

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/25/2024
NAME OF PROVIDER OR SUPPLIER  Twin Oaks Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1123 N Bolton St Jacksonville, TX 75766	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50071</p> <p>Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 6 residents (Resident # 54) reviewed for resident rights.</p> <p>The facility did not ensure Resident # 54 was spoken to or addressed in a dignified manner.</p> <p>This failure could place residents at risk of decreased feelings of self-worth and decreased quality of life.</p> <p>Findings included:</p> <p>Record review of facility face sheet dated 09/25/2024 indicated Resident # 54 was a [AGE] year-old female admitted to facility on 07/03/2024 with diagnosis of Fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing, lack of coordination, Depression, Anxiety Disorder.</p> <p>Record review of Admission MDS dated [DATE] indicated Resident # 54 had a BIMS of 09 indicating moderately impaired cognition and mood issues with feeling depressed and sad.</p> <p>During interview on 09/24/24 at 2:00pm CNA-F stated she did not witness the incident with Resident #54 initially but was called in to assist with getting her up off the floor and assuring she was ok and back in bed comfortably. CNA-F stated LVN-L voice was very heavy and she cannot say for sure if she was yelling at Resident #54 or if she was just reacting in an emergency manner to assure the resident was ok. CNA-F did witness Resident #54 crying and saying LVN-L was yelling and rude to her and she was angry at the nurse-L.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/24/24 at 02:17 PM the AD stated she remembered everything about the incident on 8/2/2024 with Resident #54. The AD stated she was going to Resident #54's room to get a list of items to be picked up from Wal-Mart and she saw her call light was on and she entered the room and Resident #54 was on the floor. The AD asked Resident #54 if she was ok and told Resident #54, she will be right back and went got the LVN-L on duty and NA-F. As soon as LVN-L entered the room LVN-L started yelling and asking her what the hell was she doing on the floor for approximately 30 seconds before LVN-L and NA-F picked her up and put her back on the bed. LVN-L continued yelling at Resident #54 as to why she got out of bed. Resident#54 was trying to explain that she did not get out of bed and was getting out of her chair to get back in the bed due to being left sitting up in her room. The AD said nurse and NA-F picked Resident #54 up from the floor and put her on her bed. The AD stated after about 30 minutes and Resident #54 was crying and getting increasingly upset she told LVN-L to leave the room. The AD said LVN-L left the room and NA-F went and got the ADON whom completed an assessment of Resident #54 and determined she had calmed down and not showing further signs of distress. The AD does not recall seeing LVN_L back at the facility since the incident.</p> <p>During an interview on 09/25/24 at 03:56 PM the Administrator stated she had been employed since February 2024. The Administrator said AD came to her and reported that Resident #54 was crying due to LVN-L raising her voice at her for trying to get out of bed on her own. Administrator stated she immediately went to Resident #54's room and Resident #54 was upset as she explained the situation. Administrator stated she assured Resident #54 that LVN-L would no longer be taking care of her. Administrator then reported to ADON that LVN-L would be sent home on a pending investigation concerning Resident #54. Administrator stated she suspended the LVN-L immediately pending further investigation. Administrator stated Resident #54 does not show other signs of distress since the incident. Administrator stated Resident #54 told her during the incident she was crying more from being angry due to the way she was talked to and not that she was harmed in any way. Administrator said LVN-L came back to the facility after the investigation was completed and only entered her office in the facility and she was then terminated. Administrator said no other issues of inappropriate interactions had been noted with Resident #54 or any other resident in the facility.</p> <p>During an interview on 09/24/24 at 10:50am RP stated Resident #54 had talked about staff mistreating her, treating her like shit or things will come up missing. RP identified Resident #54 as an honorary old lady and can be mean, negative, and short towards people. RP stated he normally weighs what she said as a complaint with a grain of salt. RP stated Resident #54 is lonely and he was working to get her moved into a facility near him so she can be closer to him and other family members so Resident #54 would get visits and be monitored better. RP stated Resident #54 had no one in the area where she resides, and he felt that contributed to her mood swings. RP stated Resident #54 don't like to talk about issues as she doesn't want to be a burden to anyone. RP stated no issues with staff and whenever he called to check on Resident #54 staff had been very helpful.