

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 04/23/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable and homelike environment for 7 of 7 residents (Residents #1- #7) and 4 of 6 halls (100, 200 secure unit, 500, and 600 halls) reviewed for physical environment.</p> <p>The facility failed to ensure the rooms for Residents #1- #7 and the 600-hallway area were clean and in good repair on 04/23/2024.</p> <p>This failure placed residents at risk of decreased quality of life.</p> <p>Findings included:</p> <p>Observation on 04/23/24 at 10:18 AM revealed a large light brown stain of pooled and dried liquid on the ceiling tiles of the 600 hall and a coating of black dust collecting in a large area around the air conditioner vent nearby.</p> <p>Review of the undated face sheet for Resident #1 reflected an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including dementia, age-related cataract (clouding of the lens of the eye), and cognitive communication deficit (problems communicating caused by impaired cognition).</p> <p>Observation and interview on 04/23/24 at 10:22 AM revealed Resident #1 sitting in a chair in his room on the 100 hall, which he had to himself. In the ceiling over the other bed in the room was an approximately two foot by six-inch paint and texturing plaster peeling and chipping away along a seam in the ceiling drywall. The air conditioning vent over the bed had a black substance present inside it and rust on the grate. Resident #1 stated the ceiling in his room had been that way for a long time, but he was not sure how long. He stated it had been like that for months, at least. He stated the facility had offered him a room change until the ceiling was repaired, but he refused because he did not want to move out of his room. Resident #1 stated he had no breathing problems or other ill effects from the issues.</p> <p>Review of the undated face sheet for Resident #2 reflected an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including dementia, major depressive disorder, and cognitive communication deficit (problems communicating caused by impaired cognition).</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 04/23/24 at 10:32 AM revealed a large patch on the wall behind and one to the side of Resident #2's bed in his room on the 500 hall was scratched, torn, and scuffed down to the drywall. Resident #2 was asleep in his bed and did not awaken when addressed.</p> <p>Review of the undated face sheet for Resident #3 reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia and hypertensive retinopathy (damage to the retinas from high blood pressure that can lead to vision loss).</p> <p>Observation and interview on 04/23/24 at 01:20 PM revealed Resident #3 sitting on the edge of her bed in her room on the 100 hall. On the wall behind her head was a large area (approximately one foot by six inches) on which the paint and texturing plaster had been scraped and torn away, exposing the drywall. Resident #3 stated she had noticed the damage to her wall, but she thought the facility would be taking care of it.</p> <p>Review of the undated face sheet for Resident #4 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including irritable bowel syndrome, anxiety disorder, and recurrent depressive disorders.</p> <p>Review of the admission MDS assessment for Resident #4 dated 04/24/24 reflected the BIMS assessment had not been completed yet.</p> <p>Review of the undated face sheet for Resident #5 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including major depressive disorder, constipation, and hemiplegia/hemiparesis (paralysis on one side of the body).</p> <p>Review of the quarterly MDS for Resident #5 dated 02/08/24 reflected a BIMS score of 15, indicating intact cognition.</p> <p>Observation and interview on 04/23/24 at 01:26 PM revealed Residents #4 and #5 in their room on the 100 hall, sitting in their wheelchairs. Resident #4 stated the bathroom door did not close properly, and Resident #5 stated the floor was coming up in the bathroom. Resident #5 stated the facility was aware and kept telling them they would fix it, but it had been like that a long time. She stated they did not have anybody in maintenance, and it was obvious, because nothing was being repaired. Observation revealed the bathroom door did not fit in the doorframe and thus could not be closed all the way. The floor in their bathroom was one solid sheet of linoleum, and it was no longer affixed to the subfloor but was peeling off at the sides. The insect screen on their window had several holes in it. Resident #4 stated she did not like the lack of privacy, and the bathroom was already small enough as it was. She stated it made her feel like the facility did not care about them.</p> <p>Review of the undated face sheet for Resident #6 reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, Alzheimer's disease, major depressive disorder, generalized anxiety disorder, and unspecified lack of coordination.</p> <p>Review of the quarterly MDS for Resident #6 dated 03/14/24 reflected a BIMS score of 3, indicating severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 04/23/24 at 01:34 PM revealed Resident #6 walking independently up the hall of the 200 hall/secure unit to her room. She stated, That is my room and gave permission to enter. The bathroom light switch in Resident #6's room was loose and not fully connected to the wiring behind it. The screws that bolted an air vent to the wall by the bedroom door had come out, and the vent was hanging loose on the duct opening. There was a large armoire in the room with the drawer second from the bottom missing, and the front of the drawer in her bedside table had been removed and leaning against the side of the table.