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	02/26/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50872 Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 3 of 7 (Resident #6, #49, and #203) residents reviewed for accommodations. The facility failed to ensure that Residents #6, #49, and #203 had their call lights within reach while lying in bed. This failure could place residents at risk of injury, for not receiving timely care, and for not receiving nursing interventions. Findings included: Record review of Resident #6's face sheet, dated 02/26/2025, revealed an [AGE] year-old female, admitted on [DATE], with diagnoses that included cerebral infarction (a condition in which the blood flow to the brain is cut off causing brain damage), hemiplegia (the complete paralysis on one side of the body), and cognitive communication deficit (a condition that affects the ability to communicate effectively). Record review of Resident #6's quarterly MDS, dated [DATE], revealed a BIMS score of 00 which indicated severe cognitive deficits. Record review of Resident #6's care plan, dated 11/15/2024, revealed Problem [Resident #6] is at risk for falls due to: Paralysis to the left side with an approach that included Increased staff supervision with intensity based on resident need. Encourage [Resident #6] to use call light when assistance is needed. Record review of Resident #49's face sheet, dated 02/26/2025, revealed a [AGE] year-old male, admitted on [DATE], with diagnoses that included aphasia (inability to talk), hemiplegia and hemiparesis following a cerebral infarction (one sided paralysis and weakness due to a lack of blood flow to the brain), and lack of coordination. Record review of Resident #49's comprehensive MDS, dated [DATE], revealed Resident #49 was unable to complete a BIMS assessment and had both short- and long-term memory problems. (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: 675101	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #49's care plan, dated 01/20/2025 and last revised 02/25/2025, revealed no care plan related to call lights. Record review of Resident #203's face sheet, dated 02/26/2025, revealed a [AGE] year-old male, admitted on [DATE], with diagnoses that included cerebral infarction, respiratory failure (a condition of not enough oxygen or too much carbon dioxide in the blood), and patent foramen ovale (a small opening between the upper heart chambers). Record review of Resident #203's record revealed an admission MDS was in process. Record review of Resident #203's care plan, dated 02/13/2025, revealed no care plan related to call lights. During an observation on 02/24/2025 at 09:50 AM, Resident #49 was lying in bed and his call light was on the floor near the head of the bed next to a fall mat, trash can, and enteral feeding pole. During an observation on 02/24/2025 at 09:55 AM, Resident #203 was lying in bed and his call light was sitting inside of a water basin on top of the nightstand approximately 4 feet from Resident #203. During an observation on 02/25/2025 at 02:46 PM, Resident #6 was lying in bed and her call light was on the floor between the bed and the wall and out of reach. During an interview on 02/26/2025 at 01:23 PM, CNA F stated she had worked at the facility for about 5 months. She stated all staff were responsible for ensuring the call lights were within reach for all residents when in bed. She stated that was something everyone was supposed to look at any time staff go into a resident's room. She stated if the call lights were out of reach it could cause the resident to become scared, increase their fall risk, and it could prevent the residents from getting the help they required. During an interview on 02/26/2025 at 02:48 PM, HK L stated she didn't know what a call light was. She stated she had not been trained to ensure the call light was within resident's reach. During an interview on 02/26/2025 at 03:57 PM, LVN C stated that all staff were responsible for ensuring call lights were within reach. She stated the DON and the ADON did rounds to ensure staff were placing call lights within reach. LVN C stated if the call light was not within reach, then it could be considered neglect because the residents couldn't get what they needed. During an interview on 02/26/2025 at 04:40 PM, the ADON stated she had worked at the facility for about 4 1/2 years. She stated that all staff members were responsible for ensuring the call lights were within reach. She stated she and the DON performed daily rounding and that was one thing that they checked for. The ADON stated if a call light wasn't within reach, then it could be considered neglecting the resident because if they had an emergency it would interfere with their care. (continued on next page)

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 02/26/2025
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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/2025 at 04:57 PM, the DON stated she had worked at the facility for 8 to 9 years. She stated the aides, the nurses, and everyone in the building should have ensured call lights were within reach of the residents when in bed. She stated she and the ADON monitored for this during their daily rounds. The DON stated if the call light was not within reach, then the resident would not be able to communicate their needs. During an interview on 02/26/2025 at 05:19 PM, the ADM stated all of us were responsible for ensuring the call lights were within reach of the residents. She stated she expected the staff to make sure the call light was within reach of the resident anytime they were left in their room. The ADM stated the managers performed quality of life checks daily and checking call light placement was part of the checklist. She stated if the call light was not within reach, then it would affect the resident because they wouldn't be able to get the help they needed. Record review of the facility policy titled Answering the call light dated 2001 and revised in March 2021, revealed Purpose The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines 4. Be sure that the call light is plugged in and functioning at all times. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. Record review of grievances revealed no complaints or concerns related to call lights.

