STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676406	A. Building B. Wing	02/13/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food for 1 of 1 kitchen in accordance with professional standards for food service safety. The facility failed to keep a crate of milk off the floor. The facility failed to date items in the nourishment refrigerator. The facility failed to label items in the nourishment refrigerator/freezer. This deficient practice could place residents at risk for food borne illness.The findings include: Observation on 02/10/2026 at 9:30 a.m., of the kitchen refrigerator revealed the following: -1 crate of individual milk boxes on the floor under shelving During an interview on 02/10/2026 at 9:55 a.m., the DM stated that items in the fridge should be 8 inches from the floor and 16 inches from the ceiling. The DM stated the risk to the residents for leaving items on the floor in the refrigerator could be mold, a dirty floor or critters getting into the items. The DM stated items are labeled with a date, so they know when the item was opened and when they are getting ready to expire. The DM stated if there were no dates on opened items they would not know when they were opened. During an interview on 2/12/2026 at 11:46 a.m., the DM stated they were not sure who was responsible for the nourishment refrigerator. Observation on 02/12/2026 at 11:54 a.m., of the nourishment refrigerator/freezer revealed the following: -1 cottage cheese, with no seal and a lid, with no open date or resident name -1 sealed cottage cheese with no resident name -3 [NAME] homestyle chicken noodle soups with no resident names -1 [NAME] chicken soup with no resident name -1 Amy's frozen cheese enchiladas meal with no resident name During an interview on 02/12/2026 at 11:54 a.m., the DON stated they were unsure of who was responsible for the nourishment refrigerator. The DON stated items in the nourishment refrigerator/freezer should have the resident's names on them and if opened the date when the item was opened. The DON stated the risk could be someone else being able to take the item and if the item had no date, it would be thrown away. During an interview on 02/12/2026 at 1:51 p.m., the DDM stated there is no specific policy regarding the nourishment refrigerator/freezer, During an interview on 02/12/2026 at 2:22 p.m., the Administrator stated the dietary department is responsible for the nourishment refrigerator. Record review of the facilities policy, Food Storage: Cold Foods, revised date 2/2023, reflected: Procedures All food items will be stored 6 inches above the floor and 18 inches below the sprinkler unit.

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to permit a resident to return to the facility after being hospitalized and failed to document sufficient preparation and orientation to residents to ensure a safe and orderly transfer or discharge from the facility for 1 of 3 residents (Resident #18) reviewed for transfer and discharge rights:The facility failed to ensure Resident #18 was readmitted to the facility, after being sent to the hospital on 1/19/26 for evaluation and treatment related to behavioral symptoms. The facility did not document Resident 18's medical record the reason for not accepting Resident #18 to return to the facility.This failure could place discharged residents and residents residing in the facility at risk of being discharged and not allowed to return to the facility causing a disruption in their care and/or services.The findings included:Record review of Resident #18's face sheet dated 2/10/26 reflected an [AGE] year-old female admitted to the facility on [DATE] and discharged on 1/19/26 with diagnoses that included diabetes, depression, and hypercholesterolemia (high cholesterol levels in the blood).Record review of Resident #18's most recent quarterly MDS assessment dated [DATE] reflected the resident was cognitively intact for daily decision-making skills.Record review of Resident #18's comprehensive care plan with revision date of 5/13/25 reflected the resident had dementia and was at risk for cognitive decline in decision-making skills with interventions that included frequent interactions with the resident to ensure all needs were being met. Resident #18's comprehensive care plan reflected the resident had the potential to demonstrate behaviors related to dementia including being accusatory, alleging personal items were being stolen, refusing medications, and assistance with personal care. Resident #18's comprehensive care plan reflected discharge planning expectation, based on care plan meetings and talking with family was for long term care with interventions that included discharge planning to include medication management.Record review of Resident #18's Psychiatric Initial Evaluation dated 12/15/25 and completed by the Psych NP reflected Resident #18's treatment recommendations