

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  05/02/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42600</p> <p>Based on interviews and record review, the facility failed to provide pharmaceutical services including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals for 1 of 4 residents (Resident #1) reviewed for pharmacy services.</p> <p>The facility failed to ensure Resident #1's Tylenol-codeine 3 were acquired and administered according to physician's orders.</p> <p>These failures could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a potential for decreased health status and decreased quality of life.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet reflected a [AGE] year-old female admitted on [DATE] with diagnoses of atherosclerotic heart disease (buildup of fats in the artery walls), unspecified dementia (symptoms that negatively affect memory, thinking, and social abilities), pain, other recurrent depressive disorders (repeated periods of significant sadness, loss of interest), and anxiety disorder (excessive worry, fear that interfere with daily life).</p> <p>Review of Resident #1's physician orders reflected Resident #1 had an order for Tylenol-codeine 3 tablet scheduled every 8 hours with a start date of 02/28/2025.</p> <p>Review of Resident #1's MAR reflected Resident #1's Tylenol-codeine 3 was not administered on 05/01/2025 at 12:00 AM and 8:00 AM. Reasons listed on the MAR for 12:00 AM reflected Not Administered: Other and for 8:00 AM Not Administered: Drug/Item Unavailable.</p> <p>Review of Resident #1's care plan dated 03/09/2025 reflected Resident #1 had complaints of acute pain related to having chronic back pain, sciatic nerve pain, and restless leg syndrome. Approach included to administered medications (Tylenol #3) as directed by MD.</p> <p>Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 (no cognitive impairment). Further review reflected Resident #1 received a scheduled pain medication regimen. Resident #1's quarterly MDS pain assessment interview revealed Resident #1 had pain frequently.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/02/2025 at 10:59 AM, Resident #1 stated earlier this week she ran out of her Tylenol 3. Resident #1 stated she also received a muscle relaxer, and her pain was okay when she missed her Tylenol 3. Resident #1 stated she had pain and sciatica and that was why she needed her Tylenol-3.</p> <p>During an interview on 05/02/2025 at 2:28 PM, LVN A stated Resident #1's Tylenol 3 was marked as not administered because it was not available or in the facility. LVN A stated narcotics were required to be called in by the NP for refills. LVN A stated she believed Resident #1 had one refill available. LVN A stated she believed the day shift had ordered the refill. She stated Resident #1's pharmacy needed to be called by a certain time for refills. LVN A stated she worked the 6:00 PM to 6:00 AM shift the evening Resident #1's medication was not available as it was scheduled at 12:00 AM during this shift. LVN A stated the medication had been ordered from the pharmacy and it was closed, if it was not ordered by a certain time, it did not get delivered to the facility. LVN A stated the facility had an e-kit but the request for a narcotic had to be called into the pharmacy and the medication needed was in the middle of the night. LVN A stated she believed the DON could call the medication in. LVN A stated she could not use the e-kit for Resident #1 because it was connected to a different pharmacy than what Resident #1 used. LVN A stated the code for the e-kit was provided by the pharmacy for controlled medications. LVN A stated Resident #1 was asleep when the medication was supposed to be given and did not have any obvious signs or symptoms of pain. LVN A stated Resident #1 also had PRN Tylenol and did not request it. LVN A stated she believed someone went to the pharmacy in the morning and picked up Resident #1's medication. LVN A stated normally she would have notified the NP or the MD for missed medication or refusals. LVN A stated she did not call the NP or on-call and notify them because it was not an emergency, she had been stepped on in the past for calling the NP or MD for non-emergencies .</p> <p>During an interview on 05/02/2025 at 2:51 PM, MA B stated if she saw a medication was out, she would have notified the nurse, and the nurse would handle it from there .</p> <p>During an interview on 05/02/2025 at 2:59 PM, LVN C stated scheduled narcotic medications were refilled by calling the NP or the MD to refill the medication. LVN C stated if she could not get the medication within a few hours or a day, she would see if the resident could get something else while they waited for the medication. LVN C stated it was never okay for a resident to go without their scheduled medication. She stated she would have notified the doctor and asked if they wanted to prescribe something else. LVN C stated the on-call information was posted and there were numbers you could call anytime .</p> <p>During an interview on 05/02/2025 at 3:19 PM, the DON stated scheduled narcotics could be called in by a physician anytime, day or night. The DON stated staff could call the DON and she could have called the pharmacist. The DON stated most every medication was in the e-kit. The DON stated residents should not miss scheduled doses of a narcotic medication. The DON stated if Resident #1 was asleep, staff were able to delay the medication, but it should have been given unless the staff received an order to hold the medication. The DON stated staff did not let her know Resident #1's Tylenol 3 was out and she expected staff to let her know the medication was missed and the staff to notify the NP or the MD because they could have provided a different kind of medication, if needed. The DON stated she expected nurses to document if they ordered a refill and stated they did not always do that. The DON stated medications should have been ordered 5-7 days before the resident ran out of the medication. The DON stated the e-kit was not specific to one pharmacy, it was to any resident in the building. The DON stated Resident #1's Tylenol 3 was available in the e-kit .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/02/2025 at 3:45 PM, the NP stated she was familiar with Resident #1. She stated she was aware the facility ran out of Resident #1's Tylenol 3 and the facility just had to go pick it up but it was difficult logistically and she was unsure if the facility had someone to get it. The NP stated she was notified when she was at the facility the morning of 05/01/2025 that the medication had run out. The NP stated it was zero concern for her and stated Resident #1 was drug seeking. The NP stated that based on her assessment Resident #1 did not have pain. The NP stated Resident #1 had regular Tylenol if she needed it. The NP stated it was not a dire emergency and if it was, the facility could have called the on-call number but that was not an appropriate thing to call on-call for.</p> <p>Review of the facility policy titled Person-Centered Medication Administration (Liberalized Medication Pass), dated February 2025, reflected the facility has a liberalized schedule and if a provider orders that a medication is to be given at a specific time due to specific health benefits to the resident, the medication will be administered as ordered.</p>