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 02/26/2025
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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observations, interviews, and record review, the facility failed to ensure 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 for 2 of 3 shower rooms (shower rooms A and B), 2 of 24 resident rooms (Residents #18 and 35), and in 2 halls and 1 common area (halls 100 and 600 and the rotunda) reviewed for physical environment. 1. The facility failed to ensure shower rooms A and B were clean from 02/24/25 to 02/26/25. 2. The facility failed to ensure the rooms for Residents #18 and 35 were clean from 02/24/25 to 02/26/25. 3. The facility failed to ensure the 100 and 600 halls and the rotunda were free of unpleasant odors from 02/24/25 to 02/26/25. These failures placed residents at risk of discomfort and diminished quality of life. Findings included: 1. Observation on 02/24/25 at 10:03 AM revealed shower room A (entrance on the 100 hall) had a first aid bandage, hair, and a disposable glove on the floor of the shower. The toilet had a brown substance caked on it in several areas, and the trash can was overflowing. The mirror over the sink was spattered with white specks. The substance on the mirror came off when wiped with a tissue. A gallon jug of body soap was open on a low shelf, and the lid was not visible in the area. Observation on 02/24/25 at 11:40 AM revealed shower room B (entrance on the 500 hall) had brown substance crusted on the seat and the bowl of the toilet, beads of yellow liquid on the toilet seat, dried yellow fluid on the floor, and black/brown tracks on the floor under the sink and toilet. Observation on 2/25/25 at 08:03 AM revealed shower room A still had a first aid bandage, hair, and a disposable glove on the floor of the shower. The toilet still had a brown substance caked on it in several areas, and the trash can was overflowing. The mirror over the sink was still spattered with white specks. Observation on 2/25/25 at 08:07 AM revealed shower room B still had had brown substance crusted on the seat and the bowl of the toilet, beads of yellow liquid on the toilet seat, dried yellow fluid on the floor, and black/brown tracks on the floor under the sink and toilet. Observation on 02/26/25 at 11:02 AM revealed shower room A still had a first aid bandage, hair, and a disposable glove on the floor of the shower. The toilet still had a brown substance caked on it in several areas, and the trash can was overflowing. The mirror over the sink was still spattered with white specks. (continued on next page)

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 02/26/2025
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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/26/25 at 11:04 AM revealed shower room B still had had brown substance crusted on the seat and the bowl of the toilet, beads of yellow liquid on the toilet seat, dried yellow fluid on the floor, and black/brown tracks on the floor under the sink and toilet. 2. Review of the undated face sheet for Resident #18 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included intellectual disabilities, depression, and history of urinary tract infection. Review of the quarterly MDS for Resident #18 dated 11/18/24 reflected a BIMS score of 07, indicating severely impaired cognition. It reflected he was occasionally incontinent of bowel and had an indwelling catheter. It reflected he was independent with toileting hygiene. Review of the care plan for Resident #18 dated 12/15/24 reflected the following: [Resident #18] has impaired cognitive abilities related to his diagnosis of Intellectual Disabilities. There was no care plan item related to behaviors of poor hygiene. Review of the undated face sheet for Resident #35 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included dementia with behavioral disturbances and anxiety disorder. Review of the annual MDS for Resident #35 dated 12/19/24 reflected a BIMS score of 03, indicating severely impaired cognition. It reflected he required supervision or touching assistance with toileting hygiene. Review of the care plan for Resident #35 dated 01/23/25 reflected the following: [Resident #35] experience decreased bladder continence. [Resident #35] will attain improved level of bladder continence. There was no care plan item related to behaviors of urinating in wastebaskets or piles of clothing. Observation and interview on 02/24/25 at 10:16 AM revealed Resident #18's bed was unmade, and the sheet had a yellowish moisture stain from the edge of the bed toward the center with a dark brown streak mark in the middle. His toilet had streaks of a thick brown substance on the underside of the seat and within the bowl. There was an unpleasant odor in his room and bathroom. Resident #18 did not respond to questions about the condition of his room, though he did engage in some light conversation. Observation and interview on 02/24/25 at 10:24 AM revealed Resident #35's room had an overwhelming foul odor. His bathroom had white flecks covering the mirror, brown crusted substance on the toilet, and the wastebasket had standing yellow liquid in it. The floor around the base of the toilet was not tiled, and there was a dark brown/black crust both on the toilet base itself and the floor below. Resident #35 stated his room looked good to him and asked if it looked clean enough. Observation on 02/25/25 at 08:20 AM revealed Resident #18's bed and bathroom still unmade, and the sheet still had a yellowish moisture stain from the edge of the bed toward the center with a dark brown streak mark in the middle. His toilet had still streaks of a thick brown substance on the underside of the seat and within the bowl. There was still an unpleasant odor in his room and bathroom. (continued on next page)

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 02/26/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/25/25 at 08:22 AM revealed Resident #35's room and bathroom still had an overwhelming foul odor which was even stronger than on 02/24/25. His bathroom had white flecks covering the mirror, brown crusted substance on the toilet, and the wastebasket had standing yellow liquid in it. The floor around the base of the toilet was not tiled, and there was a dark brown/black crust both on the toilet base itself and the floor below. Observation on 02/26/25 at 03:30 PM revealed Resident #18's bed was still unmade, and the sheet still had a yellowish moisture stain from the edge of the bed toward the center with a dark brown streak mark in the middle. His toilet had still streaks of a thick brown substance on the underside of the seat and within the bowl. There was still an unpleasant odor in his room and bathroom. Observation on 02/26/25 at 03:30 PM revealed Resident #35's bedroom and bathroom still had an overwhelming foul odor which was even stronger than on 02/24/25. His bathroom had white flecks covering the mirror, brown crusted substance on the toilet, and the wastebasket had standing yellow liquid in it. The floor around the base of the toilet was not tiled, and there was a dark brown/black crust both on the toilet base itself and the floor below. 3. Observation from 02/24/25 at 09:00 AM to 04:00 PM, on 02/25/24 from 07:30 AM to 03:30 PM, and 02/26/25 from 08:00 AM to 06:20 PM revealed the facility had a foul odor (urine, among others) that was detectable everywhere in the facility except the secure unit (200 hall) and dining room but became stronger when on the 100 and 600 halls and in the rotunda (center of the wagon wheel-shaped building). During an interview on 02/26/25 at 02:48 PM, HK L stated she had worked at the facility for a few weeks and worked 08:00 AM to 02:00 PM. She stated she was not taught to have a specific procedure or order of cleaning areas of the facility, but most days she was responsible for cleaning 100, 300, and 500 halls as well as the rotunda. She stated she was responsible for cleaning the shower rooms on those halls, but she was not allowed to work any overtime and could not finish her work most days. She stated she had noticed the foul odor in the facility, and the odor came mostly from a few rooms on the 600 hall. She stated the housekeeping staff were instructed to go into those rooms and clean more often, but she did not usually work that hall. She stated none of the residents had complained to her about the odor, but the staff did not like it. (continued on next page)

