

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675101	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER Oakland Manor Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N Main St Giddings, TX 78942	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30633</p> <p>Based on observation, interview, and record review the facility failed to ensure residents had the right to be free from abuse and neglect for 1 (Resident #1) of 5 residents reviewed for abuse and neglect in that:</p> <p>CNA A yelled (verbal abuse) at Resident #1, and refused to make up her bed so she could lie down on 04/12/23.</p> <p>The noncompliance was identified as past noncompliance (PNC). The non-compliance began on 4/12/23 and ended on 4/13/23. The facility corrected the noncompliance before the survey began.</p> <p>This failure (of verbal abuse) could place residents at risk of physical or emotional distress, and injury.</p> <p>Findings included:</p> <p>Review of the Face Sheet for Resident #1 reflected she was admitted on [DATE] with diagnoses of: Atrial Fibrillation, Alzheimer's disease, Hypothyroidism, Seizures, Chronic Obstructive Pulmonary Disease, major depressive disorder and Dementia with unspecified behavior disturbance.</p> <p>Review of the MDS significant change assessment for Resident #1 dated 11/13/23 reflected a BIMS score of 03 indicating severe cognitive impairment. Her functional assessment reflected she required set up for meals and extensive assistance for most of her ADLs. She was assessed as occasionally incontinent of urine and frequently incontinent of bowel.</p> <p>Review of the Care Plan for Resident #1 dated 4/02/24 reflected interventions were in place for: Seizures, a scheduled toileting plan, Memory problems, Abnormal bleeding r/t anticoagulation medications, diabetes, attention seeking behaviors (such as claiming she had fallen), poor safety awareness and history of Syncope (falls).</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility incident investigation (unfinished to five-day mark on 4/15/24) reflected on 4/12/24 two staff reported a CNA used foul language towards Resident #1 and refused to provide care (making a bed). RP and medical director were notified. The DON and administrator were present at the time the Housekeeper and Transport Aide made the report. Witness statements from the Housekeeper and the Transport Aide were included in the packet. Staff were all inserviced on Abuse Neglect & Exploitation on 4/15/24 by the DON. The CNA named was suspended for the investigation.</p> <p>Review of the Progress Notes for Resident #1 reflected the facility transport aide reported to the nurse and the DON that CNA A had told the resident she would not put a fitted sheet on her bed just to have the resident defecate on it (in foul language). Resident #1 stated she could not help having diarrhea and needed sheets on her bed. The CNA refused and did not put any bedding on the bed. The medical director and resident's RP were notified (note DON already aware). The Social worker was notified and spoke with the resident. A Skin assessment for Resident #1 did not reveal any signs of injury.</p> <p>In an interview and observation on 4/15/24 at 10:25 am, Resident #1 stated she did not recall the incident where a CNA spoke badly to her. She stated she could transfer back to bed on her own. There were notices at her bedside reminding her to ask for help and use her call light. The surveyor notified the charge nurse that Resident #1 was attempting to self-transfer back to bed.</p> <p>In an interview on 4/15/24 at 10:45 am, the Administrator stated the Housekeeper and Transport Aide reported the verbal abuse of Resident #1 right away. The administrator stated the witnesses informed her the aide used foul language and refused to make up the resident's bed. The administrator stated the social worker reported to her CNA A had threatened to retaliate against the resident if she reported any problems.</p> <p>In an interview on 4/15/24 at 11:50 am, Housekeeper B (who overheard the incident) stated CNA A told Resident #1 she would not put a fitted sheet on her bed because the resident would just shit on it anyway. Housekeeper B stated the CNA used a sarcastic tone and gave the impression of being lazy. She stated she had not heard anyone else complain about the rudeness of staff.</p> <p>In an interview on 4/15/24 at 12:27 pm, CNA G stated she was working on the day the incident occurred. She stated Resident #1 was forgetful and did not comply with care sometimes. She stated Resident #1 was once a resident of Memory Care and would forget to use her call light to ask for assistance. She stated Resident #1 required frequent checks and bed linen changes. She stated it was unacceptable to refuse to help a resident, to refuse to change a bed and yelling at a resident was abuse.</p> <p>In an interview on 4/15/24 at 12:33pm, CNA A stated she was in a situation with multiple residents at the time of the alleged incident. She stated she helped Resident #1 return from the dining room and then went back to assist others. She stated she returned with Resident #2 (#1's the next room up the hall) who was bleeding profusely from her thumb. CNA A stated she did not use foul language with Resident #1 and only stated she would be right back as soon as she finished helping Resident #2. She stated the nurse declined to help Resident #2. CNA A stated she applied a band aide from her own supplies to Resident #2 because the bleeding from a cut to her thumb was so bad. CNA A stated there was so much blood she helped Resident #2 change her clothing.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of Resident #2 on 4/15/24 at 12:45 pm revealed she had no band aides or dressings to her fingers. Resident #2 was resting quietly in bed and did not reply to surveyor when he introduced himself.</p> <p>In an interview on 4/15/24 at 12:50 pm, LVN W stated Resident #2 had a history of chewing her fingernails down to the nub and would occasionally have some bleeding. She stated Resident #2 had no incidents of bleeding in the last 30 days. LVN W stated she worked with Resident #1 frequently and she was forgetful and needed frequent reminders to stay on task. She stated the resident had memory problems and wanted to do things for herself, which had caused a number of falls. She stated Resident #1 was usually pleasant and it would not be normal for her to argue with an aide.</p> <p>In an interview on 4/15/24 at 1:15 pm, the DON stated she was not sure what the CNA cussing out Resident #1 was thinking, she stated Resident #1 wanted things her way but was cooperative with most people. She stated Resident #1 needed frequent reminders to do most of her ADLs and would refuse sometimes, but you could just reapproach her in a few minutes.</p> <p>Review of the Progress Notes for Resident #2 reflected no mention of bleeding or dressing r/t to skin damage since a fall on 2/27/24.</p> <p>Review of the Facility Abuse Neglect and Exploitation Policy dated 10/2023 reflected verbal abuse of a resident would be substantiated if overheard by other residents or staff.</p> <p>Review of the Personnel File of CNA A reflected she was educated on prevention of Resident Abuse and Verbal abuse. CNA A was hired on 11/15/2023 and was appropriately screened through EMR and licensing. No previous problems had been reported.</p>