</p> <p>On 09/24/2024 at 2:00 pm LVN-L was called twice with no answer and a text message was sent on 09/25/24 at 10:49am with no response.</p> <p>Record Review of facility policy (undated), titled Resident Rights indicated, .Respect and Dignity-The resident has a right to be treated with respect and dignity .</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273</b></p> <p>Based on observations, interviews, and record reviews the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 3 of 7 residents (Residents #16, #50 and #53) reviewed for call lights.</p> <p>The facility failed to ensure the emergency call lights in Resident #16, #50, and #53s bathrooms were accessible from the floor on 9/23/2024.</p> <p>These failures could affect residents who used their call light or desire to use the call light and place them at risk of not being able to notify staff of their needs.</p> <p>Findings include:</p> <p>Resident #16</p> <p>Record review of a facility face sheet dated 9/25/24 for Resident #16 indicated that he was an [AGE] year-old male admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: bipolar disorder (a mental health condition that causes extreme mood swings), dementia, and parkinsonism (brain conditions that cause slowed movements, rigidity (stiffness) and tremors).</p> <p>Record review of a comprehensive MDS assessment dated [DATE] for Resident #16 indicated that he had a BIMS score of 3, which indicated that he had severe cognitive impairment. He required partial/moderate assistance with toileting hygiene and supervision with toilet transfers. He was occasionally incontinent of bladder and always continent of bowel.</p> <p>Record review of a comprehensive care plan dated 9/20/24 for Resident #16 indicated that he was at risk for falls and had an intervention which read: .be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed .</p> <p>Resident #50</p> <p>Record review of a facility face sheet dated 9/25/24 for Resident #50 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] and subsequently readmitted on ,d+[DATE] with diagnoses including: respiratory failure (trouble breathing), lack of coordination, and type 2 diabetes (uncontrolled blood sugar).</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #50 indicated that he had a BIMS score of 12, which indicated that he had a moderate cognitive impairment. He required supervision with toileting hygiene and toilet transfers. He was always continent of bowel and bladder.</p> <p>Record review of a comprehensive care plan dated 9/18/24 for Resident #50 indicated that he was at risk for falls and had an intervention that read: .be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed .</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #53</p> <p>Record review of a facility face sheet dated 9/25/23 for Resident #53 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: dementia, lack of coordination, and hypertension (high blood pressure).</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #53 indicated that she had a BIMS score of 6, which indicated that she had severe cognitive impairment. She required set up assistance for toileting hygiene and toilet transfers. She was always continent of bowel and bladder.</p> <p>Record review of a comprehensive care plan dated 9/20/24 for Resident #53 indicated that she was at risk for falls and had an intervention that read: .be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed .</p> <p>During an observation and interview on 9/23/24 at 10:23 am revealed the bathroom call light was wrapped around the grab bar multiple times. Resident #16 and #53 were observed in their room. Resident #16 did not speak, and Resident #53 said that they do use the restroom and have not had to use the call lights much. Resident #53 said they have not had any falls in the bathroom.</p> <p>During an observation and interview on 9/23/24 at 10:29 am the bathroom call light was wrapped around the grab bar multiple times in Resident #50's restroom. Resident #50 said he had never needed to use the call light in the bathroom but said he knew it was in there in case he had a fall.</p> <p>During an interview on 9/25/24 at 3:06 pm Administrator said the maintenance man was responsible for checking the bathroom call light to ensure they were long enough and not wrapped around grab bars. She said he was out this week on vacation and was unavailable by phone. She said resident's might not be able to call for help if they were to fall if the call lights were wrapped around the grab bars. She said she would be having the maintenance man checking them more often once he returned. She said she would be checking them until then.</p> <p>During an interview on 9/24/25 at 4:10 pm Administrator said they do not have a call light policy.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50818</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure each resident received adequate supervision with smoking materials to prevent accidents for 2 of 5 residents (Resident #47 and Resident#62) reviewed for accidents and hazards.</p> <p>The facility failed to ensure residents were returning lighters to the staff when returning from smoking.</p> <p>This failure could place residents at risk of harm or injury and contribute to avoidable accidents.</p> <p>Findings included:</p> <p>Resident #47</p> <p>Record review of Admission Record for Resident #47 dated 9/25/24 indicated she was admitted to the facility on [DATE] and was [AGE] years old with diagnoses of nontraumatic intracerebral hemorrhage, and hemiplegia and hemiparesis affecting left non-dominate side.</p> <p>Review of quarterly MDS assessment dated [DATE] for Resident #47 indicated moderate cognitive impairment in thinking with a BIMS score of 10 She required extensive assistance with bed mobility, transfer, and toileting. She was independent with eating.</p> <p>Review of Safe Smoking assessment dated [DATE] for Resident #47 indicated she had a past accident / incident with smoking materials.</p> <p>Review of Nursing Progress note dated 6/19/2024 for Resident #47 revealed that she was falling asleep with cigarettes lit and resident was informed she had to be supervised while smoking and to keep smoking material at the nurses station.</p> <p>An observation on 9/23/2024 at 11:45 AM in the dining room revealed Resident #47 had a cigarette lighter lying on the arm of her wheelchair. In an interview at the same time Resident #47 stated that smoking materials are supposed to be kept at the nurse's station, but she keeps her lighter with her.</p> <p>Resident #62</p> <p>Record review of an Admission Record for Resident #62 dated 9/25/24 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of paraplegia unspecified, tremor unspecified, stage 4 pressure ulcers right lower back, left lower back, sacral region, bilateral above knee amputations, and other specified bladder disorders. He required extensive assistance with bed mobility, transfer, and toileting. He was independent with eating.</p> <p>Review of a Quarterly MDS assessment dated [DATE] for Resident #62 indicated he did not have any impairment in thinking with a BIMS score of 13.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of Resident #62s safe smoking assessment dated [DATE] indicated all smoking materials would be kept at the nurses' station.</p> <p>An observation and interview on 9/23/2024 at 12:00 PM revealed Resident #62 had a cigarette lighter in his room, zipped up in a green bag. Resident #62 said that smoking materials are supposed to be kept at the nurses' station, but he don't let anyone touch his cigarettes or lighter.</p> <p>During an interview on 9/23/2023 at 1:00 PM, Administrator said that facility smoking policy was that all smoking materials are to be left at the nurse's station. She stated she was aware of an incident of Resident #47 falling asleep while smoking, but she was not injured. She said they would make sure staff were supervising residents when they are smoking and smoking materials would be kept at nurse's station.</p> <p>Record review of Smoking Policy dated 11/1/17 reveals that . Matches, lighters, or other ignition sources for smoking are not permitted to be kept or stored in a resident's room .</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49017</p> <p>Based on observation, interview and record review the facility failed to ensure residents were free of significant medication errors for 1 of 5 residents (Resident #5) reviewed for significant medication errors.</p> <p>The facility failed to ensure Resident #5 was free of significant medication errors when a dose of digoxin 125 mcg and metoprolol tartrate 37.5 mg was administered on 09/22/2024.</p> <p>This failure could place residents at risk of adverse reaction related to taking medications not ordered by the physician.</p> <p>Findings include:</p> <p>Record review of a facility face sheet dated 9/25/2024 indicated Resident #5 was a [AGE] year old female that admitted to the facility on [DATE] with diagnoses of polyneuropathy (a nerve damage condition), essential hypertension (high blood pressure), tachycardia (a condition where the heart rate is faster than normal, usually more than 100 beats per minute while resting), and mild cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions).</p> <p>Record review of quarterly MDS dated [DATE] indicated Resident #5 had a BIMS score of 08 indicating moderately impaired cognition. She required supervision with ADL's.</p> <p>Record review of care plans dated 3/29/2024 indicated the Resident #5 had hypertension, impaired cognitive function and impaired vision.</p> <p>Record review of a facility medication error report dated 9/22/2024 revealed that Resident #5 was given the wrong medication. The report was completed by the ADON. The ADON was administering medications on the morning of 9/22/2024 and administered Resident #5 the wrong medication. Resident #5's physician was notified and orders to monitor resident every 30 minutes for 3 hours and if no change resume residents orders. The report did not indicate what medication was administered.</p> <p>Record review of physician orders dated 9/25/2024 revealed that Resident #5 received Metoprolol Tartrate 25mg one half tablet by mouth and Verapamil 40 mg tablet by mouth for hypertension every morning.