STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455770	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Bend Medical Center	1705 Jackson St Richmond, TX 77469

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all residents had the right to formulate an advance directive for 2 of 15 residents (Residents #161 and #163) reviewed for advance directives.The facility failed to ensure Resident #161's advance directive status met her directive to healthcare providers to not perform CPR if her breathing or heartbeat stopped. The facility failed to ensure Resident #163 had an out-of-hospital do-not-resuscitate form in his medical record that was consistent with his wishes. This failure could place residents at risk of not having their end-of-life wishes honored and having incomplete records. Findings included:Record review of Resident #161's admission record dated [DATE] revealed she was admitted to the facility on [DATE] with a diagnosis of acute cystitis (sudden inflammation of the bladder, almost always caused by a bacterial infection). She was [AGE] years old. Record review of Resident #161's order inquiry (undated) revealed a physician order for full code status (if a person's heart stops or they stop breathing, the medical team will use all available life-saving measures to attempt to save the person's life) with a start date of [DATE]. Record review of Resident #161's electronic medical record on [DATE] at 1:15pm with the Quality Director revealed Resident #161 had no code status indicated. Record review of Resident #161's paper medical record on [DATE] at 1:45pm revealed there was no OOH DNR (a medical directive indicating that healthcare providers should not attempt CPR if your heart or breathing stops) form in her chart. There was document titled Resuscitation orders/Consent Form. Record review of Resident #161's Resuscitation order/Consent Form (undated) revealed Resident #161 signed the form indicating she requested do not resuscitate. The order was not signed by a physician. In an interview and observation on [DATE] at 1:42pm, Resident #161 said she had a OOH DNR form completed at her home. She said she wished to have DNR status. She showed the surveyor a purple bracelet on her wrist that read, DNR. In an interview on [DATE] at 1:45pm, the DON said that the form in Resident #161's chart was not completed because the physician had not signed it. Record review of Resident #163's admission record dated [DATE] revealed he was admitted to the facility on [DATE] with a diagnosis of closed fracture of epiphysis of proximal fibula (a break in the upper end of the calf bone (near the knee) that has not pierced the skin). He was [AGE] years old. Record review of Resident #163's order inquiry (undated) revealed a physician order for do not resuscitate with a start date of [DATE]. Record review of Resident #163's admission MDS assessment dated [DATE] revealed he had a BIMS (a standardized screening test used by healthcare providers to evaluate a patient's cognitive function, memory, and orientation) of 12, indicating he had no cognitive impairment. Record review of Resident #163's electronic medical record on [DATE] at 1:15pm with the Quality Director revealed Resident #163 had a code status of do not resuscitate. Record review of Resident #163's paper medical record on [DATE] at 1:45pm revealed there was no OOH DNR form in his chart. There was document titled Resuscitation orders/Consent Form.Record review of Resident #163's Resuscitation order/Consent Form dated [DATE] revealed Resident #163 signed the form indicating he requested do not resuscitate. The order was signed by the physician. In an interview on [DATE] at 1:15pm, the Quality Director said the skilled nursing unit was considered out-of-hospital (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and residents should have an OOH DNR form if this code status was requested. In an interview on [DATE] at 1:45pm, the DON said that the form in Resident #163's chart was the form they used to indicate a resident's code status. She said they did not need an OOH DNR form completed. In an interview and record review on [DATE] at 10:42am, RN A said when a resident was admitted , she asked the resident and the referring hospital about the resident's code status. She said they would refer to the resident's chart to determine code status. She showed the surveyor Resident #163's Resuscitation order/Consent form and said he had a DNR order. Alert and oriented and ask the resident. If the same, then go with what they say. She said if the resident did not have a consent form in the file, then she would treat them as having a full-code status. In an interview on [DATE] at 1:35pm, Resident #163 said he wished to have DNR status.A policy regarding Advance Directives was requested on [DATE] at 2:56pm and was not provided by the time of exit.