STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675101	A. Building B. Wing	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Manor Nursing Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 resident (Resident #1) reviewed for fall mats. The facility failed to ensure Resident #1 had a fall mat in place beside his bed per his care plan. This failure could place residents at risk of falls, injuries, pain, and hospitalization . Findings included: Record review of Resident #1's undated Face Sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of traumatic Subdural Hematoma (when blood leaks between the skull and the surface of the brain after a head injury) without loss of consciousness, Muscle weakness generalized, unspecified lack of coordination, and Alzheimer's Disease (progressive disease that destroys memory and other important mental functions). Record review of Resident #1's Comprehensive MDS dated [DATE] reflected he had a BIMS score of 8 indicating moderate cognitive impairment. His Functional Abilities and Goals indicated he required partial/moderate assistance for sitting to standing, and chair/bed-to-chair transfer. Record review of the Care Plan for Resident #1 dated 04/01/2024 reflected he was at risk for falls due to decreased safety awareness. Goal: [Resident #1] will be free of falls. Approach: start date 06/26/2024 [Resident #] will have a fall mat placed next to bed due to risk for falls. Discipline: Nursing, Chartable task, No. Observation on 07/09/2024 at 9:47 AM of Resident #1 revealed he was in his bed. He had a 1/2 side rail up and the bed was in low position. There was no fall mat on the floor. In an interview on 07/09/2024 at 9:53 AM LVN A stated she was the nurse for Resident #1. She stated she was not aware he needed a fall mat beside his bed. Observation on 07/09/2024 at 11:30 AM in Resident #1's room revealed he had a fall mat beside his bed. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/09/2024 at 1:23 PM LVN A stated she had worked at the facility for one month. She stated the morning shift had been very hectic due to another resident passing away. She stated she was unsure where to look in the chart to find out if Resident #1 required a fall mat and further stated she did not look at his Care Plan. In an interview on 07/09/2024 at 2:05 PM the ADON stated she had worked at the facility for four years. She stated Resident #1 had a Care Plan that stated he needed a fall mat beside his bed. She stated LVN charge nurses should know where to look for that information as it was given to them in orientation. She further stated not having a fall mat in place could lead to a potential injury. In an interview on 07/09/2024 at 2:15 PM the DON stated her expectation was for nurses to be making rounds to check on residents frequently. She stated call lights should be in place, the bed should be in low position and a fall mat in place if it was in the resident's Care Plan. She stated the nurses and aides should know where to look in the chart to see if the resident required a fall mat. She further stated the risk of not having a fall mat in place was an increased risk for injury. In an interview on 07/09/2024 at 3:23 PM the ADM stated her expectation for residents at risk for falls was to have interventions in place to minimize injuries. She stated nurses should look at the Care Plan and follow them. She further stated the potential risk to a resident could be an injury. Record review of a facility policy and procedure titled Falls and Fall Risk, Managing dated 2001 and reviewed July 2019 reflected Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident centered approaches to managing falls and fall risk: 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific factor(s) of falls for each resident at risk or with a history of falls. 7. In conjunction with the attending physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling.