Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676406	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trucare Living Centers - Selma	16550 Retama Parkway Selma, TX 78154

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the physician reviewed the resident's total program of care, including medications and treatments, and write, sign, and dated progress notes at each visit for 4 of 5 residents (Resident #1, #2, #4, and #5) reviewed for physician visits for 1 of 2 physicians (Physician A), in that:1. Resident #1's physician (Physician A) did not provide physician visit notes between 06/08/2025 and 04/22/2026 when Physician A reported he had seen Resident #1 every other month.2. Resident #2's physician (Physician A) did not provide any physician visit notes since the resident's readmission on [DATE] when Physician A reported he had seen Resident #2 every other month.3. Resident #4's physician (Physician A) did not provide any physician visit notes since the resident was admitted to the facility on [DATE] when Physician A reported he had seen Resident #4 every other month and had last seen her in February 2026.4. Resident #5's physician (Physician A) did not provide any physician visit notes since the resident was admitted to the facility on [DATE] when Physician A reported he had had seen Resident #5 every other month and had last seen the resident in February 2026.This deficient practice could place residents at-risk for any physician identified concerns, inadequate monitoring of medical conditions and miscommunication with other health care providers.Findings Include:1. Record review of Resident #1's admission Record (Face Sheet) dated 04/26/2026, revealed she was admitted on [DATE] with diagnoses which included Hypertension Encephalopathy (severe increase in blood pressure that leads to brain swelling), rotator cuff (shoulder muscles) tear of right shoulder, anxiety disorder (excessive persistent fear or worry that interferes with daily life), low blood pressure, stroke, and high blood pressure; and Physician A was her primary medical doctor.Record review of Resident #1's MDS, a Quarterly assessment dated [DATE], revealed a BIMS score of 15 out of 15, and was independent in her cognitive skills for daily decision making.Record review of Resident #1's electronic clinical record progress notes from 06/03/2025 to 04/26/2026 revealed she had a visit note from Physician A on 06/08/2025 and on 04/22/2026, with no visit notes from Physician A between 06/08/2025 to 04/22/2026.Record review of Resident #1's electronic clinical record progress notes from 06/03/2025 to 04/26/2026 revealed there were visit progress notes from the following providers:NP C06/03/2025,06/05/2025,06/12/2025,06/19/2025,07/01/2025,07/03/2025,07/08/2025,07/15/2025,07/17/2025,(and12/08/2025. NP B06/22/2025,06/25/2025, and06/27/2025.PA D 01/07/2026,01/12/2026,01/21/2026,02/13/2026,03/04/2026,04/01/2026,04/13/2026, 04/15/2026, and04/20/2026.2. Record review of Resident #2's admission Record, dated 04/26/2026, revealed she was admitted on [DATE] and readmitted on [DATE] with diagnoses which included pneumonia (lung infection), swallowing difficulties, anemia (low iron stores in the blood), cognitive communication deficit (difficulty speaking due to memory dysfunction), atrial fibrillation (chronic heart rhythm disorder causing the heart to beat irregularly), high blood pressure and diabetes (chronic elevated blood sugars due to insufficient insulin production); and her primary physician was Physician A.Record review of Resident #2's MDS, an Annual assessment dated [DATE], revealed her BIMS score was 0 out of 15, which indicated her cognitive skills for daily decision making were severely (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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impaired.Record review of Resident #2's electronic clinical record progress notes from 01/13/2026 to 04/26/2026 revealed there were no physician visit progress notes from Physician A.Record review of Resident #2's electronic clinical record progress notes from 01/13/2026 to 04/26/2026 revealed there were visit progress notes from PA D on 01/14/2026, 01/16/2026, 01/19/2026, 01/21/2026, 01/23/2026, 01/26/2026, 01/28/2026, 01/30/2026, 02/02/2026, 02/04/2026, 02/06/2026, 02/09/2026, 02/11/2026, 02/13/2026, 02/13/2026, 03/11/2026, 03/13/2026, 04/15/2026, and 04/24/2026.3. Record review of Resident #4's admission Record dated 04/26/2026, revealed she was admitted on [DATE] with diagnoses which included lymphedema (chronic condition that causes swelling in extremities due to lymphatic fluid buildup), high blood pressure, hyperlipidemia (elevated blood level of fats, cholesterol