STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455934	A. Building B. Wing	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Oaks Living & Rehabilitation Center	2722 Old Anson Rd Abilene, TX 79603

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to periodically review and revise for 1 (Resident #2) of 5 residents reviewed for care plans - The facility failed to update the care plan to remove the intervention floor mat from bedside to prevent falls for Resident #2. This deficient practice could place residents in the facility at risk of not receiving care appropriate for their needs and could lead to injury. Review of Resident #2's electronic face sheet dated 11/06/2025 reflected a [AGE] year-old female with an admission date of 01/09/2024 and most recent admission date of 02/12/2025. Resident #2's diagnoses included: dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), muscle weakness, lack of coordination, unsteadiness of feet, abnormalities of gait and mobility, difficulty in walking, and repeated falls. Review of Resident #2's quarterly MDS assessment dated [DATE] reflected a BIMS score of 00 indicating severe cognitive impairment. Section on Functional Abilities and Goals revealed Resident #2 required assistance with transfers. Section - Health Conditions revealed Resident #2 had no calls since the prior assessment.Review of Resident #2's comprehensive care plan reviewed on 11/06/2025, reflected Resident #2 had ADL deficit related to decreased mobility and generalized muscle weakness. Part of the interventions included 1 staff to participate with transfers and repositioning in bed. Further review of care plan reflected Resident #2 was at risk for falls last revised by MDS coordinator on 06/26/2025. Part of the interventions included Floor mats at bedside. Continued review of care plan reflected Resident #2 had falls with and without injuries last revised by MDS coordinator on 08/08/2025. The focus statement included 2/25/25: Has had a fall with no injury. 2/27/25: [Resident #2] had a fall with no injury. 3/10/25 [Resident #2] had a fall with no injury. 3/11/25: [Resident #2] had a fall with no injury. 3/13/25: [Resident #2] had an assisted fall with no injury. 3/14/25: [Resident #2] had a fall with no injury. 4/2/25: [Resident #2] had a fall with no injury. 4/4/25: [Resident #2] had a fall with no injury. 4/13/25: [Resident #2] had a fall with no injury. 4/19/25: [Resident #2] had a fall with no injury. 4/20/25: [Resident #2] had a fall with no injury. 5/6/25: [Resident #2] had a fall with no injury. 5/25/25: [Resident #2] had a fall with injury. 6/24/25: [Resident #2] had a fall with no injury. 6/27/25: [Resident #2] had a fall with injury. 7/12/25: [Resident #2] had a fall with injury. 7/17/25: [Resident #2] had a fall with no injury 7/21/25: [Resident #2] had a fall with no injury. 7/25/25: [Resident #2] had a fall with no injury. 8/7/25: [Resident #2] had a fall with injury. Review of Resident #2's IDT-Care Plan Review dated 10/28/2025 reflected no mention of floor mats at bedside with additional nursing plan of care Continue with current plan of care. Review of Resident #2's Progress Notes dated 11/05/2025 at 2:15 p.m. written by LVN D, read in part Yelling was heard from other resident's stating She fell, she fell. Upon this nurse entering area resident was found sitting on the floor with bleeding noted to forehead and abrasion noted with dry blood present. Further review of progress notes since 10/08/2025 reflected no other documented falls by Resident #2.Review of Resident #2's Fall Risk Evaluation performed on 11/05/2025 reflected a score of 17 and a high-risk category. Further review reflected a history of 3 or more falls in the past 3 months. During an observation on 11/06/2025 at 10:08 a.m., Resident #2 was lying in bed on a scoop mattress and bed was in the lowest position. Resident was resting peacefully with unlabored breathing, and her eyes were closed. No floor mat was observed beside her bed.During an interview and observation on 11/06/2025 at 1:19 p.m., Resident #2 was sitting in a wheelchair in the lobby area attached to the dining room. She had steri-strips (adhesive wound strips) attached to her forehead covering a wound with no fresh drainage observed. She could not answer questions about where the wound on her forehead had come from looking confused and then feeling of her forehead when asked. There was one staff member sitting in a chair in that lobby and other residents surrounded her. There was a television on for the residents to watch. Resident #2 did not appear to be in any pain and was calm during interview. During a telephone interview on 11/06/2025 at 1:02 p.m., Resident #2's Representative stated she had been informed of the fall Resident #2 had on 11/05/2025. She stated Resident #2 had fallen out of bed in the past and the facility had changed her mattress to a scoop mattress which had helped tremendously. She stated she had asked for a floor mat during a care plan meeting but was told the facility does not use floor mats due to state guidelines. Resident #2's Representative stated she had participated in care plan meetings and that is where they had discussed the scoop mattress instead of the floor mat.During an interview on 11/06/2025 at 1:41 p.m., CNA A stated she had worked for the facility for approximately 2 months. She stated she had worked on the hall Resident #2 resided on and knew about her care. She stated Resident #2 had mostly fallen at night in the