</p> <p>Record review of blood pressure and pulse monitoring performed on 9/22/2024 every 30 minutes for 3 hours as ordered by the physician after administration of wrong medications. Vital signs remained stable during monitoring for Resident #5.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the ADON on 9/24/2024 at 11:35 AM she said had been employed at the facility since April 2024. She said on Sunday 9/22/2024 she had a medication aide that called in to work. She said she was assigned to pass medications for hall 300 and 400. She said another medication aide (MA D), was working in the facility also and had told her once she was caught up, she would come and help her with medication administration. She said MA D came and helped her. ADON said she was taking Resident #67's blood pressure and the MA D prepared the medications and placed them in a cup. The ADON said when she came back to the cart, the MA D handed her the pill cup with the medications and she administered the medications to Resident #5 that was meant for Resident #67. She said she realized after giving Resident #5 the medications, MA D told her that the medications were for Resident #67 and not Resident #5. The ADON reviewed the medications and noted that Digoxin 125 mcg and metoprolol tartrate 37.5 mg was administered to Resident #5. She said she immediately called the physician and reported to the physician that she had given Resident #67's medications to Resident #5. She said the physician told to monitor every 30 minutes for 3 hours. She said she called the physician back around 2 pm as it was time for the Resident #5 to have more medications and the physician told her it was ok to give and continue with everything. She said that Resident #5 did not have any adverse reactions from the medication error. She said she had training on medication administration on hire and had a competency skill check with the previous ADON. She said residents could be at risk for blood pressure problems and negative outcomes.</p> <p>During an interview with MA D on 9/25/2024 at 2:20 PM she said she had worked at the facility for 2 and a half years. She said that she was working on Sunday 9/22/2024 when the medication error occurred. She said that she had returned from break and that the ADON asked her to help the ADON pass out medications on hall 300. MA D said that she went over to help the ADON. MA D said that the ADON was taking residents blood pressures and MA D was preparing medications for residents to take. MA D said she was punching medications from the cards into cups. MA D said that the ADON was obtaining blood pressures, telling her the blood pressures to document and then the ADON was taking the medications to the residents. MA D said that Resident #67 was in the bathroom and her blood pressure was not obtained, MA D said she pushed her medications to the side and started to prepare Resident #5's medications. MA D said that the ADON took Resident #67's medications from the top of the medication cart. MA D said that when the ADON returned, MA D asked the ADON what Resident #67's blood pressure was and the ADON stated that she just gave Resident #5 her medication. MA D told the ADON she had not finished preparing Residents #5 medications so Resident #5 was given Resident #67's medication. MA D said that the ADON immediately went to the nurses station to notify the doctor. MA D said she gave the cart keys back to the ADON and went back to 100 hall to work.</p> <p>Record review of nurse proficiency audit dated 4/25/2024 indicated that the ADON was satisfactory in administering medication properly and documentation.</p> <p>During an interview with the administrator on 9/25/2024 she said that she has been working at the facility for 8 months. The administrator said that she was aware of the medication error that occurred on 9/22/2024. She said that medications errors are reviewed to make sure that all appropriate steps are performed to ensure resident safety. The administrator said that a review of the incident would be done during the QA/QI meeting. The administrator stated that she expected all of the nurses and medication aides to follow the five rights of medication administration. The administrator said that a resident could have adverse side effects from receiving the wrong medications.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a facility policy titled Medication Administration Procedures, Pharmacy policy and procedure manual 2003 indicated, Medications are to be poured, administered, and charted by the same licensed person. 4. Before administering the dose, the nurse must make certain to correctly identify the resident to whom the medication is being administered 12. Medications prescribed for one resident are not to be administered to any other resident Any medication error will require a medication error report that includes the error and actions to prevent reoccurrence. 20. The five rights of medication should always be adhered to 1. right drug 2. right dose 3. right resident 4. right time 5. right route.