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review the facility failed to have sufficient and competent staffing to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care for 4 residents (Residents #1, #3, #4 and # 5) out of 7 residents.The facility failed to ensure a nursing staff responded to the call light in a timely manner on June 14,15,and 16th 2026.This failure could place residents at risk of inadequate supervision, an unsafe environment, falls, serious harm and injury, exacerbations of disease processes, abuse, and death. Findings included:Record review of Resident #1's admission record dated 06/04/2026 revealed she was a [AGE] year-old female admitted with the following diagnoses: CHF (when the heart muscle is unable to pump enough blood to meet the body's needs for blood oxygen which can lead to shortness of breath). CAD (when the veins become narrowed or blocked and causes reduced blood flow to the brain. CVA (when blood flow to a part of the brain is interrupted), anxiety, heart failure and depression.Record review of Resident #1's MDS record dated 06/09/2026 revealed section C-cognition was coded-12-moderate thinking and memory. Functional abilities revealed she used a walker and required supervision and assistance in the following areas: toileting hygiene, upper body dressing, lower body dressing, putting and taking off footwears, toilet transfer, sit to stand, sit to lying, chair/bed-to-chair transfer.Record review of Resident #1's care plan report dated 06/04/2026 revealed: Fall risk. Goal: Stabilize any potential fall injury risk. Intervention: Asses for any side effects of medications particularly those related to sedation, respiration, depression and gait. Apply fall risk precautions, arm band, bed in lowest position, educate patient/family/caregiver about measures that can be taken to prevent falls, trips and slips, ensure call light and personal items are within reach, encourage use of non-slip footwear, implement hourly rounding. Anxiety. Goal: Stabilize patient's feelings of fear, dread or distress. Intervention: Provide patient with support and remain with patient as much as possible. Ineffective breathing. Goal: Stabilize breathing pattern. Intervention: Administer oxygen as ordered, assess and record depth of breathing. Record review of Resident #3's admission record dated 05/27/2026 revealed he was a [AGE] year-old male admitted with the following diagnoses: Acute osteomyelitis right foot toe (bone infection resulting to severe pain, fever and swelling), amputation, anemia(low blood count), CAD (the veins become narrowed or blocked and causes reduced blood flow to the brain), heart failure, Hypertension (high blood pressure), ESRD (the kidneys no longer function adequately), wound infection, and diabetes (irregular blood sugar levels). Record review of Resident #3's MDS dated [DATE] revealed section C-cognitive pattern was scored-09-moderate thinking and memory. Section GG-Functional abilities revealed he was dependent on staff in the following care areas: toileting and hygiene, lower body dressing, putting on and taking off footwear. Bowel continent revealed he was always incontinent. Record review of Resident #3's care plan report dated 05/27/2026 revealed, Activity intolerance. Goal: To stabilize the resident's risk for developing activity intolerance. Intervention: Perform actions which support a bedbound patient, manage the patient activity as needed. Injury risk. Goal: Stabilize injury risk. Intervention: Take precautions to reduce patient injury. Impaired physical mobility. Goal: Inability to perform independent movement will be stabilized. Intervention: Assist patient with ambulation.Record review of Resident #4's admission records dated 06/02/2026 revealed she was 64-years-old female admitted with the following diagnoses: Syncope fall (sudden temporary loss of consciousness that could lead to falls often caused by a brief drop in blood pressure, Fracture and other trauma, cancer, hypertension (low blood pressure), hip fracture and seizure disorder(abnormal electrical activity in the brain). Record review of Resident #4's MDS dated [DATE] revealed her cognition was coded a 15-normal thinking and memory. Section GG-Functional abilities revealed she required assistance and supervision in the (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following care areas: toileting, upper and lower body dressing, putting and taking off footwear.Record review of Resident #4's care plan report revealed: Activity intolerance: Goal: stabilize risk of developing activity intolerance. Intervention: Perform actions which support bedbound patients. Medication risk: Goal. Improve, on medication risk. Intervention: Monitor the effectiveness of the medication. Infection risk. Goal: Prevent infection risk. Intervention: Perform practices to prevent the spread of infection and infectious diseases, notify physicians about abnormal vital sign findings. Injury risk. Goal: To be stabilized. Intervention: Take precautions to reduce patient injury.Record review of Resident #5's admission record dated 06/14/2026 revealed he was a [AGE] year-old male admitted with the following diagnoses: Angina (chest pain or discomfort caused by reduced blood flow to the heart), UTI (infection in any part of the urinary system), ESRD (when the kidneys cannot function normally), respiratory condition, surgical wound and diabetes (irregular blood sugar). Record review of Resident #5's MDS dated [DATE] revealed his BIMS score was coded 15-normal thinking and memory. Bowel and bladder revealed he had an indwelling catheter. Required assistance with activities of daily livingRecord review of Resident #5's care plan report dated 06/14/2026 revealed: Fall. Goal: To stabilize any potential fall injury risks. Intervention: Assess for possible risks of falls, assess patient for possible side effects of medications especially those related to sedation, respirations, depression and gait. Apply fall risks precautions-bed in lowest position, orient patient and family to the environment, educate patient/family and caregivers on measures to prevent falls, trips and slips, ensure call light and personal items are within reach, supervise toileting and implement hourly rounding.In an interview with Resident #1 on 06/16/2026 at 06:48 a.m., she said the facility was noted for the long wait time when residents use the