that included psychotherapy evaluation and treatment, behavior management techniques, and recommendation for major depressive disorder management the resident declined medications but was agreeable to psychotherapy. Record review of Resident #18's Hospital Transfer Form dated 1/19/26 reflected the reason for transfer to the hospital was related to behavioral symptoms (e.g. agitation, psychosis). Record review of Resident #18's progress notes dated 1/19/26 and time stamped 10:27 a.m. and authored by the SW reflected the resident was having increased behaviors, going in and out of resident rooms, raising her voice, and threatened to fire the SW. The SW documented, after meeting with the IDT, SW will be looking for alternate placement, as this may no longer be the best fit for the resident.Record review of Resident #18's progress notes dated 1/19/26 time stamped 10:40 a.m. (late entry) and authored by the SW reflected, Psych NP, who inquired about a UTI and testing resident for a UTI. (Psych) NP spoke with nursing before meeting with resident.Record review of Resident #18's progress notes dated 1/19/26 time stamped 12:30 p.m. and authored by LVN B reflected in part, Resident #18 accused CNA C of stealing her phone and the resident grabbed CNA C's scrub top causing her to fall on the floor. Record review of Resident #18's progress notes dated 1/19/26 time stamped 12:40 p.m. and authored by the Psych NP reflected in part, Resident #18 was approached by the Psych NP and observed agitated, yelling, and verbally hostile. The Psych NP documented Resident #18 accused the Psych NP of stealing her watch and the resident attempted to strike at me by swinging her arm toward my face. The Psych NP documented Resident #18 did not respond to de-escalation attempts and remained verbally aggressive and noncompliant at the time of the incident. Per chart history, patient has a baseline of delusional thinking, including beliefs that medications are poison. Patient routinely refuses prescribed medications and does not comply with laboratory testing or urine analysis (UA) due to these beliefs. Provider advised for patient to be sent (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out to hospital for further medical evaluation.Record review of Resident #18's progress notes dated 1/19/26 time stamped 1:15 p.m. and authored by LVN B reflected the Psych NP recommended Resident #18 be sent out because she was a danger to other residents and the residents family member was made aware of clinical situation and the resident would be sent out to the hospital. During a telephone interview on 2/11/26 at 8:20 a.m., Resident #18's family member stated the resident was in the hospital beginning 1/19/26 and even before the resident was medically cleared from the hospital, the facility SW reached out to her to inform her the facility didn't want to take back Resident #18 due to safety concerns for their employees, but if the facility could not find placement, then the resident would be allowed back to the facility temporarily until they found alternate placement. Resident #18's family member stated, they dumped her (Resident #18). Resident #18's family member stated there was no care plan meeting, no discussion about discharge, only that she was notified about placement to a facility where the resident could be accepted but, the facility they sent her (Resident #18) to was of less caliber. Resident #18's family member stated the hospital case manager arranged for the resident's transfer to the new facility. During a telephone interview on 2/11/25 at 3:28 p.m., the Psych NP stated she had visited Resident #18 for a follow up on 1/19/26 and was walking into the facility when she received a text message from the SW about Resident #18 beating up a CNA. The Psych NP stated she met Resident #18 in the activity room and the resident accused her of stealing her watch. The Psych NP stated Resident #18 raised her arm to strike her, but the Psych NP blocked the resident. The Psych NP stated, Resident #18 had a history of verbal aggression, and delusions, but the physical aggression was a new onset, it was something they had not seen before. The Psych NP stated, I let the nurses know about the suspicion of a UTI. The Psych NP stated, my line of thinking was, yes, she (Resident #18) has had delusions, but this level of aggression was new onset for her, so I suspected UTI. The Psych NP stated she wanted Resident #18 to be sent to the hospital to rule out a UTI and then proceed further based on the results to determine if her behavior was medically or psychiatrically related. The Psych NP stated as of the time of the telephone interview she was not sure where Resident #18 was, believed the resident was not back in the facility, did not know if the resident remained in the hospital, and believed the facility would have been notified if Resident #18 required a higher level