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50071</p> <p>Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored in accordance with currently accepted professional principles for, 1 of 6 residents (Resident #324) reviewed for pharmacy services:</p> <p>The facility did not ensure medications were stored properly for Resident #324. Medication was left on bedside table and resident #324 is not care planned to have medication at bedside or self-administer medications. Resident #324 does not have physician orders to have medication at bed side or self-administer.</p> <p>This failure could place residents who receive medications at risk for not receiving the intended therapeutic effects of medications.</p> <p>Findings included:</p> <p>Record review of facility face sheet dated 09/25/2024 indicated Resident # 324 was a [AGE] year-old male admitted to facility on 09/13/2024 with diagnoses of acute respiratory failure with hypoxia (low oxygen levels with breathing).</p> <p>Record Review of comprehensive care plan dated 09/13/2024 did not indicate Resident # 324 could keep medication at bed side or safely self-administer medications. The care plan reflects to administer medications as ordered.</p> <p>Record review of Admission MDS dated [DATE] indicated Resident # 324 had a BIMS of 10 indicating moderately impaired cognition.</p> <p>Record review of consolidated physician orders dated 09/25/2024 indicated Resident #324 had an order for Combivent Respimat Inhalation Aerosol Solution 20-100 MCG/ACT (Ipratropium-Albuterol) 1 puff inhale orally four times a day related to Acute respiratory failure with hypoxia.</p> <p>During an observation on 09/23/24 at 10:30 am Resident # 324 was observed with medication on nightstand. He stated he did not self-administer any medications and did not know there were medication on his nightstand.</p> <p>During an observation on 09/24/24 at 1:25 pm Resident #324 had Clear Eyes maximum itchy eye relief (over the counter) eye drops on his bed side table. This medication was not care planed or ordered by a physician.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Twin Oaks Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1123 N Bolton St Jacksonville, TX 75766	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview 09/25/24 at 03:19 PM LVN-L stated she was employed with the facility for 10 months. LVN-L stated they do not store medications in resident's room. All medications are stored on each LVN's med cart for all residents in the facility. LVN-L stated due to Resident t #324 having a G-Tube and bed confined with limited ROM he cannot self-administer his medications. LVN-L stated if medications are left in the room someone else could get them or the resident could take extra doses which could be very harmful to the residents in the facility. LVN-L stated she always try to make sure all meds are put on the cart and cart is kept locked when not in use. LVN-L does not recall any meds every being left in the rooms in the past other than resident #324's inhaler. LVN-L stated they do have an issue with his wife bringing over the counter medications to him if he asks her to. LVN-L stated if she finds medication on the bedside table, she will immediately pick it up, identify it and report it to the responsible person so they can store it properly or discard it.</p> <p>During an interview on 09/25/24 at 03:38 PM LVN-K stated she has been employed with the facility for 7 1/2 month. LVN-K stated all medications should be stored in a locked med cart and not at the resident's bed side. She reports that if she sees medications inappropriately stored, she will get another nurse to witness, remove the medication, discard, or store the medication in a locked medication cart. LVN-K stated she will report the incident to her DON and report the medication error as directed by her superiors. LVN-K stated that if a resident takes the medication at the wrong time or an unprescribed med it could have minor to severe effects on a resident. She also stated that she would notify the Doctor if it were identified that the patient did not take their prescribed dose and it was too late to give or if a person took medications that were not prescribed.</p> <p>During an interview on 09/25/2024 at 2:10pm the ADON stated medications are never to be left at bedside or in a patient's room without a medication aide or nurse being present or in the process of administering the medication. The ADON stated all medication aides and nurses have been in-serviced on medication storage and should not have left any type of medication in a resident's room.</p> <p>Record Review of Medication Administration Policy dated October 25, 2017, titled Medication Administration Procedures did not address leaving medications at bed side.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50818</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in the facility's only kitchen.</p> <p>The facility did not operate the dish washer at the required temperature for sanitation of dishes.</p> <p>The facility staff was handling the lid of the trash can by the sink after washing their hands.</p> <p>These failures could place residents at risk for food-borne illnesses.</p> <p>Findings included:</p> <p>During an observation in the kitchen on 9/23/2024 at 9:10 AM a trash can next to the kitchen's handwashing sink did not have a foot-operated pedal to open the lid.