call light which lasted for over an hour. She said they left her sitting on the commode for an hour several times. Resident #1 said it happened almost daily, during both shifts. She said she told her family member several times. She said she could be having trouble with her oxygen which sometimes was disconnected. She said she relied on supplemental oxygen for survival. Resident #1 said, she could not go to restroom alone because she was not steady on her feet. She said that she sat on the commode for over an hour, and she felt unsafe and her bottom hurt. Resident #1 said one night she almost fell when staff was helping her back to her bed because she felt weak and tired after waiting for too long. She said, I do not think they have enough staff.In an interview with CNA C at 09:30 a.m., on 06/17/2026 he said responding to call lights was the responsibility of all staff. He said if a call light came on and staff did not attend to the residents in a timely manner; the residents could be impacted physically by falling. CNA C said, if Resident #1 or Resident # 5 had fallen, they could sustain an injury.In an interview with Resident #5 and family member on 06/17/2026 at 10:02 a.m., Resident #5 said he complained about the long wait time each time he used the call light for the previous two days. Resident #5 said staff told him to pull the string when he got to the restroom. Resident #5 said he needed staff assistance to get to the restroom. Resident #5 said when he called from the restroom, staff did not show up on time. Resident #5 said when I called that morning, they came because state was in the building. Resident #5's family member said their main concern was the fact that staff did not respond to the call light in a timely manner.In an interview with RN A on 06/17/2026 at 10:45 a.m., she said responding to the call light was the responsibility of every staff and she expected every staff member to make rounds regularly. She said, we checked on residents frequently. She said she knew the residents were calling because the light above the residents' room would light up as well as the call system at the nursing station. She said there as a unit secretary who would notify staff of the call light. She said if the call light response time was delayed the resident might fall. RN A said consequences of a fall to a resident could be a fracture or death.In an interview with Resident #4 on 06/17/2026 at 12:46 p.m., she thought the facility was short staffed. She said on 06/14/2026 -Sunday there was only one nurse. Resident #4 said she was on a scheduled pain medication and thought other residents too were on scheduled medications. She said when that happened, her pain level increased. She said nurses were supposed to focus on resident care and not answering the phone and call lights. She said If I do not (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	get my pain medication on time it makes me feel more pain. My pain instead of decreasing it increases. She said the nurses did not have enough support to enable them to perform their job efficiently. She said if a nurse had 15 residents there would not be efficient patient care.In an interview with Resident #3's family member on 06/17/2026 at 1:22 P.M., she said they did not see the nurse for the most part of the day. She said they saw the MA who administered medication to Resident # 3. She said it took the staff awhile to come in and Resident #3 could not ambulate. She said if staff failed to respond to the call light in a timely manner, the resident could have fallen and injured his legs or other body parts. She said this happened every day and both day and night shift. She said after waiting for too long she always had to go to the nursing station to request assistance. She said during the weekend on 6/13/26-6/14/26, he did not get his morning medication until about 2:00 p.m. In an interview with the MA on 06/17/2026 at 1:54 p.m., she said she was scheduled to work Monday through Friday and on weekends the nurses had to administer all the medications and provide other resident cares. In an interview with LVN A on 06/17/2026 at 2:00 p.pm., she said rounding on the residents every hour or two hours was the responsibility of every staff. She said if call lights were not answered in a timely manner that would delay care especially for residents who were a fall-risk which could cause injury, or pressure ulcer for residents who required brief change. LVN A said, if a resident fell, that would prolong their stay and they would be depressed. She said call lights were not answered due to insufficient staffing. She said the MA worked Monday through Friday which meant nurses administered all medications and provided care to residents on weekends. She said she was tired more on the weekends, and sometimes she did not feel like returning to work.In an interview with the DON on 06/17/2026 at 2:16 p.m., she said the facility had staff sitting on the hallway and answered the call light quickly. She said the MDS Coordinator did answer the call lights. She said she was notified of the call light concerns. She said if the call light was not answered in a timely manner that would affect the residents' and result in the following: falls, declining health and dissatisfaction. The DON said falls might delay length of stay and increased rehabilitation days. In an interview with the Quality Assurance Supervisor on 06/17/2026 at 5:37 p.m., she said the call light was everyone's responsibility. She said the facility did not have a call light policy.On 06/17/22026 at 07:00 p.m., unable to interview the ADM who was unavailable.