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 02/26/2025
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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/25 at 03:04 PM, the HKS stated she had been in her position since May 2024. She stated they had been shorthanded in the housekeeping department lately, and cleaning the shower rooms did not always happen. She stated she checked the shower rooms as often as she could. She stated the housekeeping staff were paid less than at most facilities and they were not given very many hours. She stated if the housekeepers were to stay longer to finish their cleaning, she had to give up her own hours. She stated she had hired several staff who had quit soon after hiring, because they could not make enough money. She stated she was not aware who was not allowing them to work enough hours, but the staff did not work enough hours to get the facility clean, and they had a resident population who made more mess than average. She stated she had noticed the foul odor in the facility, and the odor was because of Residents #18 and 35. She stated housekeepers were supposed to stop in those rooms more often and make sure they were clean, because both of the residents were incontinent or had the behavior of urinating in inappropriate places such as piles of clothing or waste baskets. She stated the housekeepers did not have time to clean all the areas they had to clean once, let alone enough time to go into certain rooms several times throughout the day. She stated she had reported the concerns about housekeepers having enough time to clean to her management, but nothing had changed. She stated she was responsible for the cleanliness of the facility, but she was not given the resources she needed to do her job. She stated the potential impact on the residents was they could smell bad odors or get sick. During an interview on 02/26/25 at 03:17 PM HK M stated she had worked at the facility since July 2024. She stated the hours they were allowed to work did not give them enough time to clean the whole facility or get into Resident #18 and 35's rooms more than once. She stated Resident #18 and 35's rooms made the whole facility smell bad . During an interview on 02/26/25 at 03:34 PM, CNA F stated she had worked at the facility since September 2024 and one of her duties were giving showers to her residents. She stated she was supposed to sanitize the shower rooms when they were done with each shower, but her management had never given her any sanitizing supplies. She stated the facility could have been cleaner, and it had a bad odor most of the time, but she had not reported the issue to her management. She stated she had not heard residents complain about the odor or the cleanliness of the facility. During an interview on 02/26/25 at 04:58 PM, the DON stated she was familiar with the unpleasant odors in the facility and thought they mostly came from Resident #18 and 35. She stated she thought the residents were care planned for the behaviors related to urine, feces, and poor hygiene. She stated her understanding was housekeeping was to visit those rooms more frequently to make sure there was no urine or feces present. She stated they have had major staffing challenges at the building and the housekeeping had fallen through the gaps. She stated the impact of the facility not being clean was the residents were at risk of infection. (continued on next page)

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 02/26/2025
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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/25 at 05:19 PM, the ADM stated she had spoken to the HKS about ensuring the rooms and common areas were clean at the end of each day. She stated the HKS was supposed to clean the common areas so the housekeepers could focus on rooms and shower rooms. The ADM stated the housekeepers only worked six hours a day, and if the census went up, they could work more hours, but she felt it was enough time to get all the housekeeping done. The ADM stated if they were not able to clean thoroughly in all areas in six hours, they could work additional hours. She stated she had not told anyone they could not have additional hours if they needed the time to get the job done. She stated she was aware of the odor in the facility, and it was a new situation that had occurred because they had some turnover in the housekeeping department. She stated a potential negative impact on residents was it could be a dignity issue. Review of the 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. 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary, and orderly environment; e. Clean bed and bath linens that are in good condition; f. Pleasant, neutral scents.

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 02/26/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 2 of 24 residents (Residents #35 and 104) reviewed for care plans. The facility failed to include Resident #35's behaviors of urinating in places other than the toilet in his care plan. The facility failed to include Resident #104's bilateral heel injuries in her care plan. These failures placed residents at risk of not having their care needs met. Findings included: Review of the undated face sheet for Resident #35 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included dementia with behavioral disturbances and anxiety disorder. Review of the annual MDS for Resident #35 dated 12/19/24 reflected a BIMS score of 03, indicating severely impaired cognition. It reflected he required supervision or touching assistance with toileting hygiene. Review of the care plan for Resident #35 dated 01/23/25 reflected the following: [Resident #35] experience decreased bladder continence. [Resident #35] will attain improved level of bladder continence. There was no care plan item related to behaviors of urinating in wastebaskets or piles of clothing. Observation and interview on 02/24/25 at 10:24 AM revealed Resident #35's room had an overwhelming foul odor. The wastebasket in his bathroom had standing yellow liquid in it. The floor around the base of the toilet was not tiled, and there was a dark brown/black crust both on the toilet base itself and the floor below. Resident #35 stated he did not notice an odor in his room. Review of the undated face sheet for Resident #104 reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included persistent atrial fibrillation (irregular heartbeat), hyperlipidemia (high cholesterol), dementia, anxiety disorder, hypertension (high blood pressure), atherosclerotic heart disease of native coronary artery (buildup of hardened fat in the artery restricting circulation), cardiomyopathy (disease that affects the heart muscle), and heart failure. Review of admission MDS assessment for Resident #104 dated 02/12/25 reflected a BIMS score of 02, indicating severely impaired cognition. It reflected she had a deep tissue injury (unique form of pressure ulcer that affects the underlying layers of skin, muscle, and other soft tissues. It occurs beneath intact skin and initially appears as a deep bruise. Unlike superficial injuries, deep tissue injuries are not immediately visible, making them challenging to detect and diagnose early) on both heels and was receiving treatment for pressure injury. (continued on next page)