of care based on a psychiatric issue, but I was not notified of that.During an interview on 2/11/26 at 3:48 p.m., LVN B stated Resident #18 had a history of verbal aggression, had hallucinations, but did not recall the resident displaying physical aggression. LVN B stated she was ordered by the Psych NP on 1/19/26 to transfer Resident #18 to the hospital because she was a danger to other residents in the facility. LVN B stated the Psych NP said the resident was being combative and needed psychiatric evaluation and the resident might have a UTI because the resident did not normally act that way. LVN B stated she was unsure if Resident #18 was still in the hospital at the time of the interview and assumed the resident was sent to another facility that had a locked down unit. LVN B stated that discharges from the facility included a medication reconciliation, a final discharge review, and a written progress note in the resident's record that indicated the resident was discharged and the resident condition at the time of the discharge. LVN B stated she was not aware of the facility declining Resident #18 from returning to the facility from the hospital and stated, they (residents) should come back (to the facility) once stable, it it's a suitable environment.During an interview on 2/11/26 at 4:48 p.m., the SW stated the IDT had a meeting on 1/19/26, without Resident #18's family member, related to the resident attacking a CNA C and almost striking the Psych NP. The SW stated, the Psych NP believed the resident had a UTI, but also wanted the resident sent to the hospital because the Psych NP believed Resident #18 was a threat to everybody around her. The SW stated she made contact with Resident #18's family member about referral to other facilities. The SW stated Resident #18's family member had questions about the resident being admitted back to the facility, but was told it was hard to accept her (Resident #18) back with her aggression, and she (family member) said ?but you don't know if she will do it again', but we could not take that chance. The SW stated the hospital (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determined Resident #18 had a UTI and because the resident refused to take medications, and she developed another UTI, the resident would not comply with treatment. The SW stated, no 30-day notice was given, no discharge summary was done. The SW stated, with a proper discharge, there would have to be a Discharge Planning Review, a Comprehensive Discharge Instruction Form, and the Final Discharge Summary completed. The SW stated, those forms were done collaboratively with herself and Nursing. The SW stated the aforementioned documents were not completed and should have been completed. The SW stated, we did not follow the policy, and that was not good, but thought that it was still proper (discharge) for the safety of the other residents.During an interview on 2/12/26 at 8:13 a.m., the DON stated, a proper discharge for a resident transferred to another facility or to their home consisted of a 30-day notice, arrangement for durable medical equipment, information regarding follow-up doctor appointments, and a supply of at least 7 days of medication provided to the resident at the time of discharge. The DON stated, in the case of an emergency situation in which a resident went to the hospital, the 30-day notice did not apply. The DON stated the discharge process consisted of three different assessments, which included a comprehensive assessment, a final discharge summary, and a discharge planning review. The DON stated that for a resident transferred to the hospital, a change of condition form was required. The DON stated Resident #18 was sent to the hospital related to physical aggression, and because of the aggression the resident was not allowed back to the facility for the safety of other residents and the staff. The DON stated he believed Resident #18 was accepted at another nursing facility but did not know where the resident was at the time of the interview. The DON stated, it was not a proper discharge, but we are obligated to keep everybody safe. The DON would not or could not elaborate on what a safe, proper discharge was.During an interview on 2/12/26 at 4:15 p.m., the Administrator stated, Resident #18 was diagnosed with a UTI while she was at the hospital beginning 1/19/26. The Administrator stated, the hospital would keep Resident #18 until she was ready to be discharged . The Administrator stated the SW reached out to the family about alternate placement while the resident was still in the hospital. The Administrator stated that the SW secured placement at another nursing facility and notified the resident's family member, but the family did not like the nursing facility Resident #18 had been referred to. The Administrator stated, we would not accept her (Resident #18) back because she was