

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 02/20/2025
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884</p> <p>Based on observations, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of eight residents (Resident # 1, and Resident #2) reviewed ADL care.</p> <p>1. The facility failed to ensure Resident #1 and Resident #2 nails were cleaned, trimmed, and did not have any rough edges.</p> <p>This failure could place residents at risk for poor hygiene, dignity issues, and decreased quality of life.</p> <p>Findings included:</p> <p>1. Review of Resident #1's face sheet, dated, 02/20/2025, reflected a [AGE] year-old male who was admitted on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included type 2 diabetes without complications (when your body can not use insulin properly or does not make enough insulin) unspecified lack of coordination (uncoordinated movement due to a muscle control problem that causes an inability to coordinate movements), and cerebral infarction due to embolism of left middle cerebral artery (a condition where a blood clot travels to and blocks the left middle artery in the brain, causing tissue death in the area supplied by that artery causing deficits such as weakness, speech problems and sensory loss).</p> <p>Review of Resident #1's Annual MDS Assessment, dated 01/14/2025, reflected the resident had a BIMS score of 99, which indicated he was unable to complete the BIMS interview. Resident #1 was dependent on staff for the following: personal hygiene, oral hygiene, toileting hygiene, showers, upper and lower body dressing, transfers, and bed mobility.</p> <p>Review of Resident #1s Comprehensive Care Plan, dated 02/18/2025, reflected Resident #1 was at risk for decline in ADL function. Intervention: Resident #1 required one staff assistance with bathing, hygiene, dressing, and grooming.</p> <p>Observation and interview on 02/20/25 at 10:07 AM, revealed Resident #1 was sitting in the common area with other residents on the secure unit. He had a blackish/ brownish substance underneath the middle ring and fore fingernails on his right hand. Resident #1's ring and middle fingernail on his right hand were uneven around the edges. Resident #1 was not interview able.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #2's face sheet, dated 02/20/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included needed assistance with personal care (someone required assistance with basic daily living activities such as: bathing, dressing, eating, toileting, grooming due to physical, mental, or cognitive limitations that prevent them from performing these tasks independently), unspecified dementia, unspecified severity, without behavioral disturbance (a diagnosis of dementia- interferes with a person's ability to remember, reason or able to think to such an extent that it interferes with a person's daily life and activities- where the specific type of dementia was unknown, the level of severity was not clearly defined and the person does not have behavior problems), and unspecified lack of coordination (uncoordinated movement is due to a muscle control problem that causes an inability to coordinate movements).</p> <p>Record review of Resident #2's Quarterly MDS Assessment, dated 12/30/2024, reflected Resident #2 had a BIMS score of 0, which indicated her cognition was severely impaired. Resident #2 was total dependent on staff for personal hygiene, upper and lower body dressing, and toileting hygiene. She required substantial/ maximal assistance (helper does more than half the effort) with showers, oral hygiene, and transfers.</p> <p>Record review of Resident #2's Comprehensive Care Plan, dated 01/09/2025, reflected Resident #2 tasks will be documented in the plan of care assistance (this is guide for CNAs to follow) Interventions: nail care once a day on Tuesday, Thursday, and Saturdays 6:00 PM to 6:00 AM.</p> <p>Observation and interview on 02/20/2025 at 10:37 AM, revealed Resident #2 was sitting in the common area on the secure unit with other residents. Her nails on her right hand were not smooth around the edges. She had a blackish brownish substance underneath her middle and ring fingernails on her right hand. Resident #2 was not interview able.</p> <p>In an interview on 02/20/2025 at 9:10 AM with the Activity Assistant stated she did nail care as part of her activities with the residents. The Activity Assistant stated she would cut, trim , clean and paint all residents' nails on the secure unit. The Activity Assistant stated she was not a CNA. She stated she did not know if there were residents with diagnosis of diabetes on secure unit. She stated the Activity Director did nails with all the residents and she was informed by the Activity Director it was acceptable to do nail care on all residents.