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 02/26/2025
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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan for Resident #104 reflected no care planning related to pressure injury prevention or treatment. Review of a physician order for Resident #104 reflected the following dated 02/20/25: Wound Treatment Order: Location: Bilateral Heels Clean with normal saline/wound cleanser; apply skin prep; leave OTA Observation on 02/24/25 at 12:14 PM revealed Resident #104 in the dining room with slippers on her feet that had no backs. She had deep tissue injuries (DTIs) visible on both heels. During an interview on 02/25/25 at 03:30 PM, the ADM stated the strong foul odor in Resident #35's room was the result of his behavior of urinating in wastebaskets, piles of clothing, and other inappropriate areas. She stated he had care planning for this behavior, as it was well known throughout the facility. During an interview on 02/26/25 at 04:14 PM, the CCM stated she was responsible for creating care plans. She stated she decided what to add as care plan items by completing the comprehensive MDS assessment and drawing the care areas that triggered on the assessment over to the plan in the facility's EMR . The CCM stated she was aware Resident #104 had DTIs, and there should have been a care plan item for the pressure injuries. She stated DTIs were considered pressure injuries. She stated there should have at least been a care plan item for risk of pressure injuries. The CCM stated the reason the pressure injuries were not placed on the care plan was because she had been working the floor as a charge nurse frequently, and the care plan item had slipped her mind. A potential negative impact on the resident was staff might not know what to do to improve the injuries. The CCM stated Resident #35 had known behaviors of urinating in his wastebasket, on piles of clothes and the floor, and other inappropriate places. She stated she thought he had been care planned for these behaviors, and she did not know he had not. She stated he cleaned his room with his clothes. She stated she had noticed an odor in his room, and it was the result of these behaviors. She stated he should have a care plan for the behaviors. She stated the behaviors placed him at risk for infection and slip hazards. During an interview on 02/26/25 at 04:58 PM, the DON stated Resident #35's behaviors and Resident #104's pressure injuries should have been care planned. She stated she, the ADON, and the CCM were responsible for ensuring care plans were comprehensive. The DON stated she would have expected Resident #35's behaviors related to urination and Resident #104's pressure ulcers to be care planned. She stated she monitored for compliance with comprehensive care plans by discussing all care needs during their morning clinical meetings. She stated a potential negative impact on residents was they might not get their care needs met. During an interview on 02/26/25 at 05:19 PM, the ADM stated she expected Resident #35's behaviors of urinating in places other than the toilet to be in the care plan. She stated she was surprised to learn it was not. She stated Resident #104's pressure injuries should have been care planned, as well. She stated it was the responsibility of the CCM to ensure all needs were in the care plans. She stated she monitored to ensure care needs were in the care plans by discussing it during morning meetings and asking if issues were care planned. She stated the potential negative impact of these issues not being care planned was the residents might not get necessary treatment. (continued on next page)

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 02/26/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy dated December 2020 and titled Care Plans, Comprehensive and Person-Centered reflected the following: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The services provided or arranged by the facility, as outlined by the comprehensive care plan, are provided by qualified persons, are culturally, competent, and trauma informed. 8. The comprehensive, person-centered care plan will: a. Include measurable objectives, and time frames; b. Describe the services that are to be furnished to attain or maintain the resident's highest practical, physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment.

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 02/26/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observations, interviews, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 2 of 8 residents (Residents #45 and 104) reviewed for quality of care. 1. The facility failed to follow up with treatment of a skin tear from a fall for Resident #45 after readmission from the hospital. 2. The facility failed to ensure Resident #104 had compression hose applied to both legs from 02/24/25 to 02/26/25 as ordered. These failures places residents at risk of not receiving necessary medical care, worsened swelling, infection, and hospitalization . Findings included: Record review of Resident #45's face sheet, dated 02/26/25, revealed a [AGE] year-old male, admitted on [DATE], with diagnoses that included cellulitis of left upper limb (an infection in the skin tissue), muscle weakness, unspecified lack of coordination, and other fracture of shaft of left humerus (break in the bone of the upper arm). Review of Resident #45's quarterly MDS, dated [DATE], reflected a BIMS score of 15 which indicated no cognitive impairment. Review of Resident #45's care plan, dated 02/11/25, reflected Problem: Pressure sores/ skin care with approaches including report to charge nurse any redness or skin breakdown immediately. Review of Resident #45's wound management report dated 01/26/25-02/25/25 reflected no wound management records for that time period. Review of Resident #45's nurse's note dated 02/15/25 at 02:15 AM reflected Resident #45 fell and Swelling/redness/abrasions noted to left outer arm, ST to left outer hand .resident transported to ER via EMS. Record review of Resident #45's admission observation form dated 02/17/2025 at 11:29 PM revealed Resident #45 returned from hospital and alterations in skin section revealed s/t to left hand with treatment of application of non-surgical dressing. Review of Resident #45's active and discontinued orders for the month of February 2025 reflected no orders to monitor or treat skin tear to left hand. Review of Resident #45's nurses' notes from 02/18/25-02/25/25 reflected no mention of any skin tears. (continued on next page)