literally going after people, and it was an emergency, and if she comes back and hurts somebody, I felt like I did not have another choice, she (Resident #18) was that dangerous and in this care it was an emergency and a proper discharge. The Administrator stated she did not know where Resident #18 was at the time of the interview.Record review of the facility document titled Discharge Planning and Assessments with revision date 4/5/13 reflected in part, .Facility will develop and implement an effective discharge planning process that focuses on the resident's goals, the preparation of residents to be active partners and effectively transition them to post-discharge care.Social Services or Designee will complete a Discharge Planning Review in [computer system] prior to the first comprehensive assessment.This form must be updated, as needed, to reflect any changes that may have occurred until discharge status is confirmed.When the facility anticipates a resident's discharge to a private residence or another nursing care facility.the following actions must be completed, which will assist the resident to adjust to his or her new living environment.Medical Records or Designee to obtain a discharge order from the physician.Complete the following assessments in [computer system].Comprehensive Discharge Instruction Form [Post Discharge Plan]; and Final Discharge Summary.Final Discharge Summary.These summaries will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to send a copy of the residents' discharge notice, prior to discharge, to the representative of the Office of the State Long-Term Care (LTC) Ombudsman of the residents' transfer or discharge and the reasons for the move, for 1 of 3 residents (Resident #18) reviewed for notifying the LTC Ombudsman of the residents' discharge.Resident #18 was discharged on 1/19/26 without any notice to the State LTC Ombudsman.This failure could place residents at risk of not knowing their rights or receiving the services of the State LTC Ombudsman.The findings included:Record review of Resident #18's face sheet dated 2/10/26 reflected an [AGE] year-old female admitted to the facility on [DATE] and discharged on 1/19/26 with diagnoses that included diabetes, depression, and hypercholesterolemia (high cholesterol levels in the blood).Record review of Resident #18's most recent quarterly MDS assessment dated [DATE] reflected the resident was cognitively intact for daily decision-making skills.Record review of Resident #18's comprehensive care plan with revision date 5/9/23 reflected discharge planning expectation, based on care plan meetings and talking with family was for long term care with interventions that included discharge planning for medication management and the resident's family or friend support network to be included in discharge planning if discharge was optional.Record review of Resident #18's Hospital Transfer Form dated 1/19/26 reflected the reason for transfer to the hospital was related to behavioral symptoms (e.g. agitation, psychosis). Record review of Resident #18's medical record revealed no evidence of a discharge notice to the State Ombudsman.During a telephone interview on 2/11/26 at 8:20 a.m., Resident #18's family member stated the resident was in the hospital beginning 1/19/26 and even before the resident was medically cleared from the hospital, the facility SW reached out to her to inform her the facility did not want to take back Resident #18 due to safety concerns for their employees, but if the facility could not find placement, then the resident would be allowed back to the facility temporarily until they found alternate placement. Resident #18's family member stated, they dumped her (Resident #18). Resident #18's family member stated there was no care plan meeting, no discussion about discharge, only that she was notified about placement to a facility where the resident could be accepted but, the facility they sent her (Resident #18) to was of less caliber. Resident #18's family member stated the hospital case manager arranged for the resident's transfer to the new facility. During a telephone interview on 2/11/25 at 1:42 p.m., the State LTC Ombudsman stated she did not receive notification regarding Resident #18's discharge to the hospital or discharge to another facility. The State LTC Ombudsman stated she searched through her files and e-mails regarding facility notification for Resident #18's discharge and although was able to locate discharge notification for 3 other residents from the same facility, she could not locate a discharge notification for Resident #18. The State LTC Ombudsman stated, typically, discharge information was provided to her from the facility by the Administrator. The State LTC Ombudsman stated in part, what facilities should be doing is, every month, first of every month.provide me with full discharges, with full name, date, and where they (the resident) went. That is a federal regulation. During a follow up telephone interview on 2/11/26 at 2:24 p.m., Resident #18's family member stated she contacted the State LTC Ombudsman and was instructed to call the HHSC state hotline and report that the facility failed to give a 30-day discharge notice. During an interview on 2/12/26 at 4:15 p.m., the Administrator stated she did not notify the State LTC Ombudsman regarding Resident #18's discharge because it was not considered a 30-day discharge because the resident was sent to the hospital on an emergency basis related to aggressive behavior. The Administrator stated, for a 30-day I would have (notified the Ombudsman), but I did not in this case.Record review of the facility document titled Transfer or Discharge, Emergency with revision date 3/14/19 reflected in part, .Emergency transfers or discharges may be necessary to protect the health and/or well-being of the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident(s).Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures.Notify the State Ombudsman when practicable.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for 2 of 6 residents (Resident #3 and Resident #6) who were reviewed for resident assessments. 1. The facility failed to correctly document Resident #3's use of insulin injections on the quarterly MDS assessment. 2. The facility failed to correctly document Resident #6's use of antidepressant medications on the quarterly MDS assessment. These failures could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included: 1. Record review of Resident #3's admission sheet dated 01/13/2026 with an original admission date of 4/26/2022 documented a [AGE] year-old female resident with diagnoses including depression, cerebral infarction (stroke), type 2 diabetes mellitus, hyperlipidemia (high cholesterol), and hypertension (high blood pressure). Record review or Resident #3's MDS assessment dated [DATE] documented a BIMS score of 0 indicating severe cognitive impairment and recorded the use of antidepressant, anticoagulant, antibiotic, and hypoglycemic medications. Further review of the MDS noted an answer of 5 in Section N - Medications N0350 Insulin A. Insulin injections Record the number of days that insulin injections were received during the last 7 days or since admission if less than 7 days. Record review of Resident #3's order summary included an order for the insulin Humalog with an order date of 8/04/2025 and an order for the insulin Lantus with an order date of 01/13/2026. Humalog was ordered as Humalog 100 unit/mL, Inject as per sliding scale: if 100-149=0; 150-199=2; 200-249=4; 250-299=6; 300-349=8; 350-399=10 if>400 contact MD/NP. Lantus was ordered as Lantus 100 unit/mL, Inject 5 unit subcutaneously at bedtime. Record review of Resident #3's January 2026 MAR documented the resident received injections of Lantus on 7 days during the 7 day look back period from 01/14/2026 through 01/20/2026. Further review of the January MAR documented the resident received injections of Humalog on 7 days during the 7 day look back period from 01/14/2026 through 01/20/2026. Record review of Resident #3's care plan with an initiation date of 5/11/2022 documented the resident has Diabetes Mellitus with interventions including Monitor/document/report to MD PRN s/sx of hypoglycemia: Sweating, Tremor, Increased heart rate (Tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait and Monitor/document/report to MD PRN for s/sx of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abd pain, Kussmaul breathing, acetone breath (smells fruity), stupor, coma. 2. Record review of Resident #6's admission sheet dated 5/03/2025 documented a [AGE] year-old male resident with diagnoses including dementia, depression, anxiety, hypertension, and chronic pain. Record review of Resident #6's MDS assessment dated [DATE] documented a BIMS score of 5 indicated severe cognitive impairment and recorded the use of antianxiety and opioid medications. Further review of the MDS revealed the assessment did not include the use of antidepressant medication in section N0415 High-Risk Drug Classes: Use and Indication. Record review of Resident #6's order summary included an order for the antidepressant medication Effexor XR with an order date of 6/29/2025. Effexor XR was ordered as Effexor XR 150 mg, Give 1 capsule by mouth one time a day. Record review of Resident #6's November 2025 MAR documented the resident had been receiving Effexor XR as prescribed during the 7 day look back period from 11/19/2025 through 11/25/2025. Record review of Resident #6's care plan with an initiation date of 5/05/2025 documented the resident uses antidepressant medication with interventions including Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness. ANTIDEPRESSANT SIDE EFFECTS: dry mouth, dry eyes, constipation, urinary retention, suicidal