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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 infection for 2 of 5 residents (Resident #2 and Resident #4) and 2 of 2 staffs (CNA A, CNA B) reviewed for infection control. -The facility failed to ensure CNA A proceed soiled linen accord to infection control policies and procedures. On 06/17/2026 CNA A placed Resident #2 soiled linen on the floor with ungloved hands. -The facility failed to ensure CNA B transported clean linen into Resident #4's room following infection prevention guidelines. CNA B held clean linen on her scrub. These failures could place residents at risk for spread of infection and cross contamination to residents causing resident illness and/or distress. 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 infection for 4 of 9 residents (Resident #2, #3, #4, and #161) and 2 of 2 staffs (CNA A, CNA B) reviewed for infection control. 1-The facility failed to ensure CNA A placed soiled linen in a bag and donned PPE before performing soiled linen care for Resident #2 on 06/17/2026. 2-The facility failed to ensure CNA B transported clean linen into Resident #4's room following infection prevention guidelines on 06/17/2026.3-CNA A failed to sanitize her workstation prior to entering/exiting Resident #3's room after leaving/heading to the rooms of other residents on 6/17/26. 4-RN A failed to sanitize her workstation prior to entering/exiting Resident #161's room after leaving/heading to the rooms of another resident on 6/17/26. These failures could place residents at risk for spread of infection and cross contamination to residents causing resident illness and/or distress. Findings included:1.Record review of Resident #2's admission records dated 6/10/2026 revealed he was admitted with the following diagnoses: Hemorrhagic stroke (when the blood vessels in the brain rupture), cancer, diabetes (irregular blood sugar), CVA (when blood flow supply to the brain is interrupted), and hemiplegia (paralysis that affects the arms and legs).Record review of Resident #2's MDS dated [DATE] revealed his BIMS score was blank. Functional abilities revealed he required assistance in the following care areas: eating, oral hygiene, personal hygiene, toilet transfer, sitting to lying and vice versa, turning and repositioning, chair/bed transfer, and putting on/taking off footwear. Record review of Resident #2's care plan dated 6/10/2026 revealed: Infection risk. Goal: To improve the current infection. Intervention: Notify physicians about abnormal vital signs findings, perform practices to prevent the spread of infections and infectious diseases.Observation of CNA A on 6/16/2026 at 12:45 p.m. CNA A placed soiled linen from Resident #2's bed on the floor. She picked up the soiled linen from the floor with ungloved hands and placed them on the couch.2.Record review of Resident #4's admission records dated 06/02/2026 revealed she was 64 years-old female admitted with the following diagnoses: Syncope fall (sudden temporary loss of consciousness that could lead to falls often caused by a brief drop in blood pressure, Fracture and other trauma, cancer, hypertension (low blood pressure), hip fracture and seizure disorder(abnormal electrical activity in the brain). Record review of Resident #4's MDS dated [DATE] revealed her cognition was coded a 15-normal thinking and memory. Section GG-Functional abilities revealed she required assistance and supervision in the following care areas: toileting, upper and lower body dressing, putting and taking off footwear.Record review of Resident #4's care plan report revealed: Medication risk: Goal. Improve, on medication risk. Intervention: Monitor the effectiveness of the medication. Infection risk. Goal: Prevent infection risk. Intervention: Perform practices to prevent the spread of infection and infectious diseases, notify physicians about abnormal vital signs.Observation of clean linen transportation by CNA B on 06/17/2026 at 09:20 a.m. She transported clean linen to be used for Resident #4's room by carrying them against her scrub.In an interview with CNA B on 06/17/2026 at (continued on next page)

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CNA C said if staff placed linen be it clean or dirty on the bare floor, they were violating infection rules. CNA C said he was not told to transport clean line from the linen closet in a bag into the residents' rooms. He said he was told to carry clean linen away from his body with clean hands or anything that could be a source of contamination prevention. In an interview with CNA D on 06/17/2026 at 10;09 a.m., she said to prevent cross-contamination when she removed dirty and soiled linen from the residents' bed she placed them in a bag. She said she would not place them on the floor because that would be considered infection control violation. CNA D said when she had to transport linen from the clean linen closet to the residents' rooms, she made sure the linen did not touch her scrubs.In an interview with CNA A on 06/16/2026 at 12:45 p.m., she said she had to change the linen because