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 02/26/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 02/24/25 at 11:57 AM revealed Resident #45 had a dressing to the left hand with initials and dated 01/14/25. Resident stated he broke his arm and got a skin tear to his hand when he fell recently. He stated he had just returned from a follow up with the orthopedic doctor. He stated the date on the dressing was wrong, but he didn't know when the dressing had been changed . During an interview on 02/26/25 at 10:46 AM, LVN C stated skin assessments were done weekly, by the nurse for that hall, according to the schedule. She stated she was unaware of the skin tear to Resident #45's left hand. She reviewed the resident's chart and stated the skin tear was documented on the admission assessment, but no orders were written for the skin tear. LVN C stated the resident needed to have the skin tear monitored because he had an infection from a skin tear to the left elbow in January 2025. She stated if it was not monitored then it could get infected and not get the appropriate treatment. During an interview on 02/26/25 at 01:23 PM, CNA F stated if she noticed a new skin issue, then she was expected to report it to the nurse and document it on the shower sheet in the electronic health record. She stated if she noticed an old dressing on a resident then she would tell the nurse and the DON or the ADON. CNA F stated the skin tear could cause increase in pain if not monitored. During an interview on 02/26/25 at 02:33 PM, CNA G stated if she noticed a new skin tear on a resident then she would report it to the nurse. She stated the skin tear could get worse if its wasn't monitored. Review of the undated face sheet for Resident #104 reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included persistent atrial fibrillation (irregular heartbeat), hyperlipidemia (high cholesterol), dementia, anxiety disorder, hypertension (high blood pressure), atherosclerotic heart disease of native coronary artery (buildup of hardened fat in the artery restricting circulation), cardiomyopathy (disease that affects the heart muscle), and heart failure. Review of admission MDS assessment for Resident #104 dated 02/12/25 reflected a BIMS score of 02, indicating severely impaired cognition. It reflected she was completely dependent on staff for lower body dressing. It reflected she was taking a diuretic medication (reduces fluid overload in the body when the heart can no longer circulate the fluids adequately). It reflected she had a deep tissue injury (unique form of pressure ulcer that affects the underlying layers of skin, muscle, and other soft tissues. It occurs beneath intact skin and initially appears as a deep bruise. Unlike superficial injuries, deep tissue injuries are not immediately visible, making them challenging to detect and diagnose early.) on both heels and was receiving treatment for pressure injury. Review of the care plan for Resident #104 dated 02/25/25 reflected the following: Resident is on diuretic medication r/t HTN/CAD. Monitor cardiovascular system and fluid status to determine effectiveness of diuretic. Review of a physician's order dated 02/19/25 reflected the following: Apply compression hose to bilateral legs every day as tolerated and remove at HS . Review of the February 2025 MAR for Resident #104 reflected her compression hose were marked as Not administered: Drug/item not available on 02/24/25 and 02/25/25 by LVN D. There was no entry marked for 02/26/25. (continued on next page)

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 02/26/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/25 at 03:57 PM, LVN C stated she was aware Resident #104 had an order for compression hose to be on both legs during the day shift each day. LVN C stated the hose were not applied today, 02/26/25. She stated the hose was not applied, because she got behind in her duties. LVN C stated there had been some days when hose was not applied because she needed a bigger size. The ones they had available were size large, and Resident #104 might have needed a size XL. LVN C stated she did not know if her nurse managers had been notified Resident #104 might have needed a bigger size hose, but the size was not the reason why the hose were not applied today. LVN C stated the hose were helping Resident #104, and the swelling on her legs had gone down since they started applying the hose. LVN C stated she had been trained to follow all physician orders. A telephone attempt was made on 02/26/25 at 04:15 PM to interview LVN D, but contact was not returned as of 03/05/25. During an interview on 02/26/25 at 04:40 PM, the ADON stated a head-to-toe skin assessment was required on all residents when they were [re]admitted . She stated the process was to notify the MD of skin issues and obtain an order for treatment and start the order. She stated skin assessments were done weekly by the nurse that worked the hall on the scheduled day. The ADON stated if the skin tear wasn't monitored then it had the potential to get infected. She stated residents with orders for compression hose should have compression hose applied each day. She stated she did not know Resident #104 very well, as the ADON had been on leave just after Resident #104 admitted to the facility. She stated the nurse management team monitored for compliance with orders by checking the administration report. She stated the report would include any missed treatments no matter what the reason given for the missed administration. She stated she and the DON were responsible for ensuring compliance with quality-of-care issues. She stated the potential negative impacts of compression hose not being applied were increased edema and discomfort. During an interview on 02/26/25 at 04:57 PM, the DON stated she expected the nurse that admitted a resident to do a complete assessment that included a complete skin assessment. She stated if there was an issue with the integrity of the skin, then the nurse needed to document it and contact the MD for treatment orders. She stated the doctor should have been contacted for orders for treatment of a skin tear. The DON stated if the skin tear was not monitored then an infection could have developed. The DON stated she did not know Resident #104 was ordered compression hose daily. She stated the nurse management team had discussions about adding compression hose once Resident #104's initial swelling had gone down on her legs, but when she had first admitted to the facility, the swelling on her feet and legs were so bad, the hose could not have been applied. The DON stated she and the ADON were responsible for making sure the orders were followed, but it was easier to do when she did not have to work the floor as a charge nurse, which she often had to do. The DON stated a potential negative impact of Resident #104 not receiving her compression hose application was her feet would continue to get edematous (swollen) and it could compromise circulation. During an interview on 02/26/25 at 05:19 PM, the ADM stated it was required for skin tears to be reported to the physician and to receive treatment. She stated it was also required for a resident ordered compression hose to receive the compression hose each day unless she refused. The ADM stated the DON and the ADON were responsible for ensuring compliance in these areas, but they had a medication noncompliance report that they pulled each morning and went over in the morning meeting. She stated she did not know why these issues were not reviewed in the morning meeting. The ADM stated the potential negative impact of both failures was the injuries could have worsened. (continued on next page)

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 02/26/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled Provision of Quality of Care, dated February 2025, revealed the following policy Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. The policy explanation and compliance included 1. Each resident will be provided with care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. 4. Qualified people will provide the care and treatment in accordance with professional standards of practice, the resident's care plan, and the resident's choices. 50872