</p> <p>In an interview on 02/20/2025 at 10:45 AM, CNA A stated the CNAs were responsible for cleaning, trimming, and filing all residents' nails except for the residents with a diagnosis of diabetes. She stated the nurses were responsible for all the residents' nails with a diagnosis of diabetes. CNA A stated the residents nails were usually cleaned on their shower days and as needed. She stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill such as vomiting and diarrhea. She stated a resident may cause a skin tear if their fingernails were not smooth. CNA A stated she was in-serviced on cleaning, filing, and trimming residents' nails but she did not recall the date. She stated she had given care to Resident # 1 and Resident # 2, and she was not aware of these residents refusing nail care.</p> <p>In an interview on 02/20/2025 at 10:55 AM, CNA B stated the Activity Staff was responsible for nail care for all the residents including residents with diabetes. CNA B stated she was trained on nail care; however, she did not recall the date.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/20/2025 at 11:35 AM LVN C stated the Activity Staff was responsible for nail care for all the residents including residents with diabetes. LVN C stated she did not recall the date of last in-service on nail care.</p> <p>In an interview on 02/20/2025 at 1:05 PM CNA D stated the nurses, and the CNAs were responsible for nail care. She stated the nurses were responsible to trim and clean all resident's nails with a diagnosis of diabetes. She stated it was the CNAs responsibility to clean and trim all other residents' nails during showers or as needed. She stated if there was a blackish substance underneath the resident's nails, there was a possibility the substance had bacteria. CNA D stated if a resident swallowed the bacteria there was a possibility a resident may become ill with stomach problems and may develop a stomach infection. CNA D stated she was not aware of Resident #1 or Resident # 2 refusing nail care. CNA D stated she was in-serviced on nail care; however, she did not recall the date.</p> <p>In an interview on 02/20/2025 via phone the Activity Director stated she does nail care on residents every Monday morning. She stated she trimmed, cut , cleaned, and would paint the female residents' nails. She stated she did nails on both males and females. The Activity Director stated she did residents' nails with diagnosis of diabetes. She also stated she had a nail electric machine at her house she purchased and she would bring it to the facility and use this electric machine to file residents' nails. She stated no one had mentioned to her that she was not qualified to do residents nails. The Activity Director stated she was a CNA at one time, however, she let her CNA license expire and she was not currently a CNA.</p> <p>In an interview on 02/20/25 at 03:36 PM, the Director of Nurses stated if a resident ingested the blackish substance on their fingers or underneath their fingernails, there was a possibility the substance may be some type of bacteria. She stated unless she knew what type of bacteria it was difficult to determine if a resident would become physically ill. She stated all residents were expected to receive nail care during showers and as needed. The Director of Nurses stated the CNAs completed nail care on all residents except for the residents with diagnosis of diabetes. She stated all residents with a diagnosis of diabetes, the nurse was responsible for their nail care. The Director of Nurses stated she expected the CNAs to report any changes in all residents' nails to the nurse supervisor. She stated if a resident had rough nails, there was a potential a resident may scratch themselves. She stated it was the nurse supervisor's responsibility to monitor ADL care. She stated the activity staff was not responsible for nail care. She stated they would paint residents' nails; however, it was not the facilities protocol for activity staff to cut, trim or clean any residents' nails. The Director of Nurses stated only CNAs and Nurses was qualified to cut, trim and clean residents nails.</p> <p>Record review of the facilities Fingernails, Toenails Policy, dated February 2018, reflected The purpose of this procedure was to clean the nail bed, to keep nails trimmed, and to prevent infections. The following information should be recorded in the resident's medical record:</p> <ol style="list-style-type: none"> 1. The date and time that nail care was given. 2. The name and title of the individual who administered the nail care. 3. The condition of the resident's nails and nail bed , including: <ol style="list-style-type: none"> a. Redness or irritation of skin of hands and feet. <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Breaks or cracks in skin, especially between toes.</p> <p>c. Pale, Bluish, or gray discoloration of feet.</p> <p>d. Bluish or dark color of nail beds.</p> <p>e. Corns or calluses.</p> <p>f. Ingrown nails.</p> <p>g. Bleeding; and/or</p> <p>h. Pain.</p> <p>4. Any difficulties in cutting the resident's nails.</p> <p>5. Any problems or complaints made by the residents with his/her hands or feet or any complaints related to the procedure.