ideations. During an interview with the MDS Coordinator on 2/12/2026 at 9:45 AM, the MDS Coordinator stated they follow the RAI manual regarding formulation of the MDS assessment. The MDS Coordinator stated after they have gathered the information for the MDS assessment, she sends it to corporate for a scrub down and to (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	make corrections if needed, then the assessment is given to the DON for signature before transmission. The MDS Coordinator stated the assessment should be accurate, and she was responsible for making sure it was accurate before it was transmitted. The MDS Coordinator stated it was important for the MDS to be accurate because it is a reflection of the care a resident is receiving at the facility. During an interview with the DON on 2/12/2026 at 10:09 AM the DON stated the MDS should be accurate in order to provide the best care for residents. The DON further stated his expectation for staff is to get the best, most accurate data for the MDS and care plan. During a second interview with the DON on 2/12/2026 at 11:12 AM, the DON stated they follow the RAI regarding MDS assessments. Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1, dated October 2025 noted in Section N: Medications The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident. Section N0415: High-Risk Drug Classes: Use and Indication noted Code all high-risk drug class medications according to their pharmacological classification, not how they are being used. Column 1: Check if the resident is taking any medications by pharmacological classification during the 7-day observation period (or since admission/entry or reentry if less than 7 days).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure preadmissions screening for individuals with a mental disorder and individuals with intellectual disability for 1 of 6 residents (Resident #39) reviewed for PASARR accuracy. The MDS Case Manager failed to accurately screen Resident #39 for mental illness upon admission to the facility. This deficient practice could place the residents at risk of not receiving the necessary care and services. The findings included:Record review of Resident #39's face sheet, dated 02/11/2026, revealed a [AGE] year-old female admitted to the facility on [DATE] with a primary diagnosis of spinal stenosis, lumbar region with neurogenic claudication (narrowing of spinal canal which can lead to nerve compression). Record review of Resident #39's MDS, dated [DATE], revealed the resident's BIMS score was a 15 out of 15 which suggested the resident's cognition was intact for daily decisions. Record review of Resident #39's diagnosis information on the face sheet dated 02/11/2026 revealed a diagnosis of bipolar disorder, unspecified, (a mental condition characterized by significant mood swings, including manic episodes and depressive episodes) with an onset date of 02/05/2025. Record review of Resident #39's PASARR Level 1 screening, dated 02/05/2025 and completed at the hospital, revealed section C0100. Mental Illness: Is there evidence or an indicator this is an individual that has a mental illness recorded as a no. Record review of Resident #39's PASARR Level 1 screening, dated 02/05/2025 and completed at the nursing facility, revealed section C0100. Mental Illness: Is there evidence or an indicator this is an individual that has a mental illness recorded as a no. During an interview on 02/13/2026 at 8:45 a.m., the MDS Case Manager stated they were responsible for looking over PASSAR documents when a resident is admitted and reviews the clinical record for accuracy for the PASSAR assessment. The MDS case manager confirmed Resident #39 were marked as no for mental illness on their PASSAR. The MDS case manager confirmed Resident #39 having a mental illness. The MDS case manager stated the importance of an accurate PASSAR would be residents being able to receive the specialized serves or counseling they require. During an interview on 02/13/2026 at 9:26 a.m., the MDS case manager stated they did not have a policy for PASSAR assessments.

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Trucare Living Centers - Selma	16550 Retama Parkway Selma, TX 78154