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 02/26/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50872 Based on observations, interviews, and record review, the facility failed to ensure pharmaceutical services were provided to meet the needs of each resident: specifically, expired or opened medical supplies were stored in 1 of 2 (100/200-hall Nurses' medication cart) medication carts. The facility failed to ensure expired or open supplies were removed from the 100/200-hall Nurses' medication cart that included one 5 x 9 Xeroform dressing that expired 01/2025, one sterile cotton tipped applicator that expired 08/01/2024, five 4 x 4 drain sponges that expired 12/05/2024, one 2 x 2 hydrogel saturated dressing that expired 11/15/2024, one 1 x 8 Xeroform dressing that expired 03/2024, three 6 x 7 Silicone Composite Dressings that expired 02/22/2025, and one opened package of rolled gauze bandage. These failures could place residents at risk of contamination causing illness or decreased effectiveness of medication. Findings included: Observation on 02/26/2025 at 11:50 AM of the 100/200 hall Nurses' medication cart with LVN E in attendance revealed one 5 x 9 Xeroform dressing that expired 01/2025, one sterile cotton tipped applicator that expired 08/01/2024, five 4 x 4 drain sponges that expired 12/05/2024, one 2 x 2 hydrogel saturated dressing that expired 11/15/2024, one 1 x 8 Xeroform dressing that expired 03/2024, three 6 x 7 Silicone Composite Dressings that expired 02/22/2025, and one opened package of rolled gauze bandage. During an interview on 02/26/2025 at 11:58 AM, LVN E stated the nurses' including herself were responsible for checking for expiration dates. She stated there used to be a schedule to ensure it was getting done but she hadn't seen that schedule in a long time. She stated open packages should be thrown away and not put back in the cart because it was no longer sterile. LVN E stated if the saturated dressings were used, they may not be as effective. During an interview on 02/26/2025 at 03:57 PM, LVN C stated the nurses were responsible for checking for expired medication and supplies in their carts. She stated if the supplies were used after the expiration date they may not be as effective. During an interview on 02/26/2025 at 04:40 PM, the ADON stated the nurses were responsible for checking expiration dates in their carts. She stated the pharmacist also checked all the carts once a month. She stated if the supplies were used, they may not be as effective. During an interview on 02/26/2025 at 04:57 PM, the DON stated it was a combination of everyone that was responsible for ensuring all expired medications and supplies were removed from the medication carts. She stated the pharmacist checked all the carts once monthly and provided a report each month. She stated she expected her staff to not use an expired supply. She stated the integrity of the product could be affected after the expiration date. (continued on next page)

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 02/26/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/2025 at 05:19 PM, the ADM stated the DON was responsible for ensuring expired medication and supplies were removed from all medication carts. She stated if supplies were used after the expiration date, then it could cause an injury. Record Review of the facility policy and procedure titled Storage of Medications dated 2001 and revised in November 2020 revealed: Policy heading the facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy interpretation and Implementation . 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinues, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Record review of grievances indicated no complaint or concerns from residents about expired medications or supplies being administered.

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 02/26/2025
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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40884 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute food in accordance with professional standards for food service safety for one of one kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure fruit cobbler was covered, dated, or labeled after being in the refrigerator. 2. The facility failed to ensure CK K did not store her shoes on the kitchen utility cart in the kitchen. 3. The facility failed to ensure CK J properly used proper hand hygiene during food preparation. This failure could place residents who ate food from the kitchen at risk for foodborne illness. Findings included: 1. Observation on 02/24/2025 at 9:05 AM in the open front refrigerator located across from the steam table reflected a large pan of fruit cobbler not labeled, covered, or dated. Interview with the Dietary Manager on 02/24/2025 at 9:14 AM stated the fruit cobbler was made on Sunday (02/23/2025) to be served for lunch on 02/24/2025. She stated the fruit cobbler was expected to be covered, labeled, and dated. The Dietary Manager stated there was a possibility if staff were placing items in the refrigerator, their sleeve or anything on their clothes, could touch the cobbler. She stated it was a possibility the fruit cobbler may become contaminated when not covered. She stated a resident had a potential of developing stomach issues if the resident ingested some type of bacteria. 2. Observation on 02/24/2025 at 9:10 AM there was a pair of shoes located on the second shelf of a three-shelf utility cart in the kitchen. The shoes were touching hair nets the staff wore in the kitchen. Interview on 02/24/2025 at 9:14 AM the Dietary Manager stated the shoes belonged to the afternoon shift cook. She stated it was unsanitary for shoes to be stored anywhere in the kitchen area. The Dietary Manager stated there was a potential the hair nets were contaminated. She stated if the utility cart was not sanitized after the shoes were removed there was a possibility clean dishes, food, and/or silverware may become contaminated. She stated her expectations were not to have any staff personal items stored in the kitchen. (continued on next page)

