STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F197	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Oaks Manor	112 Pioneer Dr Booker, TX 79005

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 (Resident #2) of 13 residents reviewed for resident rights. Resident #2 was observed with her catheter bag not in a privacy bag for 3 days exposing her catheter bag to an open hallway and the outside environment. This failure could place residents at risk for feeling uncomfortable and disrespected leading to isolation and deterioration in general health conditions. Findings included: Record review of Resident #2's face sheet printed 6/11/26 revealed she was an [AGE] year-old female resident admitted [DATE] and readmitted on [DATE] with diagnoses to include chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), encounter for palliative (specialized medical care focused on relieving symptoms (such as pain, nausea, or shortness of breath) and the mental stress of serious illness) care, and wedge compression fracture of unspecified thoracic vertebrae (a structural collapse of the front of a bone in the mid-back). Record review of Resident #2's significant change of condition MDS assessment printed 6/11/26 and completed 4/16/26 listed Resident #2 with a BIMS of 4 indicating she was severely cognitively impaired, she had a functionality of being dependent on staff for her toileting hygiene, and she required an indwelling catheter. Record review of Resident #2's care plan printed 6/11/26 with admission date of 7/06/25 revealed the following: Focus - The resident has Indwelling Catheter: Pressure Ulcer Date Initiated: 04/18/2026 Record review of Resident #2's Order Summary Report printed 6/11/26 with Active Orders As Of: 6/11/26 revealed the following order:- 16F foley catheter to promote wound healing to pressure ulcer Verbal Active 03/19/2026 During an observation on 06/09/2026 at 10:35 AM Resident #2 was sleeping in her bed and did not wake to knocking or introduction. Resident #2 was noted to have a catheter bag hanging from the left side of her bed in view of the window to the sidewalk and street. There was no privacy bag covering the catheter bag. The window had no blinds or curtains to obstruct the view from the sidewalk into the room. During an observation on 06/09/2026 at 10:44 AM an unidentifed staff member entered Resident #2's room and place a privacy bag on the catheter bag. During an observation on 06/10/2026 at 7:02 AM Resident #2 was observed in her room sleeping in her bed. Resident #2's catheter bag could be observed from the hallway through her open doorway and was not in a privacy bag. Noted the 3 residents that resided further down the hall had passed Resident #2's room to go to the dining room for the am meal. During an observation on 06/10/2026 at 7:58 AM Resident #2 was observed in her room being assisted by a staff member with her am meal. Resident #2's catheter bag continued to hang from the foot of her bed without a privacy bag and was still in view of the hallway. [NAME] liquid could be observed in Resident #2's catheter bag. During an observation on 06/10/2026 at 9:08 AM 8 unidentified residents and two unidentified staff were noted at the end of the hall completing an activity next to Resident #2's room. Resident #2's catheter bag that was not covered for privacy could be seen from the hallway through her open door. During an observation on 06/11/2026 at 8:22 AM Resident #2 was observed in her bed sleeping and did not wake. Resident #2's catheter bag could be observed through (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her open door from the hallway that did not have a privacy bag. Noted 300cc's of amber liquid in the catheter bag. One resident was observed in the hallway in her wheelchair that had just passed Resident #2's room. During an observation and interview on 06/11/2026 at 8:28 AM the ADON observed Resident #2 from the hallway and reported Resident #2;s catheter bag was left uncovered and could be observed. The ADON reported the catheter bag should be in a privacy bag to maintain the resident's dignity. During an observation and interview on 06/11/2026 at 8:33 AM RN D (the charge nurse responsible for Resident #2 this shift) observed Resident #2 and reported the catheter bag should be covered for privacy. That if the catheter bag was left uncovered then the resident could have an issue with dignity even shame. RN D reported she would get it covered immediately and entered the room to complete the task. During an interview on 06/11/2026 at 10:32 AM the DON reported that the catheter bag for each resident should be covered at all times, staff should check to make sure they were covered at all times, and if the catheter bag was left