</p> <p>6. If the resident refused the treatment, the reason why and the intervention taken.</p> <p>7. The signature and title of the person recording the data.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>40884</p> <p>Based on interview and record review, the facility failed, to provide an ongoing activities program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction for residents residing on secure unit, 100 hall, 500 hall and 600 hall.</p> <p>1. The facility failed to provide activities on secure unit for the month of January 2025.</p> <p>2. The facility failed to provide activities on 100, 500 and 600 halls 25 days out of 31 days for the month of January 2025, and 13 out of 20 days for the month of February 2025.</p> <p>This failure placed residents at risk for boredom, depression, increased behaviors, and diminished quality of life.</p> <p>Findings include:</p> <p>Review of the January 2025 Activity Calendar for the secure unit reflected it was the same calendar for residents not residing on the secure unit.</p> <p>Review of the secure unit group activity participation binder on 02/20/2025 reflected activities did not occur on the secure unit for the month of January 2025.</p> <p>Review of the activity participation records on 02/20/2025 for the halls not on the secure unit (100, 500 and 600) reflected the residents did not receive activities such as: group, in room activities or offered activity items for independent activities on the following dates in January 2025:</p> <p>1. January 1st thru January 5th</p> <p>2. January 8th thru January 12th</p> <p>3. January 14th thru January 19th</p> <p>4. January 21st thru January 26th</p> <p>5. January 29th thru January 31st</p> <p>Review of the activity participation records for the halls not on the secure unit (Halls 100, 500, and 600) reflected the residents did not receive activities such as groups, in room activities or offered activity items for independent activities for the following dates in the month of February 2025:</p> <p>1. February 1st thru February 2nd</p> <p>2. February 5th thru February 9th</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. February 11th thru February 16th</p> <p>Review of Activity Assistant Personnel Record on 02/20/2025 reflected the Activity Assistant date of hire was 02/10/2025.</p> <p>Review of the Activity Director Personnel Record on 02/20/2025 reflected the Activity Director's date of hire was 11/06/2024 and she did have her Activity Professional License (does not expire).</p> <p>Review of the activity calendar and a party given by management staff for the residents was not on the January 2025 or February 2025 calendars</p> <p>Observation on 02/20/2025 at 10:00 AM there were five residents sitting in the dining room and two of the residents had their heads on the table. There was not any activities being offered to residents independently or in a group.</p> <p>Interview on 2/20/2025 at 9:10 AM Activity Assistant stated she had only been employed as Activity Assistant since 02/10/2025. She stated she does activities on the secure unit and sometimes she will do activities when the Activity Director was not at the facility for the other residents on 100, 500 , and 600 halls. She stated the secure unit and the following halls were the only areas in the facility where residents resided. The Activity Assistant stated she did not have any participation records of activities she did for the 100, 500 or 600 halls. She stated it was very important for residents to receive activities. She stated if the residents did not receive activities it could affect their cognition, may become depressed or lonely. The Activity Assistant stated it was protocol to document the participation of residents in activities.</p> <p>Interview on 02/20/2025 at 10:05 AM the Director of Nurses stated activities are a vital part of a resident's life. If a resident was not receiving activities there was a possibility the resident may become more depressed, anxious, and overall effect of their quality of life. She stated activities helps a resident's cognition, their self-esteem and enhances their quality of life while living in a nursing home. The Director of Nurses stated some of the management staff would have a party once a week for the residents. She stated she did not know if it was documented or not</p> <p>Interview via phone on 02/20/2025 at 1:45 PM The Activity Director stated she only worked Mondays and Tuesdays. She stated she left activity items out for the residents to do but she did not know if the residents used any of the activity items. She stated all her participation records was in the activity room. The Activity Director stated she did not have any other participation records. She stated she did not know for sure if all the activities on the calendar was being done with the residents when she was not in the facility. She stated she did not have any records indicating if the activities were being conducted with the residents in her absence. The Activity Director did not elaborate who was responsible for activities in her absence. She stated the Administrator was her supervisor. She stated if a resident was not receiving any activities the resident may become bored, become depressed, their mental status may decline, and it would affect their quality of life. She stated when she was not in the facility the department head such as Business Office Manager, Social Worker, MDS Coordinator, etc. would have a party once a week. The Activity Director stated all activities was expected to be documented to indicate the residents who attended the activity and to prove activity did occur according to the activity calendar. The Activity Director stated she was responsible for the participation record documentation and the Activity Assistant was responsible for activity participation records on the secured unit.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 02/20/2025 at 4:00 PM Resident # 5 stated she was bored and did not have anything to do there was never any group activities. She stated she wanted to meet with a group of people and have friendships.</p> <p>Interview on 02/20/2025 at 4:15 PM Resident #6 stated she felt there was not any activities at this nursing place and she wished they had something to do in a group with other residents. She stated she became bored especially in afternoons and on weekends. She stated in AM she watched tv in her room but this was not enough activities for her.</p> <p>Interview on 2/20/2025 at 3:30 PM The Business Office Manager stated the management staff would do activities one day a week in the afternoon and have a party. She stated they did not have any participation records to reflect a party occurred one day a week. The Business Office Manager stated she knew participation records was expected to be documented to prove any activities did occur with the residents.</p> <p>Review of the facilities Activity Documentation Policy, dated January 2020 reflected the following records, at a minimum, are maintained by the Activity Department personnel: attendance records, activities evaluation, activities calendar, activity progress notes and individualized activities care plan or activities portion of the comprehensive care plan.</p>

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884</p> <p>Based on observation, interview and record review, the facility failed to ensure all residents were provided a nourishing, palatable, well-balanced diet that meets daily nutritional and special dietary needs for one (Resident #4) of five residents reviewed for needs and preferences.</p> <p>The facility failed to ensure Resident #4 received a diabetic diet as listed on his meal ticket and ordered by the physician.</p> <p>This failure placed residents at risk for altered nutritional status and decreased quality of life.</p> <p>Findings include:</p> <p>Record review of Resident #4's face sheet, dated 02/20/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses which included type 2 diabetes without complications (when your body can not use insulin properly or does not make enough insulin) unspecified lack of coordination (uncoordinated movement due to a muscle control problem that causes an inability to coordinate movements), unspecified dementia, unspecified severity, with behavioral disturbance (a diagnosis of dementia- -interferes with a person's ability to remember, reason or able to think to such an extent that it interferes with a person's daily life and activities- where the specific type of dementia was unknown, the level of severity was not clearly defined and the person does have behavior problems), and cognitive communication deficit (difficulty communicating effectively due to problems with memory, attention, reasoning, or organization)</p> <p>Record review of Resident #4's Quarterly MDS Assessment, dated 11/19/2024, reflected Resident #4 had a BIMS score of 4, which indicated his cognition was severely impaired. Resident #4 required supervision or touching assistance with eating, personal hygiene, upper and lower body dressing, and toileting hygiene. Resident #4 had diagnosis of diabetes mellitus. Resident #4 required a therapeutic diet such as: low salt, diabetic, or low cholesterol. He did not have five percent weight loss in the last month or loss of ten percent or more in the last six months.</p> <p>Review of Resident #4's Comprehensive Care Plan, edited on 12/23/2024 reflected Resident #4 had nutritional status/diet. Intervention: determine likes/ dislikes. Diet as ordered: received a regular LCS diet, thin liquids, fortify all meals and bedtime snack. Fluid consistency: thin liquids. Resident #4 had cognitive loss (a gradual decline in mental abilities). Interventions: Anticipate needs and observe for non-verbal cues. Explain what you intend to do while providing care. Allow Resident #4 to participate as able. Orient Resident #4 to person, place, and time.</p> <p>Review of Resident #4's Physician Orders, dated 2/20/2025, reflected Resident #4 had an order for insulin 100 unit/milliliters; amount: 12 units; subcutaneous (beneath, or under, all the layers of skin) at bedtime 8:00 PM. He received metformin tablet (diabetic medication); 1,000 milligram; amount one tablet; oral twice a day 7:00 AM -10:00 AM, 7:00 PM -10:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #4's Blood Sugar Vital Report reflected on 02/20/2025 at 6:55 AM Resident #4's blood sugar was 98 mg/dl. His blood sugar at 11:45 AM was 231 mg/dl.</p> <p>Review of Resident #4's Nurses Notes on 2/20/2025 at 4:45 PM revealed there was not a nurses note entry for 2/20/2025.</p> <p>Review of Resident #4's meal slip on 02/20/2024 at 12:10 PM reflected Resident #4 required low concentrated sweet /regular diet. Dessert 1/2 square of gingerbread.</p> <p>Reviewed Resident #4's medical record and there was not any type of documentation of Resident #4 released authorization he understood eating desserts may affect his physical condition.</p> <p>Observation on 02/20/2025 at 12:13 PM reflected Resident #4 had a full size serving of dessert (gingerbread).</p> <p>Interview on 02/20/2025 at 12:18 PM CNA A stated Resident #4 received a full size serving of dessert. She stated the nurses checks the meal trays and compare the meal trays with the meal ticket prior to the meal cart being delivered to the secure unit.</p> <p>Observation on 02/20/2025 between 12:19 until 12:30 six meal trays of non-diabetic residents had the same size dessert as Resident #4.</p> <p>Observation and interview on 02/20/2025 at 12:25 PM Resident #4 did eat the entire piece of gingerbread. Resident #4 was not interview able.</p> <p>Observation on 02/20/2025 between 12:00 PM and 12:35 PM of four diabetic residents' meal tray and they were served half portion of gingerbread .</p> <p>Interview on 2/20/2025 at 2:05 PM The Dietary Manager stated anyone with a low concentrated diet was expected to receive half portion of dessert. She stated the facility protocol is more lenient on desserts for the diabetics and they receive half the portion of a dessert.</p> <p>Interview on 02/20/2025 at 2:20 PM The Registered Dietician Consultant stated the facility has a liberal diet with residents on a low concentrated diet. She stated any resident on low concentrated diet was expected to receive half portion of dessert. The Registered Dietician Consultant stated when the nurse checks the blood sugar of residents with diabetes and their blood sugar was elevated before meal, the resident with elevated blood sugar was not to receive the dessert and receive a dessert without sugar. She stated any blood sugar over 200 would be considered elevated and would not be served a half portion of dessert. The Registered Dietician Consultant stated the resident would need a sugar free dessert.</p> <p>Interview on 02/20/2025 at 3:36 PM The Director of Nurses stated she checked the meal trays and compared the resident's meal tray to the meal ticket. She stated she could not recall why she would allow Resident #4 meal tray go to the secure unit without considering his blood sugar and the size of the cake. She stated if a resident's blood sugar was over 200 it would be beneficial for that resident receive non-sugar dessert. She stated there was a possibility Resident #4's blood sugar may increase after eating a full serving of cake. She stated any resident with blood sugar over 200 did not need a full serving of dessert.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's low concentrated sweets diet policy, dated 2021, reflected The low concentrated sweets diet is less restrictive than a calorie-controlled diet and may be appropriate for diabetics with controlled blood sugar levels. The low concentrated sweets diet follows the regular diet with reduced portions of regular desserts, some unsweetened desserts made with sugar-substitute, unsweetened fruits or those rinsed of sugar syrup, sugar substitute, diet jelly and diet syrup. This diet as opposed to the calorie-controlled diet may be preferred for the institutionalized person who is generally unmotivated or not -compliant with caloric restrictions. Desserts: all types- 1/2 serving; may also serve reduced calorie desserts if desired.</p>		

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 02/20/2025
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884</p> <p>Based on interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that are complete and accurate for 1 (Resident #3) of 5 residents reviewed for medical records.</p> <p>The facility failed to ensure nursing staff documented if the medical physician, nurse practitioner or family was contacted after Resident #3 fell on [DATE].