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 02/26/2025
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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/25/2025 at 3:05 PM CK K stated the shoes located on the three-shelf utility cart belonged to her. She stated she kept her shoes in the kitchen when she went home for the day. CK K stated she wore another pair of shoes into the kitchen and changed into the tennis shoes she left on the utility cart or other places in the kitchen (she did not specify the other places she left her shoes). CK K stated she left her shoes in the kitchen after her shift due to not wanting her dogs to chew on her good shoes at her house. She stated she had been in-serviced not to leave personal items in the kitchen. CK K stated the shoes were contaminated and if they touched the utility cart or anything the staff used to prepare residents meals these items would be considered contaminated. Observation on 02/25/2025 at 11:05 AM CK J pureeing residents' lunch meal. CK J removed gloves and placed new gloves on her hands. She did not wash or sanitize her hands prior to replacing new gloves on her hands. CK J touched the fourchette (area of the glove where the fingers are placed) and palm area of the glove when removing the gloves from the container. She touched her right side of her shirt, touched the handle of the can opener attached to the food preparation table, touched the menu binder, touched the lid, and outside of the thickener can after placed new gloves on her hands. CK J did not change her gloves when she began to place the broccoli into the puree processor. She touched the broccoli with her hands as she placed it in the puree processor. Interview on 02/25/2025 at 11:20 AM CK J stated, I did touch my clothes, the handle of can opener, the recipe binder, and the can of the thickener. She stated all these items were considered contaminated and she was expected to remove the gloves, wash hands, and place new gloves. CK J stated she could have contaminated the broccoli with possible bacteria on her gloves. She stated if the food was contaminated there was a potential a resident may become physically ill such as stomach issues with diarrhea. CK J stated she received an in-service related to hand hygiene. She stated she did not remember the date of the in-service. Interview on 02/26/2025 at 11:45 PM the Administrator stated all dietary staff were expected to wash hands or change gloves in between tasks. She stated if a cook was wearing gloves and touched anything considered contaminated, there was a possibility the cook may contaminate the food. She stated there was a potential a resident may become ill such as diarrhea or vomiting if the resident ingested contaminated food. She stated shoes or any dietary staff personal items were not to be stored in the kitchen. The administrator stated there was an area away from the kitchen, by the bathroom or the dietary manager's office, the staff were permitted to store personal items. The Administrator stated shoes stored on the kitchen utility cart was unacceptable and not sanitary. She stated all foods were expected to be covered, labeled, and dated. The Administrator stated if food was not covered there was a possibility anything type of bacteria may fall on the food and a resident may become ill such as vomiting or diarrhea if they ingested the bacteria. Interview on 02/26/2025 at 10:40 AM with the Dietary Manager requested Label, Dating, Storage of food Policy and it was not provided at time of exit. Review of the Facility Policy on Employee Sanitation , dated 10/01/2018, reflected The Nutrition and Foodservice employees of the facility will practice good sanitation practices to minimize the risk of infection and food borne illness. Gloves are not a substitute for thorough and frequent hand washing. When using, gloves always wash hands before touching or putting on new gloves. Change gloves between each food preparation task. After touching items, utensils or equipment not related to task. After touching hair, face, or any other source of contamination. (continued on next page)

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 02/26/2025
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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the FDA Food Code 2022 reflected the following: Pathogens can contaminate and/or grow in food that is not stored properly. Drips of condensate and drafts of unfiltered air can be sources of microbial contamination for stored food. Shoes carry contamination onto the floors of food preparation and storage areas. Even trace amounts of refuse or wastes in rooms used as toilets or for dressing, storing garbage or implements, or housing machinery can become sources of food contamination. Moist conditions in storage areas promote microbial growth. . The hands are particularly important in transmitting foodborne pathogens. Food employees with dirty hands and/or fingernails may contaminate the food being prepared. Therefore, any activity which may contaminate the hands must be followed by thorough handwashing in accordance with the procedures outlined in the Code.

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 02/26/2025
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)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50872 The facility failed to ensure a functional emergency call light system in the bathroom for 1 of 5 (Resident # 38) residents reviewed for communication systems. The facility failed to ensure the emergency call light in the bathroom was functional for Resident #38. This failure could place the residents at risk of falls causing injury. Findings included: Record review of Resident #38's face sheet, dated 02/26/2025, revealed a [AGE] year-old female, admitted on [DATE], with diagnoses that included: Type 2 diabetes mellitus (a condition that affects how the body uses sugar as a fuel), muscle weakness, lack of coordination, chest pain, hypertension (high blood pressure), bipolar disorder (a chronic mood disorder that causes intense shifts in mood, energy levels and behavior), and atherosclerotic heart disease (condition that occurs when plaque builds up in the arteries, hardening them and limiting blood flow to the heart). Record review of Resident #38's quarterly MDS, dated [DATE], revealed a BIMS score of 15 which indicated no cognitive impairment. Record review of Resident #38's Morse Fall Scale (a standardized fall risk assessment tool), dated 01/02/2025, revealed a score of 40 indicating a moderate fall risk. The fall scale revealed resident had a history of falls. Record review of Resident #38's care plan, dated 01/02/2025, revealed Resident uses half bed rails for request of resident, assist with movement in bed, security with transfers with approaches that included Keep call bell within reach of resident. Record review of Resident #38's care plan, dated 01/17/2024 and last revised on 12/23/2024, revealed [Resident #38] is prescribed anticoagulant therapy, she takes aspirin with approaches that included Protect resident from injury/trauma. Record review of Resident #38's care plan, dated 08/07/2023 and last revised on 12/15/2024 revealed [Resident #38] has a history of falls R/T to her having a unsteady gait at times. With approaches that included Keep call light in reach at all times. During an interview and observation on 02/24/2025 at 09:55 AM, Resident #38 stated her call light in the bathroom was not functioning and the facility had attached a squeaky toy to the handrail in the bathroom, but no one could hear it. She stated she was a high fall risk because she had falls in the past. She stated she couldn't remember how long the bathroom light had not been working. During an observation, the call light cord in the bathroom was pulled and no lights went off in the room, bathroom, or outside of the room door and no audible alarm could be heard. During an observation of use of the squeaky toy the sound from the device was barely audible in the room with the bathroom door open. (continued on next page)