uncovered it could be a dignity issue for the resident. During an interview on 06/11/2026 11:06 AM CNA E (the CNA responsible for Resident #2 this shift) reported CNA staff check the resident every two hours, and a resident's catheter should be in a privacy/black bag so it would not be in view. CNA E reported if the catheter bag was not in a privacy bag, then the resident could be embarrassed because you could see the pee. CNA E reported it could also affect other residents or families who could see the catheter bag uncovered. Record review of facility provided policy titled, Nursing Facility Requirements for Licensure and Medicaid Certification Handbook - Statement of Resident Rights revised 1/03/08, revealed the following: You have the right:6. to privacy.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who use psychotropic drugs received gradual dose reductions (unless clinically contraindicated) in an effort to discontinue those drugs for 3 (Resident #1, #2, and #7) of 5 residents reviewed for unnecessary medications. Resident #1 was on two psychotropic medications with no attempted gradual dose reductions in the past 12 months. Resident #2 was on one psychotropic medication with no attempted gradual dose reductions in the past 12 months. Resident #7 was on two psychotropic medications with no attempted gradual dose reductions in the past 12 months and one psychotropic medication with one gradual dose reduction completed since admission 5/09/2025. This failure could affect residents resulting in excessive sedation, dizziness, blurred vision, weight gain/loss, falls, feelings of isolation, and/or increased depression.Findings included: Resident #1: Record review of Resident #1 face sheet printed 6/09/26 revealed he was a [AGE] year-old male admitted to the facility originally on 1/01/2025 and readmitted on [DATE] with diagnoses to include Post traumatic stress disorder (disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), depression (a common, serious mental health condition characterized by persistent sadness, loss of interest in activities, and low energy, lasting at least two weeks), and anxiety disorder (a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Record review of Resident #1's quarterly MDS assessment printed 6/10/26 was completed 4/18/26 listed Resident #1 with a BIMS of 99 indicating he was severely cognitively impaired, and he was independent with most of his activities of daily living. Record review of the care plan printed 6/11/26 with admission date of 6/05/25 for Resident #1 revealed the following: Focus - The resident uses psychotropic medications Date Initiated: 01/20/2025. Intervention - Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness for possible decrease, elimination or change of psychotropic medication. Date Initiated: 01/20/2025. Record review of Resident #1's Order Summary Report printed 6/10/26 with Active Orders As Of: 6/10/26 revealed the following order:- QUEtiapine Fumarate Tablet 25 MG Give 1 tablet by mouth at bedtime related to POST TRAUMATIC STRESS DISORDER, UNSPECIFIED (F43.10) Active 02/10/2025. (Seroquel - atypical antipsychotic) - TraZODone HCl Tablet 100 MG Give 1 tablet by mouth at bedtime for INSOMNIA related to POSTTRAUMATIC STRESS DISORDER, UNSPECIFIED (F43.10) TO BE ADMINISTERED AT BEDTIME Active 01/01/2025. (Trazadone - atypical antidepressant) Record review of the facility provided document untitled signed by LPH 6/02/2026 for Resident #1 revealed Psychoactive Drugs-Dose-Last Change: Seroquel 2.5mg qHS - 2/10/25 PTSD Trazadone 100mg HS - 1/01/25 PTSD/InsomniaDuring an observation and interview on 06/09/2026 at 10:54 AM Resident #1was in his room, in his bed under his covers with a coat over his head. Resident #1 did not respond to knocking or introduction. During an observation and interview on 06/09/2026 at 1:43 PM Resident #1 was in his room in his bed laying on top of his covers. SS H attempted to interview Resident #1. He became loud, had mumbled speech, and was unable to understand. Resident #2:Record review of Resident #2 face sheet printed 6/09/26 revealed she was an [AGE] year-old female admitted on [DATE] and readmitted [DATE] with diagnosis to include major depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of Resident #2's significant change of condition MDS assessment printed 6/11/26 was completed 4/16/26 listed Resident #2 with a BIMS of 4 indicating she was severely cognitively impaired and she had a functionality of being dependent on staff for most of her activities of daily living. Record review of the care plan printed 6/11/26 with admission date of 7/06/25 for Resident #2 revealed the following: Focus - The resident is palliative care d/t failure to thrive. Date Initiated: 06/26/2025. Interventions - (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Offer pain medication or antianxiety medication of ordered and to keep resident comfortable. Record review of Resident #2's Order Summary Report printed 6/10/26 with Active Orders As Of: 6/10/26 revealed the following order: Zoloft Oral Tablet 50 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for DEPRESSION. Active 08/19/2024. Record review of the facility provided document untitled signed by LPH 6/02/2026 for Resident #2 revealed Psychoactive Drugs-Dose-Last Change: Zoloft 50 qd - 6/20/2024 Depression During an observation on 06/09/2026 at 10:35 AM Resident #2 was asleep in her room and did not wake to knocking or introduction. Resident #7: Record review of Resident #7 face sheet printed 6/09/26 revealed he was a [AGE] year-old male admitted on [DATE] with diagnoses to include bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder (a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression (a common, serious mental health condition characterized by persistent sadness, loss of interest in activities, and low energy, lasting at least two weeks). Record review of Resident #7's quarterly MDS assessment printed 6/10/26 was completed 5/23/26 listed Resident #7 with a BIMS of 15 indicating he was cognitively intact, and he required partial/moderate supervision with most of his activities of daily living. Record review of the care plan printed on 6/11/26 with admission date of 5/09/25 for Resident #7 revealed the following: Focus - The resident uses anti-anxiety medications & antidepressants r/t bipolar disorder &Anxiety. Date Initiated: 05/31/2025. Interventions - Monitor for side effects and effectiveness for possible decrease, elimination or change of psychotropic medication. Record review of Resident #7's Order Summary Report printed 6/11/26 with Active Orders As Of: 6/11/26 revealed the following order:- Paxil Oral Tablet 40 MG (Paroxetine HCl) Give 40 mg by mouth one time a day related to DEPRESSION, UNSPECIFIED (F32.A). Active 05/09/2025. (Paxil - antidepressant) - Wellbutrin XL Oral Tablet Extended Release 24 Hour 150 MG (Bupropion HCl) Give 150 mg by mouth one time a day related to BIPOLAR DISORDER, CURRENT EPISODE DEPRESSED, MILD OR MODERATE SEVERITY, UNSPECIFIED (F31.30). Active 05/09/2025. (Wellbutrin - atypical antidepressant) - BusPIRone HCl Tablet 15 MG Give 1 tablet by mouth two times a day for anxiety. Active 07/09/2025 Start Date 07/09/2025. (Buspar - Anxiolytics (anti-anxiety drugs) Record review of the facility provided document untitled signed by LPH 6/02/2026 for Resident #1 revealed Psychoactive Drugs-Dose-Last Change: Paxil 40mg qd - 5/10/25 - Depression Wellbutrin CL 150mg 5/10/25 - Bipolar Buspar 15mg BID 7/09/25 - Anxiety During an observation and interview on 06/10/2026 at 12:14 PM Resident #7 was observed entering his room after completing lunch. Resident #7 was dressed well but was guarded with his conversation and did not wish to answer any questions. Resident #7 was not in any distress. During a group interview on 06/11/2026 at 11:11 AM with the DON and ADON both reported no GDRs were completed for Resident #1, #2, and #7. They DON and ADON reported that they did not want the physicians to increase doses to address behavioral issues. That as a facility they want to use alternative steps to address resident behavioral issues. They reported that they also have families that did not want the residents' medications changed. SS H attempted to explain the residents' psychotropic medications need to be addressed by the physicians to ensure they are not used improperly, and they again repeated that they have attempted in the past and often have difficulty coordinating and would prefer not risk having the residents' medications increased. This surveyor explained the reason for the GDR request three separate times, and they gave the same answer. During a telephone interview on 06/11/2026 at 11:29 AM the LPH wanted to know the residents age, medication, and diagnoses. The LPH stated that she was unaware the residents were supposed to have a GDR done. The LPH reported each resident was stable on the current medication and dose. The LPH reported the physicians were in the facility frequently but often would not document they had addressed the resident's medication concerns. The LPH stated she Could certainly start writing letter to the physicians for the medications to be addressed. Record review of facility policy titled Antipsychotic use in residents-update 04/25/2025 revealed: Procedure:7. Upon monthly review of resident medical records, the Consultant Pharmacist (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	will make recommendations/adjustments.a. This review will also include any other psychotropic medication(s), which is due for review by the attending/psychiatrist at this time.