and triglycerides), chronic obstructive pulmonary disease (chronic lung disease that restricts airflow, making breathing difficult), and cellulitis (bacterial skin infection) of a limb (leg or arm); and her primary physician was Physician A.Record review of Resident #4's MDS, a Quarterly assessment dated [DATE], revealed a BIMS score of 12 out of 15, which indicated her cognitive skills for daily decision making were moderately impaired.Record review of Resident #4's electronic clinical record progress notes from 10/17/2025 to 04/26/2026 revealed there were no physician visit progress notes from Physician A.Record review of Resident #4's electronic clinical record progress notes from 10/17/2025 to 04/26/26 revealed there were visit progress notes from the following providers:NP C10/20/2025 and 12/04/2025.PA D12/31/2025,01/12/2026,02/17/2026,02/19/2026,03/11/2026, and 04/15/2026.4. Record review of Resident #5's admission Record dated 04/26/2026, revealed she was admitted on [DATE] with diagnosis of anxiety disorder (excessive persistent fear or worry that interferes with daily life), hyperlipidemia (elevated blood level of fats, cholesterol and triglycerides), bipolar disorder (chronic mental health condition characterized by intense mood swings with emotional highs and lows), neuromuscular dysfunction of the bladder (nerve damage that causes loss of bladder control), and fibromyalgia (chronic disorder characterized by widespread musculoskeletal pain and fatigue); and her primary physician was Physician A.Record review of Resident #5's MDS, an Annual assessment dated [DATE], revealed a BIMS score of 15 out of 15, and she was independent in her cognitive skills for daily decision making.Record review of Resident #5's electronic clinical record progress notes from 02/05/2025 to 04/26/2026 revealed there were no physician visit progress notes from Physician A.Record review of Resident #5's electronic clinical record progress notes from 02/05/2025 to 04/26/2026 revealed there were visit progress notes from the following providers:NP B02/22/2025,02/27/2025,03/16/2025 and05/29/2025. NP C 08/11/2025,09/23/2025,10/15/2025,10/22/2025,11/14/2025, and12/22/2025. PA D01/14/2026,01/17/2026,02/09/2026,03/02/2026,03/04/2026,03/16/2026,03/18/2026,03/20/2026,03/23/2026,(and04/24/2026.In an interview on 04/26/2026 at 3:36 p.m., the DON said Physician A was in the facility weekly to see his residents and did not know why the physician did not have any progress notes for Resident #2, #4, and #5; or any further notes for Resident #1.In a telephone interview on 04/26/2026 from 3:40 p.m. to 3:53 p.m., Physician A said he was in the facility weekly to see residents along with his PA (PA D) who was in the facility three times a week. Physician A said he would write a visit note in the residents' electronic clinical record after each visit. Physician A said that he looked at Resident #2's, Resident #4's, and Resident #5's clinical record, he did not see his physician notes in their electronic clinical record, and he must not have put a note in their electronic clinical record. Physician A stated he was sure he visited Resident #1, Resident #2, Resident #4 and Resident #5 in February 2026 because he saw all his residents that month. Physician A said that he had seen Resident #1, Resident #2, Resident #4, and Resident #5 numerous times during their stay at the facility. Physician A said that he would visit all his skilled nursing facility residents once a month for the first three months, then the long-term care residents he would visit them every two to four months, depending on their acuity level, and his visits are alternated by the NP or PA who would see the residents at least monthly.In a telephone interview on 04/26/2026 at 3:55 p.m., the Administrator (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Trucare Living Centers - Selma		STREET ADDRESS, CITY, STATE, ZIP CODE 16550 Retama Parkway Selma, TX 78154	

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said she would check the residents' electronic clinical record after a physician has visited the facility to ensure they have a note in the residents clinical record but a lot of times they [the physicians, NPs, PAs] do not write the note right away and will write the notes a couple of days later. The Administrator stated they did not have a policy on accuracy of clinical records or ensuring the physician wrote a note after each visit. The Administrator stated she did not see any harm that could happen to a resident by not having a physician visit in the electronic clinical record because Physician A was in the facility weekly and he was in communication with the nurses, Administrator, and the DON.