the family complained Resident #2 vomited on the linen. She said when she placed the soiled linen on the floor without placing them in a bag and later placed them on the couch, she had transferred bacteria from the linen to the couch. She said that meant violating infection prevention. CNA A said the right thing would have been to place the soiled linen in a bag and take it out after she finished. CNA A said the soiled linen placed on the floor meant cross-contamination and spread of bacteria and staff exposure. She said she was trained to wear PPE when handling soiled linen. She said she did not wear PPE and placed the soiled linen on the floor and later onto the couch because she was in a rush.In an interview with the DON on 06/17/2026 at 2:16 p.m., she said all staff were trained to place soiled and dirty linen in a bag and not on the floor because those types of linen were considered contaminated. She [NAME] if the soiled and dirty linen were not placed in a bag, there was a concern about infection transmission. The DON said staff were trained to carry clean linen away from their body. She said during a process of transporting linen from the clean linen closet to the residents' room, staff had to put the linen in a bag. 3.Record review of Resident #3's MDS dated [DATE] revealed a [AGE] year old male admitted to the facility on [DATE] with a primary diagnosis of amputation. He has the following diagnoses, anemia, CAD (coronary artery disease), heart failure, hypertension (high blood pressure), renal insuffiency (impaired kidney function), diabetes, and wound infection (diabetic foot ulcer). His BIMS score was a 9. He is on enhanced barrier precautions. 4.Record review of Resident #161's MDS dated [DATE] revealed an [AGE] year old female admitted to the facility on [DATE] with a primary diagnosis of acute cystitis (infection of the bladder). Her other diagnoses are heart failure, hypertension, and UTI w/MDRO (urinary tract infection with a multi-drug resistant organism). Her BIMS score is a 15. She is on contact isolation. During observation and interview on 06/17/2026 at 7:44 am RN A entered Resident #161's room, which was on contact isolation for VRE (vancomycin resistant enterococcus), with her workstation (which contained medications). She gave medications to Resident #161 and when finished, exited Resident #161's room without sanitizing workstation. She was about to enter the next resident's room when the surveyor pointed this out to her. RN A stated that she didn't realize that she had done that and that she was just nervous. She said she would make sure she did it going forward. She stated that she had received training on infection control in training when she started, and had also received in services on infection control. She said that the risks to a resident could be the spread of bacteria, viruses, and infection. During observation and interview on 06/17/2026 at 8:04 am, CNA A entered Resident #3's room with her workstation containing resident medications. She failed to sanitize it prior to exit of previous resident's room & entry of Resident #3's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room. She gave medications to Resident #3 and when finished, exited Resident #3's room without sanitizing workstation. She was about to enter the next resident's room when the surveyor pointed this out to her. CNA A stated that she didn't realize that she was doing that and that she didn't realize she needed to do that. She stated that she sanitized it prior to med pass and does so afterward. She said she did understand the rationale behind it and would ensure she did it going forward. She stated that she had received training on infection control when she started and had received in services. She said that the risks to a resident could be spreading infection and making them sick. In an interview on 06/17/2026 at 2:00 pm with the DON, she stated that her expectation for her staff is that when they go from one resident's room to another they will perform hand hygiene and sanitize equipment. She said this especially important when going between resident rooms on isolation precautions (contact) due to the fact that antibiotic resistant bacteria can be transmitted which can easily spread hard to eliminate infections which can harm residents. She said that staff know better than this because they have received training on it. In an interview on 06/17/2026 at 3:51pm with the Infection Preventionist, she stated that nurses, med aides, and CNAs all get infection prevention training when they hire on as well as in services and skills fairs where they're checked off for competency. She said that nurses and med aides should be using hand hygiene and sanitizing their carts in between residents during med pass. She said it is especially important when going in/out of isolation rooms to prevent the spread of MDROs (multi-drug resistant organisms). She said the risks to residents if staff are not following these practices is the spread of infection. When told we had observed two different staff doing this within minutes of each