was a PPE cart inside the door of his room. During an observation on 12/15/2025 at 10:22 AM CNA A and LVN B entered Resident #53's (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room to reposition him. They both applied gloves but no gown and began providing care. Both adjusted his linen and lifted him into the bed and then readjusted his pillows and linens. They removed their gloves and performed hand hygiene before leaving the room. During an interview on 12/15/2025 at 10:25 AM CNA A said she was trained on EBP but had gotten confused on applying a gown and gloves for positioning. She said that she did make contact with the resident and his linens so she should have applied a gown and gloves before completing the task. She said by not following EBP she could spread infections to other residents. During an interview on 12/15/2025 at 10:26 am LVN B said she had received training on EBP and had also gotten confused on using a gown for positioning. She said the gown acted as a barrier between her and the resident and positioning a resident would require both gown and gloves. She said by not following EBP infections could spread. During an interview on 12/17/2025 at 9:03 am the Infection Preventionist said that she and the DON were responsible for oversight of the infection control program. She said that all staff were trained in EBP on hire, annually and as needed throughout the year. She said that EBP should be followed, and staff should be wearing a gown and gloves for high contact care to prevent the transmission of pathogens. She said she expected all staff to follow the infection control program. During an interview on 12/17/2025 at 9:55 am the DON said that she and the Infection Preventionist were responsible for oversight of the infection control program including EBP. She said that for residents that require EBP staff should be wearing gowns and gloves with all high contact care. She said she expected EBP to be followed every time high contact care was given to prevent the spread of infections. During an interview on 12/17/2025 at 10:13 am the Administrator said that the DON and Infection Preventionist were responsible for oversight of the infection control program. She said all staff were trained in EBP on hire, yearly and as needed, including competency checks for EBP. She said she expected all staff to follow the infection control policy and procedures to prevent the spread of infections. Record review of a course completion history report dated 12/17/2025 indicated CNA A had completed EBP training on 7/23/25 and LVN B had completed EBP training on 8/05/2025. Record review of an undated staff tool titled Enhance Barrier Precautions indicated, .Wear gown and gloves for high contact care including:DressingBathing/showeringTransferringProviding hygieneChanging linens Changing briefs or assisting with toiletingDevice care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilatorWound care: any skin opening requiring a dressing . Record review of a facility policy dated 6/17/2024 titled Enhanced Barrier Precautions indicated, .Enhanced Barrier Precautions shall be used at this facility per CDC requirements.		