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 resident environment remained as free of accident hazards as was possible for 1 of 18 residents (Resident #5) reviewed for accidents and hazards:The facility failed to ensure Resident #5 did not have a pair of scissors in his room.This failure could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health. The findings included:Record review of Resident #5's face sheet dated 2/13/26 reflected a [AGE] year old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included reduced mobility, dementia, anxiety disorder, restless leg syndrome, and hemiplegia (complete paralysis of one side of the body) and hemiparesis (weakness of one side of the body) affecting right dominant side.Record review of Resident #5's most recent quarterly MDS assessment dated [DATE] reflected the resident was moderately cognitively impaired for daily decision-making skills and required substantial to maximal assistance with ADLs.Record review of Resident #5's comprehensive care plan with revision date 6/16/25 reflected the resident had an ADL self-care performance deficit related to impaired balance. Record review of Resident #5's Functional Abilities and Goals document dated 6/16/25 reflected the resident required substantial/maximal assistance with upper body dressing including the ability to dress and undress above the waist, including fasteners.During an observation on 2/12/26 at 9:34 a.m., Resident #5 was observed with a blue handle pair of scissors on the top of a chest of drawers located at the foot of the bed. During an observation on 2/13/26 at 8:06 a.m., Resident #5 was observed with a blue handle pair of scissors on the top of a dresser next to the resident's television. During an observation and interview on 2/13/26 at 8:09 a.m., CNA D observed a pair of blue handle scissors on Resident #5's dresser and stated, he probably should not have them (scissors) because it was a potential for an accident. CNA D stated items such as scissors, or disposable razors were sharp and could cause injury to the resident if it not used properly and it was also a hazard because there were other residents in the unit who wandered into resident rooms, and they could have access and get hurt. CNA D stated he tried to make rounds at least every two hours and sometimes more often and one of the things he looked for were items such as scissors. CNA D stated the scissors in Resident #5's room would have to be reported to the charge nurse or the administrative staff.During an interview on 2/13/26 at 8:15 a.m., Resident #5 stated he did not know there was a pair of blue handle scissors in his room and denied ever seeing them or using them.During a joint interview on 2/13/26 at 8:43 a.m., the DON and Administrator stated there was an ongoing issue with Resident #5's family taking scissors from the activity room and using them in the resident's room. The DON stated the facility had a system in process where a staff was assigned to a unit to monitor for items such as scissors and rounding occurred before their morning meetings or in the afternoons. The DON stated the facility had residents who wandered and for Resident #5 to be allowed to have access to the scissors, he would have to be assessed for safety, and it would have to be care planned. The Administrator stated, if a resident gained access to the scissors, they could cut themselves or hurt themselves. Record review of the facility document titled Safety and Supervision of Residents with revision date 12/13/17 reflected in part, .Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes.Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles for 1 of 2 medication carts (the 300/400 hall medication aide cart) assessed for medication storage and labeling. The facility failed to ensure all medications located inside the 300/400 hall medication aide cart were stored in properly labeled containers. This failure could place residents at risk of receiving inadequate treatments or ingesting medications for which they were not prescribed.The findings included: During an observation of the 300/400 hall medication aide cart on 02/12/2026 at 8:10 AM, a clear dosing cup with loose pills was observed sitting in the drawer of the medication cart. During an interview with MA A on 02/12/2026 at 8:10 AM, MA A stated that dosing cups with pills should not be left in the cart. MA A further stated that the pills in the cup should have been disposed of if they were not going to be administered immediately. MA A stated if pills were left in dosing cups to be administered at a later time, the person administering the medications could be confused and give the pills to the wrong resident. During an interview with the DON on 02/12/2026 at 10:09 AM, the DON stated pills that are not dispensed should not be left in the cart. The DON stated his expectation for staff was they should dispose of any medications that could not be administered, and that staff should not have put pills into a dosing cup if a resident was not present to take them, or if they had not checked with the resident first to ensure they were ready to take them. The DON stated if medications were left in the carts in dosing cups it could cause a medication error, because if there was no label, the medication could be given to the wrong resident. Record review of the facility policy titled Labeling of Medication Containers with a revision date of April 2007 noted All medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 of 2 residents (Residents #5) reviewed for infection control:The facility