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 02/26/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 02/26/2025 at 01:00 PM in Resident #38's bathroom and room with two surveyors revealed the squeaky toy device was not audible in the hall at all with the bedroom door closed. Observation also revealed emergency call light system for the bathroom remained nonfunctional. During an interview on 02/26/2025 at 01:23 PM, CNA F stated she had worked at the facility for about 5 months. She stated CNAs and MAINT were responsible for ensuring the call lights were functioning. CNA F stated if she realized a call light was not working then she would notify the DON. She stated she wasn't sure if there were random checks to ensure the call lights worked. CNA F stated she had never seen the emergency call light for Resident #38 on. She stated the call lights not functioning could cause the resident to become scared, increase their fall risk, and it could prevent the residents from getting the help they required. CNA F stated she had seen the squeaky toy attached to the handrail, but she wasn't sure what it was for. She stated she had not used it but if it's anything like my child's toy, you wouldn't be able to hear it [from the hall]. During an interview on 02/26/2025 at 02:55 PM, the MAINT stated he had only worked at the facility for 3 weeks. He stated he was responsible for ensuring the call light systems were in functioning order. The MAINT stated he would randomly pick rooms down each hall and test the call light systems. He stated he did this on a weekly basis. He stated if the call lights were not working then he would fix them. He stated he expected the staff to verbally tell him if they noticed a call light was not working immediately. He stated he just discovered that staff could put request in the online tracking system, and he had started to encourage staff to use this system as well. The MAINT stated a non-functioning call light system could affect the resident in many ways, depending on the resident it could be life or death and it could increase the risk of falls. During an interview on 02/26/2025 at 04:40 PM, the ADON stated she had worked at the facility for about 4 1/2 years. She stated that all staff members were responsible for ensuring the call lights work. She stated she wasn't sure how it was monitored to ensure the call lights were working. She stated that was the MAINT responsibility. The ADON stated if a call light system doesn't work then it could be considered neglecting the resident because if they had an emergency it would interfere with their care. During an interview on 02/26/2025 at 04:57 PM, the DON stated she had worked at the facility for 8 to 9 years. She stated the MAINT was responsible for ensuring all the call lights were functioning. She stated she expected all staff to notify the MAINT if the call light was not working. She stated she didn't know how the MAINT monitored to ensure the call lights were functioning. The DON stated if the call light was not functioning then the resident would not be able to communicate their needs. During an interview on 02/26/2025 at 05:19 PM, the ADM stated the MAINT was responsible for ensuring the call lights were in working order. She stated she expected the staff to notify the MAINT of any non-working call lights. The ADM stated the MAINT did random weekly checks of the call lights. She stated if the call light system did not work then it would affect the resident because they wouldn't be able to get the help they needed. (continued on next page)

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 02/26/2025
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)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled Answering the call light dated 2001 and revised in March 2021, revealed Purpose The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines 3. Explain to the resident that a call system is also located in his/her bathroom. 4. Be sure that the call light is plugged in and functioning at all times. 7. Report all defective call lights to the nurse supervisor promptly. Record review of grievances revealed no complaints or concerns related to call lights.

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 02/26/2025
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)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 38073 Based on interviews and record review, the facility failed to provide training on abuse, neglect, exploitation, and misappropriation of resident property, procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property, and dementia management and resident abuse prevention to their staff for 4 of 8 staff (RN A, CNA N, CNA O, and CNA P) reviewed for staff training requirements. The facility failed to provide RN A, CNA N, CNA O, and CNA P with orientation, as required by their abuse/neglect prevention policy and procedure prior to scheduling them to work with residents. This failure placed residents at risk of abuse and neglect. Findings included: Review of the personnel file for RN A reflected a hire date of 02/15/24. Her personnel file did not include documentation of the required orientation. Review of the personnel file for CNA N reflected a hire date of 06/24/24. His personnel file did not include documentation of the required orientation. Review of the personnel file for CNA O reflected a hire date of 01/17/23. Her personnel file did not include documentation of the required orientation. Review of the personnel file for CNA P reflected a hire date of 12/03/24. Her personnel file did not include documentation of the required orientation . During an interview on 02/26/25 at 04:24 PM, the HR stated she had been the HR at the facility for years. She stated she was responsible for ensuring orientation was conducted for new hires. She stated the owners had recently implemented a new process for onboarding new staff, and she had stopped doing her old process, which was all on paper. She stated she had discovered that the new process did not have any provision for orientation. She stated she thought the staff had been trained in abuse and neglect, because they had additional computer-based training they completed after they started, but the failure to conduct orientation meant they were not trained in abuse/neglect prevention prior to starting work with residents. The HR stated the potential negative impact to residents was staff would not know how to identify and report abuse or neglect. During an interview on 02/26/25 at 04:58 PM, the DON stated she was familiar with the facility orientation procedure. She stated the HR did a portion of the orientation, and then department heads came in and did the topics that were specific to their departments. She stated required topics were covered during the orientation. She stated not providing orientation to new staff before they started working with residents could impact residents negatively especially if the staff, they hired were not experienced with long term care. The DON stated she monitored for compliance on required trainings and orientation by asking frequently. (continued on next page)

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 02/26/2025
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)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/25 at 05:19 PM, the ADM stated it was the responsibility of the HR to complete the orientation for new hires. The ADM stated the orientation was very general, and the department heads came in to introduce themselves and speak about what they did in the building. She stated the orientation was required to ensure the required topics were addressed before new staff had contact with residents. She stated staff missing orientation could potentially impact residents because staff might not know the right way to take care of them. Review a sample copy of the facility's New Hire Orientation Checklist reflected the following: MANDATORY IN-SERVICES . Abuse prevention Resident rights . Restraints, restraint reduction Review of undated facility policy titled Abuse and Neglect Policy and Procedure reflected the following: Our facility implements an effective system for the prevention of abuse and neglect The facility during its orientation program and through ongoing training, provides all employees with information regarding abuse and neglect, reporting requirements, prevention, intervention and detection. The facility will train employees, through orientation and ongoing sessions on issues related to abuse/neglect prohibition practices and reporting. 1. a. An orientation leader will be assigned to the new associate. A classroom session will be scheduled for new employee to discuss related to abuse prohibition practices. 2. Documentation of training will be present in the employee file: a. What constitutes abuse, neglect, and misappropriation of resident property. b. Appropriate interventions to deal with aggressive and/or catastrophic reaction of residents. How staff should report their knowledge related to allegations without fear of reprisal. How to recognize signs of burnout, frustration, and stress that may lead to abuse.