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment requirement for 1 of 1 kitchen staff (Dietary Manager) reviewed for qualifications. The facility failed to ensure the individual functioning as the Dietary Manger possessed the appropriate certification, training, and qualifications to direct the food and nutrition services department. This failure could place residents who consume food prepared from the kitchen at increased risk of food borne illness and not receiving adequate nutrition.Findings included: Record review of ADS's undated employee file revealed she was hired into the Dietary Manager position on 08/19/25. Record review of a facility receipt dated 4/1/2026 revealed payment for the ADS's enrollment in an online Dietary Manager training course on 04/10/2026. During an interview on 06/10/26 at 10:33 AM, the ADS stated she began working in the dietary supervisor role in September 2025. The ADS stated she began online Dietary Manager certification classes in May 2026 and was currently on the first module of the course. The ADS stated she was not certified as a Dietary Manager. The ADS stated she logged onto the training course the previous evening but did not complete any course work and had been on vacation the prior week. The ADS stated the only course work she completed occurred in May. The ADS stated she felt overwhelmed with her job responsibilities and did not have sufficient time to complete both her work duties and the training course. She stated not having a certified DM in the kitchen could mean that things would not be done right, staff would not be trained correctly, and bad things could happen. During an interview on 06/10/26 at 10:40 AM, [NAME] C stated she had worked at the facility for 4 years and that they currently do not have a certified DM, but believed the ADS was taking classes to obtain that certification. She stated a negative outcome for not having a certified DM could be that things would not be done right in the kitchen, staff would not be trained properly, and things could go wrong. During an interview on 06/11/26 at 9:39 AM, the BOM stated the ADS had not completed Dietary Manager training. The BOM stated the ADM supervised the ADS and was responsible for ensuring required training was completed for non-nursing staff. She stated she was unable to identify a negative potential outcome related to the absence of a trained DM and stated that the ADM would be responsible for answering that question. In an interview on 06/11/26 at 9:44 AM, the RD stated she had provided consulting services to the facility for approximately three to four years. She stated the ADS was not a certified DM, but it was her understanding the ADS was enrolled in an online DM course but not sure how much progress had been made. The RD stated she consulted with the ADS monthly and more frequently if needed. The RD stated she believed the ADS had functioned as the Dietary Manager for approximately seven to eight months. She stated the absence of a trained DM could result in insufficient knowledge of nursing home regulations and special diets but that she had not observed any negative outcomes related to dietary services at the facility. In an interview on 06/11/26 at 10:00 AM, the ADM stated the ADS was not certified as a DM and it was ultimately his responsibility for making sure all staff were trained. He stated he believed the ADS had been functioning in the role since August or September 2025. The ADM stated he understood that they enrolled the ADS for online DM classes in April 2026. The ADM stated he would not answer the question about why there had been a long length of time between hiring the ADS and the time it took to get her signed up for classes. He stated he was not aware that she was only on her first module of the course until yesterday. The ADM stated a negative outcome for not having a trained DM could be wrong diets served to residents and possible choking issues. During an interview on 06/11/26 at 10:23 AM, the ADM stated the facility did not have a policy identifying qualifications or requirements for the Dietary Manager position. The ADM provided the surveyor with the ADS's job duties.Record (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of the facility document titled, Policy and Job Duties Cont., not dated, included in part: Job Summary: The purpose of this portion is to supervise the Dietary Services with regularly scheduled consultation from a qualified dietician. The Supervisor is directly responsible to the Administrator.Nothing in the document revealed any mention of what the qualifications were for a Dietary Supervisor/Dietary Manager.