other, she stated she had witnessed multiple staff doing this herself (she did not specify when or what action was taken). In an interview on 06/17/2026 at 5:52 pm with Resident #161, when asked what the process is like when staff give her medications she said; staff comes to the room, they knock on the door, they come into the room, they bring their cart in, they put on PPE, scan her bracelet, and then give her the medications as they explain what they are and what they are for. She said that she had not ever witnessed anyone sanitize the cart after entering the room or before leaving. In an interview on 06/17/2026 at 5:55 pm with Resident #3, when asked what the process is like when staff give him medications he said staff comes to the room, they bring their cart in, and then they give him his medications. Resident #3 stated that he had never witnessed staff sanitize the cart after coming into the room or before exiting.Record review of policy: Isolation Precautions effective date 11/2001, last revised 06/2024, section E Contact Precautions subsection 6 Patient Care Equipment page 9 states When possible, dedicate the use of noncriticalpatient-care equipment and items such as a stethoscope,sphygmomanometer, bedside commode, or electronic rectal thermometerto a single patient (or cohort of patients infected or colonized with thepathogen requiring precautions) to avoid sharing between patients. If useof common equipment or items is unavoidable, then adequately clean anddisinfect them before use for another patient.Record review of facility's policy titled: Job Description/Performance Expectation: Skilled Nursing Unit Certified Nursing Assistant; revised on 04/11/2023 stated: The CNA applies safety and infection control principles, environment and all patient care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455770	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Bend Medical Center	1705 Jackson St Richmond, TX 77469

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public on 1 of 2 hallways (Hall B) reviewed for environmental concerns.-The facility failed to ensure the ceiling in Hall B was free from water buildup, water pooling and a smoke damper leaking water on to the floor on 6/17/26. These failures could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe.The findings included:In an observation on Hall B on 6/17/26 at 10:04am, the following was observed: -Between rooms [ROOM NUMBERS], there was a ceiling tile that was stained with a brown and yellow stain that was about 7 inches wide and in the shape of one-fourth of a circle. -The lighting panel on the ceiling between rooms [ROOM NUMBERS] had water pooling on the right and left side of the panel.-The smoke damper panel between rooms [ROOM NUMBERS] was leaking water and there was water dropping in a slow stream onto the floor. In an interview on 6/17/26 at 4:40pm, the Facilities Director, when asked about Hall B, he stated that hot air near Hall A met cold air in Hall B and it created moisture. He said the air duct above the hallway was producing water and pooling in the ceiling. Record review of the facility's policy regarding Physical Environment revised on 6/2026 read, (The facility) is committed to providing an environment that is safe, functional and supportive of staff, practitioners and other individuals who enter our buildings. (the facility) assures through our management of the environment, that risks are assessed and identified in order to mitigate and better manage those risks.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an effective pest control program for 2 of 5 residents' rooms (room [ROOM NUMBER] and 19) and surrounding areas reviewed for pests.The facility failed to ensure Resident #4 and Resident #5's rooms were free of pests on 06/14/ 2026 and 06/16/2026.The facility failed to ensure the common shower area was free of pests.This failure could place residents at risk of increased exposure to pests and vector-borne diseases and infections as well as negative reputation of the physical environment of the facility.Findings included: Record review of Resident #4's admission records dated 06/02/2026 revealed she was 64 years-old female admitted with the following diagnoses: Syncope fall (sudden temporary loss of consciousness that could lead to falls often caused by a brief drop in blood pressure, fracture and other trauma, cancer, hypertension (low blood pressure), hip fracture and seizure disorder(abnormal electrical brain disorder). Record review of Resident #4's MDS dated [DATE] revealed her cognition was coded with a 15-indicating normal thinking and memory. Section GG-Functional Abilities revealed she required assistance and supervision with the following care areas: toileting, upper and lower body dressing, and putting and taking off footwear.Record review of Resident #4's care plan report revealed: Activity intolerance: Goal: stabilize risk of developing activity intolerance. Intervention: Perform actions which support bedbound patients. Medication risk: Goal. Improve, on medication risk. Intervention: Monitor the effectiveness of the medication. Infection risk. Goal: Prevent infection risk. Intervention: Perform practices to prevent the spread of infection and infectious diseases, notify physicians about abnormal vital sign findings. Injury risk. Goal: To be stabilized. Intervention: Take precautions to reduce patient injury.Record review of Resident #5's admission record dated 06/14/2026 revealed he was a [AGE] year-old male admitted with the following diagnoses: Angina (chest pain or discomfort caused by reduced blood flow to the heart), UTI (infection in any part of the urinary system), ESRD (when the kidneys cannot function normally), respiratory condition, surgical wound and diabetes (irregular blood sugar). Record review of Resident #5's MDS dated [DATE] revealed his BIMS score was coded 15-normal thinking and memory. Bowel and bladder revealed he had an indwelling catheter. Required assistance with activities of daily livingRecord review of Resident #5's care plan report dated 06/14/2026 revealed: Fall. Goal: To stabilize any potential fall injury risks. Intervention: Assess for possible risks of falls, assess patient for possible side effects of medications especially those related to sedation, respirations, depression and gait. Apply fall risks precautions-bed in lowest position, orient patient and family to the environment, educate patient/family and caregivers on measures to prevent falls, trips and slips, ensure call light and personal items are within reach, supervise toileting and implement hourly roundingIn an interview with Resident #4 on 06/17/2026 at 12:46 p.m., she said she saw 2 roaches on 06/14/2026 in her room. Resident #4 said when she saw the roaches, she felt she was in an unclean environment. She said she had the feeling the roaches would crawl on her body while she slept at night. She said CNA B killed the roaches.In an interview with Resident #5 on 06/17/2026 at 1:02 p.m., he said his family member killed a roach in his room the day before. He said when they saw the live roach, they were startled and paused to imagine where it came from. Resident #5 said with the roach in his room he felt disgusted, anxious and he panicked. He wondered if it was lack of hygiene and wondered if there were other roaches in the building. The family member who was in the room at the time of the interview confirmed she saw the roach.In an interview with CNA B on 06/17/2026 at 1:02 p.m., she said on 06/12/2026 she saw a roach in front of Resident #4's door. She said she killed and discarded the dead roach in a trash but did not notify the nurse because the nurse saw her killing the roach. She said she could not remember the name of the nurse. In an interview with the Case Manager on 06/17/2026 at 1:31 p.m., she said the staff reported concerns with roaches to her and she would call the House Supervisor and notify them of the location. The House Supervisor would then call the exterminator. The Case Manager said staff notified her (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there were roaches, spiders, and ants in the public shower. She said staff used to complain about spiders, roaches, and ants.In an interview with the DON on 06/17/2026 at 2:16 p.m., she said nobody told her about roaches, and spiders. She said she knew of ants. She said if she was made aware of the roaches and spiders, she would have notified the maintenance supervisor and that would have been taken care of. In an interview with the facility management supervisor on 06/17/2026 at 4;26 p.m., he said the pest control company comes in every Monday of the week. He said the last time pest control was in the building specifically for the SNF department was on 06/09/2026. He said he could not recall the purpose of the pest control.Record review of facility's pest control invoices revealed pest control was in the building on the following dates in 2026 and not specifically on Mondays for roaches, ants and spiders: 04/03-Cafeteria and kitchen, 04/06-kitchen, 04/16-bathrooms, breakrooms and kitchen, 04/17-offices, 5/15-building, 5/21-bathrooms, breakrooms and building, 5/27-kitchen. The pest control record review was not differentiated between the hospital from the SNF.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to electronically submit to CMS complete and accurate director care staffing information no less frequently than quarterly for one of four quarters reviewed for payroll based journal data. This failure placed residents at risk of not being aware of the facility's staffing information which may result in adverse health outcomes due to low staffing levels. Findings include: Record review of the PBJ Staffing Data Report for Quarter 2 of 2026 (January 1-March 31) generated on 6/17/26 revealed the facility failed to submit data for the quarter. In an interview on 6/17/26 at 5:30pm, the Quality Director stated the coordinator was responsible for submitting staffing data to CMS. She said the previous coordinator told the facility she was submitting the data to CMS. She said they found out that she had not submitted the data and she no longer worked at the facility.