failed to ensure CNA E utilized proper hand hygiene between glove changes and did not place a clean brief on the resident's bed during incontinent/peri-care on Resident #5. This failure could place residents at-risk for infection due to lack of hand hygiene and could result in infection or illness.The findings included:Record review of Resident #5's face sheet dated 2/13/26 reflected a [AGE] year old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included reduced mobility, dementia, anxiety disorder, restless leg syndrome, and hemiplegia (complete paralysis of one side of the body) and hemiparesis (weakness of one side of the body) affecting right dominant side.Record review of Resident #5's most recent quarterly MDS assessment dated [DATE] reflected the resident was moderately cognitively impaired for daily decision-making, required substantial to maximal assistance with ADLs, and was frequently incontinent of bladder and bowel. Record review of Resident #5's comprehensive care plan with revision date 6/16/25 reflected the resident had bladder incontinence with interventions that included for staff check for incontinence and wash, rinse, and dry perineum. Resident #5's comprehensive care plan reflected the resident was incontinent of bowel with interventions that included to check the resident every two hours, assist with toileting, and provide peri care after each incontinent episode.Observation on 2/12/26 at 9:34 a.m., during incontinent/peri care revealed Resident #5 was instructed by CNA E to roll over to his right and was observed with copious amounts of stool. CNA C handed CNA E disposable wipes and CNA E used several wipes to clean the stool off the resident. CNA E then removed the soiled brief from the bed and tossed it in the trash. CNA E then removed her soiled gloves, did not wash her hands with soap and water, sanitized her hands and put on a new pair of gloves. CNA E then took a clean brief and placed it on the resident's bed. CNA E then retrieved more disposable wipes from CNA C and continued to clean stool from Resident #5's anal area. CNA E then removed her gloves, did not wash her hands with soap and water, sanitized her hands, and put on a new pair of gloves. CNA E then took the brief resting on the bed and placed it on the resident. CNA E, after completing incontinent/peri care to Resident #5, fastened the resident's brief, took the resident's pajama pants and put them on Resident #5. CNA E then removed her gloves and sanitized her hands. During an interview on 2/12/26 at 9:50 a.m., CNA E stated she realized Resident #5 had stool and instead of sanitizing her hands, she should have washed her hands with soap and water because you never know if the glove is torn and it is a break in infection control and was considered cross contamination. CNA E stated she realized she should have washed her hands with soap and water after coming in contact with stool, but it was too late, I just messed up. CNA E stated, even though she continued to clean Resident #5's anal area to ensure there was no more stool, placing the clean brief on the bed she considered the area to be clean because the brief did not touch the resident's skin during that time. CNA E stated, if cross contamination had occurred, the resident could get an infection. CNA E stated competencies were done at least monthly, including incontinent/peri care and believed the last competency was done within the past two weeks. During an interview on 2/12/26 at 10:41 a.m., the DON stated he expected staff to use hand sanitizer between glove changes, unless there was stool, then the expectation would be for the staff to wash their hands with soap and water because there was a chance of coming in contact with stool. The DON stated it was considered an infection control issue and cross contamination which could result in passing an infection to the resident. The DON stated that the environment should be clean before the brief was placed on the bed, and when the aide placed the clean brief on the resident's bed, and continued to provide incontinent/peri care, at that point the brief (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have been discarded as it was also considered cross contamination.Record review of the facility document titled Handwashing/Hand Hygiene with revision date 3/1/22 reflected in part, .This facility considers hand hygiene the primary means to prevent the spread of infections.All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations.When hands are visibly soiled.Use alcohol-based hand rub.or alternatively, soap.and water for the following situations.Before and after direct contact with residents.Before handling clean or soiled dressings.Before moving from a contaminated body site to a clean body site during resident care.After contact with a resident's intact skin.The use of gloves does not replace hand washing/hand hygiene.