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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. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure freezer and pantry items were properly stored, labeled, and dated.This failure could place residents at risk of food-borne illnesses. Findings included:Observation of the freezer on 06/09/26 at 10:24 AM revealed the following:1. (1) bag of breaded meat, no label or date.2. (3) bags of white meat, dated, no label.3. (1) bag of meat, dated, no label.4. (6) bags of what looked like bread, dated, no label.5. (5) frozen pies in boxes, no label or date. 6. (2) opaque brown bags, dated, no label. 7. (1) bag frozen breaded vegetables, dated, no label.8. (4) packages of meat, no label or date.9. (2) packages of what looked to be hot dogs or sausages, dated, no label. Observation of the pantry on 06/09/26 at 10:27 AM revealed the following:1. (1) bag that contained what looked like cereal, dated, no label.2. (2) large clear bags that contained individual bags of popcorn, no label or date. In an interview on 06/09/26 at 10:36 AM, the ADS stated she started as supervisor of the kitchen in September 2025 and that it was everyone's responsibility to label and date food and if this did not happen, food could go bad and residents could get sick.In an interview on 06/10/26 at 10:40 AM, [NAME] C stated she had worked at the facility for 4 years and that it was everyone's responsibility to label and date food and that not doing it could put residents at risk of getting sick and being served out-of-date food.In an interview on 06/09/26 at 10:41 AM, [NAME] A stated she had worked at the facility for 31 years and everyone who worked in the kitchen was responsible for labeling and dating food. She stated if this did not happen, residents could become sick. In an interview on 06/09/26 at 10:43 AM, [NAME] B stated it was everyone's responsibility to label and date food and if this was not happening, the kitchen could serve bad food which could make residents sick. Record review of facility policy, titled Refrigerators and Freezers dated December 2014, revealed the following information in part:7. All food shall be appropriately dated to ensure proper rotation by expiration dates.Record review of facility in service meeting held on June 11, 2026, titled, Why is it important to label and date food items in the kitchen for safety? revealed the following in part: -Food safety compliance: Labeling and dating items ensure adherence to health regulations, minimizing the risks for food borne illnesses. - Cross contamination prevention: Proper labeling and dating helps prevent confusion and clearly identifies the food type, keeping our residents safe from food allergy reactions and great potential harm.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #1) of 13 residents reviewed for comprehensive care plans. -The facility failed to address the use of a catheter in Resident #1's care plans. This failure could place residents at risk for not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being.Findings included: Record review of Resident #1's face sheet printed 6/09/2026 revealed an [AGE] year-old male resident admitted on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), retention of urine (the inability to completely or partially empty the bladder), history of urinary tract infections, and benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland that commonly affects men as they age, often causing bothersome urinary symptoms). Record review of Resident #1's quarterly MDS assessment printed 6/10/26 was completed 4/18/26 listed Resident #1 with a BIMS of 99 indicating he was severely cognitively impaired, he was independent with most of his activities of daily living, and he had an indwelling catheter (a closed sterile system with a catheter and balloon inserted in the urinary bladder to allow for bladder drainage). Record review of Resident #1's order summary with Active Orders as of: 6/10/26 revealed the following order:- CHANGE 14FR FOLEY CATHETER MONTHLY AND PRN every shift. Active 02/25/2026.- CATHETER CARE EVERY SHIFT. Active 02/25/2026. Record review of Resident #1's care plan printed 6/10/26 with date of admission 1/01/25 revealed no care plan for the use of a catheter. During an observation on 06/09/2026 at 10:59 AM Resident #1 was in his room sleeping in his bed under his covers with his head covered. Resident #1 did not wake or react to knocking or introduction. Observed was Resident #1's catheter bag hanging from the foot of his bed in a privacy bag. During an interview on 06/11/2026 at 8:35 AM the ADON reported Resident #1 did have a catheter and has had a catheter for several months. The ADON reviewed Resident #1's chart and reported Resident #1 did not have a care plan for his catheter. When questioned if the resident should have his catheter care planned, the ADON stated, Of course. The ADON stated, If a resident does not have his catheter care planned then staff who are unfamiliar with that resident might not know he had a catheter. During an interview on 06/11/2026 at 9:53 AM MDS G reported she completes and updated the care plans when she did the MDS's. MDS G reviewed Resident #1 electronic chart and reported Resident #1 did have a catheter marked on his last MDS, but it was not addressed on his care plans. MDS G stated, It was just missed. MDS G reported if the care plan did not address the resident