</p> <p>This failure placed residents at risk of not receiving the proper care and having medical records that are not current/accurate</p> <p>Findings included:</p> <p>Record review of Resident #3's face sheet, dated 02/20/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #3 had diagnoses which included unspecified lack of coordination (uncoordinated movement is due to a muscle control problem that causes an inability to coordinate movements), unspecified fracture of right pubis, subsequent encounter for fracture with routine healing (part of the hip bone located on the right side of your body),vitamin D deficiency (body does not have enough vitamin D. Vitamin D is essential for bone health), muscle weakness (lack of muscle strength or power. It can affect one area of the body or the entire body), and cognitive communication deficit (difficulty communicating effectively due to problems with memory, attention, reasoning, or organization).</p> <p>Record review of Resident #3's Annual MDS Assessment, dated 02/07/2025, reflected Resident #3 had a BIMS score of 3, which indicated her cognition was severely impaired. She required glasses for vision impairment. Resident #3 required substantial/ maximal assistance (helper does more than half the effort) with the following: eating, oral hygiene, toileting hygiene, and showers. She was dependent on staff for toilet transfer. Resident #3 required supervision or touching assistance with bed mobility and the following transfers: sit to stand, chair to bed , and bed to chair. She required partial assistance from another person to complete self-care, indoor mobility, and functional cognition (the resident needs for assistance with planning regular tasks, such as shopping or remembering to take medication prior to current illness or injury).</p> <p>Record review of Resident #3's Comprehensive Care Plan, revised on 02/04/2025, reflected Resident #3 had a potential risk for falls related to impaired balance and impaired vision. She had an unwitnessed fall on 12/23/2024. Interventions: Resident #3 will sit on floor at times to look for items. Encourage Resident #3 to call for assistance if she believes light does not work. Assess Resident #3 for use of glasses. Encourage Resident #3 to wear glasses when out of bed. Assess Resident #3's footwear for proper fit ad non-skid soles. Encourage use of call light. Resident #3 had a diagnosis of vitamin D deficiency; Resident #3 was at risk for fractures due to her vitamin deficiency. Intervention: Administer medications as ordered by Primary Care Physician. Monitor Vitamin D levels through labs as ordered by Primary Care Physician.</p> <p>(continued on next page)</p>		

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 02/20/2025
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #3's nurses note, dated 01/04/2025 reflected post fall follow-up: initial progress note post-fall.</p> <p>Mental status: no change from baseline. Injuries identified at the time of initial fall : no injury noted at the time of the fall. Delayed injury identified at this time: no delayed injury noted. Vital signs: Vital signs within Resident's baseline. Pain: no pain reported. Neurological checks: witnessed fall without head injury. Since the fall, Resident #3 required: no change in amount of assistance. Interventions: wheelchair breaks locked. Resident response to fall interventions: current interventions are effective. Diagnostic tests: not applicable. Additional notifications: none. Signed by LVN</p> <p>Interview on 02/20/2025 at 3:05 PM The Director of Nurses stated the nurse was expected to document on 01/04/2025 if the family, physician, or DON was notified of the fall. She stated the nurse was expected to document if there were any new orders. The Director of Nurses verified by reviewing Resident #3's nurses' documentation on 01/04/2025 the nurse did not document if nurse practitioner, medical doctor or family was notified of Resident #3's fall. She stated if the nurse did not chart the notifications, it reflected the notifications was not made by the nurse. The Director of Nurses stated she expected for the nurse practitioner or the medical doctor to be notified after a resident fell and documented in the residents' nurses' notes in the electronic medical record. She stated there was a potential a resident would not receive the care they may need and a fracture could be missed if the nurse practitioner or medical doctor was not notified. The Director of Nurses stated LVN E was the nurse assigned to Resident #3. She stated LVN E witnessed on 01/04/2025 Resident #3's fall.</p> <p>Interview on 02/20/2025 at 4:15 PM, attempted to call LVN E. A voice message was left to return phone call. LVN E never returned phone call for an interview prior to survey exit.</p> <p>Interview via phone on 02/20/2025 at 5:01 PM the Nurse Practitioner stated she had a record of being notified of a fall for Resident #3. She stated Resident #3 did not have any pain and she denied giving any new orders for Resident #3.</p> <p>Review of the facility's Fall Protocol dated, November 2024, reflected Notify the resident's attending physician and family in an appropriate time frame. When a fall results in significant injury or condition change, notify the practitioner immediately by phone. When a fall does not result in significant injury or a condition change, notify the practitioner routinely such as by fax or by phone the next office day.</p>		