</p> <p>Review of the undated face sheet for Resident #7 reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, anxiety disorder, and unspecified lack of coordination.</p> <p>Review of the quarterly MDS for Resident #7 dated 01/18/24 reflected a BIMS score of 3, indicating severe cognitive impairment.</p> <p>Observation and interview on 04/23/24 at 01:36 PM revealed stains and black dust surrounding the air conditioning vent in the ceiling of Resident #7's room on the 200 hall/secure unit. The bathroom light had two bulbs in the fixture, one of which did not come and the other of which flickered occasionally but mostly did not come on. The bathroom smelled very strongly of stale urine. Resident #7 entered her room, ambulating with her walker, and stated she used the bathroom in her room sometimes. She stated if she was in the living room, she used the bathroom in the hall, but she went to the bathroom by herself and used the bathroom in her room. She expressed surprise at the fact the bathroom was dark and stated she had not realized the light was not coming on.</p> <p>During an interview on 04/23/24 at 10:56 AM, the ADM stated there was no maintenance director for the facility, but the regional maintenance director for the company visited the facility once per week.</p> <p>During a telephone interview on 04/23/24 at 12:14 PM, the RMAINT stated he had been at the facility the day prior (04/22/24) and had done a walkthrough noting the issues with sheetrock and drywall in the building on a spreadsheet. He stated he had a drywall contractor who worked exclusively for the company doing drywall repairs, and that contractor would be visiting the facility the next day (04/24/24) to go through the list of sheet rock damage and prepare to repair the issues. He stated there had been a few leaks in the ceiling, and the plumbers had been there to fix the leaks but did not repair drywall damage. He stated most of the drywall patch work would be in resident rooms, but some would be in common areas and hallways. He stated he had sent the spreadsheet to the ADM with all the spots that needed to be repaired. The RMAINT stated most of the repairs were just a matter of paint, but some of them would require taping and bedding. He stated he was not aware of any other outstanding issues in the building but was always pulled in 20 different directions when he visited the facility.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/23/24 at 01:00 PM, the ADM stated the RMAINT would be at the facility the following day, 04/24/24, with a contractor to work on the ceilings. The ADM stated she already had the approval from corporate to repair all of those issues. The ADM stated the one in Resident #1's room occurred during the cold front earlier this year when a sprinkler head broke. She stated they moved his roommate, but he did not want to move. The ADM stated there was another leak in the air conditioning unit, and that caused some of the other damage on the 100 hall. She stated the contractor would fix the sheetrock, drywall, and painting starting tomorrow. The ADM stated they had cleaned the air conditioning vents but she was not aware of the ceiling damage or the dust on the 600 hall. She stated the housekeeping department had cleaned the air conditioning vents. The ADM stated she had not had a maintenance director in the building since November 2023. The ADM stated she was trying to hire someone for the maintenance director position, but it was proving very difficult in their area. She stated they have had applicants, but many of them did not pass the criminal background checks, and others never showed up for the interviews. The ADM stated she advertised on the job boards and in the local newspaper and has offered her staff a referral bonus of \$500 if they referred a successful candidate. She even stated with these measures, they have not been lucky. The ADM stated her corporate office was supportive, but they did not have interim maintenance directors and only sent the RMAINT to the facility on ce per week. She stated there was another man who was the maintenance director at a sister facility, and he came to the building on Saturdays to help out. The ADM stated she had to leave for an appointment. She was not available to walk through the building and observe the failures that were observed after 01:00 PM.</p> <p>During an interview and observation on 04/23/24 at 04:00 PM, the AADM stated she worked at a sister facility and would be covering for the ADM during a leave of absence The AADM stated she was at the facility becoming oriented before the ADM's leave began on 04/28/24. The AADM walked the facility and observed each of the above listed failures. While in the bathroom for Resident #7, she noted the foul odor in the bathroom and saw there was feces in the toilet. She flushed the toilet, but the feces did not go down the pipe. She stated she did not know what was in place at the facility to prevent failures such as those, but they should have been repaired. She stated potential negative outcomes of the failures on residents were infection in the case of the toilet in Resident #7's room, fall risk in the case of the floor in Resident #4's and 5's bathroom, and for all the issues, they could have made it undesirable to live in the facility if the resident was aware of his or her surroundings and embarrassing when visitors came to the building. She stated if there was a process in place currently, the process was not working.</p> <p>Review of facility policy dated February 2021 and titled Homelike Environment reflected the following: Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflected personalized, homelike setting. These characteristics include: a. Clean, sanitary and orderly environment; b. Comfortable, adequate lighting; f. Pleasant, neutral scents.</p>		