care such as the catheter, then the resident could be affected in a way that they can get a UTI, infection, or have increased pain. During an interview on 06/11/2026 at 10:37 AM the DON reported if a resident's care, to include such things as a catheter, was not addressed in the resident care plan then protocols could be violated such as infection control or the staff would not be able coordinate with the family during a care conference if they do not know what the resident was getting. Record review of the facility provided policy titled Care Plan Completion effective 6/10/25, revealed the following: 2. The facility will develop a Comprehensive Person-Centered Care Plan for each resident within 7 days after completion of the comprehensive assessment that includes:-Measurable objective and timeframes to meet the residents medical, nursing.needs.-Services to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F197	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Oaks Manor	112 Pioneer Dr Booker, TX 79005

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided with such care consistent with professional standards of practice for 1 (Resident #1) of 13 residents reviewed for respiratory care. The facility failed to change the oxygen hydration bottle for Resident #1 for 5 months. This failure could place resident at risk for complications such as shortness of breath, confusion, respiratory failure, infection, and exacerbation of their condition.Findings included: Record review of Resident #1's face sheet printed 6/09/26 revealed an [AGE] year-old male resident admitted [DATE] and readmitted on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and anxiety disorder (a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Record review of Resident #1's quarterly MDS assessment printed 6/10/26 was completed 4/18/26 listed Resident #1 with a BIMS of 99 indicating he was severely cognitively impaired, he was independent with most of his activities of daily living, and he was listed for the use of oxygen therapy. Record review of Resident #1's order summary with Active Orders as of: 6/10/26 revealed the following order:- Oxygen: Oxygen at 2L per NC every shift. Active 01/01/2025. Record review of Resident #1's care plan printed 6/10/26 with date of admission 1/01/25 revealed the following: Focus The resident has COPD. Date Initiated: 01/20/2025.Interventions Have continuous supplemental oxygen via n\c as ordered. Date Initiated: 01/20/2025. During an observation on 06/09/26 at 10:54 AM Resident #1 was in his room in his bed under his covers with a coat over his head. Resident #1 was observed receiving oxygen from an oxygen concentrator next to his bed. Observed a less than 1/4 full hydration bottle attached to the oxygen concentrator. The oxygen hydration bottle was dated 12/30/25 and was milky and discolored. Resident #1 did not respond to knocking or introduction. During an observation on 06/09/26 at 1:43 PM Resident #1 was observed in his room in his bed lying on top of his covers. Resident #1's oxygen hydration bottle was dated 12/30/25. This surveyor attempted to interview Resident #1, and he became loud with speech that was unintelligible. During an observation on 06/10/26 at 07:02 AM Resident #1 was not in his room. Resident #1's oxygen hydration bottle was dated 12/30/25 During an observation and interview on 06/10/26 at 11:09 AM RN F entered Resident #1's room, checked his oxygen hydration bottle, and reported the oxygen hydration bottle was dated 12/30/25. RN F reported the night shift was supposed to check all the respiratory equipment weekly and this should have been changed. RN F reported she would change the oxygen hydration bottle immediately. RN F reported if the oxygen equipment was not changed timely and properly such as the hydration bottle then the resident was at risk for mold or bacteria which could result in a respiratory infection. During an interview on 06/11/26 at 8:40 AM the ADON reported resident's respiratory equipment such as their oxygen hydration bottle should be changed at least monthly. The ADON stated, If a hydration bottle was not changed for 5 months, it could be an issue, a sanitary issue, and the resident possibly could get an infection. During an interview on 06/11/26 at 10:33 AM the DON reported nurses should check the residents' oxygen each time they were in the resident's room or as needed. The DON reported the night shift checked the residents tubing and hydration and filters for the need to be changed or reported for repair. The DON reported staff change tubing every two weeks. The DON reported the hydration bottles are changed as needed. The DON reported if they were not changed frequently then the oxygen tubing could become occluded (blocked) or other complications can occur. The DON reported if the staff did not change a hydration bottle the resident should be ok. Record review of the facility provided policy titled Cleaning and Maintenance of Oxygen Concentrators date issued 8/24/25, revealed the following: Purpose: The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F197	A. Building B. Wing	06/11/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	purpose of this policy is to provide guidelines for the safe and effective operation of oxygen concentrator use by residents.Procedure:5. Tubing and humidifier canisters shall be replaced monthly by a charge nurse, except where more frequent replacement is specified.