</p> <p>During an observation on 9/23/2024 at 9:15 AM in the kitchen, Dietary Aid G ran the dishwasher at 110 degrees instead of the required 120 degrees according to the temperature gauge on the front of the dishwasher. A metal plate on the front of the dishwasher indicated dishwasher temperature must be 120 degrees for sanitization.</p> <p>A record review of Temperature/Chemical log dated September 1 through 24, 2024, revealed multiple instances of the dishwasher being operating temperatures between 100-200 degrees.</p> <p>During an interview on 9/23/2024 at 9:15 AM Dietary Aid G said that the dishwasher was supposed to be run at 120 degrees, but the Dietary Supervisor had not turned on the hot water.</p> <p>During an interview on 9/23/2024 at 9:20 AM the Dietary Supervisor said that staff use a clean paper towel or a clean towel to open the lid, or just leave the lid off and they were not using the trash can with a foot-operated pedal because it was too small. She said she was unaware of staff operating the dishwasher below 120 degrees because she was off sick. She said she always reminded staff and does frequent in-services regarding operating the dishwasher.</p> <p>Record review of an in-service dated 9/10/2024 indicated .check dishwasher, make sure you run machine to 120 before you start .</p> <p>During an interview on 9/26/2023 at 3:00 PM, the Administrator said the Dietary Supervisor was responsible for training all kitchen staff and that all kitchen staff had already been in-serviced again and Dietary Aide G had been counseled. She said the Dietary Supervisor would start checking the Temperature/Chemical log twice daily going forward. The Administrator said that the facility would obtain a larger trash can with a foot-operated lid for the kitchen. A copy of the kitchen sanitation policy was requested but not provided.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994</b></p> <p>Based on observations, interviews, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 6 residents (Resident #6, #31, #55 and #62) and 4 of 8 staff (CNA A, CNA B, RN M, CNA F) reviewed for infection control.</p> <p>CNA A failed to wear a gown while emptying a foley catheter drainage bag for Resident #6 who was on enhanced barrier precautions on 9/23/2024.</p> <p>CNA B did not sanitize or wash her hands between glove changes and touched clean items with dirty gloves when providing incontinent care to Resident #31 on 9/23/2024.</p> <p>The facility failed to ensure that RN M donned a gown while providing wound care to Resident #55 on 9/24/24.</p> <p>CNA F failed to keep Resident #62's foley catheter drainage bag off of the ground and stepped on the bag twice while assisting with wound care for Resident #62.</p> <p>These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices.</p> <p>Findings included:</p> <p>1. Record review of a facility face sheet dated 9/24/2024 indicated Resident #6 was a [AGE] year-old male that admitted to the facility on [DATE] for diagnosis of dementia.</p> <p>Record review of a Quarterly MDS assessment dated [DATE] indicated Resident #6 could not complete BIMS assessment and had an indwelling catheter.</p> <p>Record review of a comprehensive care plan dated 7/30/2024 indicated Resident #6 was on enhanced barrier precautions and gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity.</p> <p>Record review of a facility consolidated order report dated 9/24/2024 indicated Resident #6 had an indwelling catheter and required enhanced barrier precautions.</p> <p>During an observation on 09/23/24 at 10:15 am Resident # 6 was in the bed asleep with head elevated and call light in reach. Indwelling catheter present to bedside. Enhanced barrier precautions in place and sign and PPE outside the room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 9/23/24 at 10:20 am, CNA A entered the room of Resident #6 and emptied the foley bag wearing gloves only. She said she had worked at the facility for [AGE] years. She said Resident #6 was on precautions for a wound she thought. She said she was trained on enhanced barrier precautions and was told she only had to wear a gown if she was in contact with the resident's body. She said she should have put a gown on because she could come in contact with the resident's urine, and it could have splashed on her clothes that could spread infections.</p> <p>2. Record review of an Admission Record for Resident #31 dated 9/24/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), neuromuscular dysfunction of bladder (abnormal function of the bladder due to nerve damage), type 1 diabetes (a chronic condition that occurs when the body does not make or produce enough insulin), and paraplegia (paralyzed on the lower half of the body).</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #31 indicated he did not have any impairment in thinking with a BIMS score of 15. He was frequently incontinent of urine. Bowel was not rated because the resident had an ostomy (a surgical opening in the stomach that allows urine or feces to exit the body).</p> <p>Record review of a care plan dated 7/21/2017 for Resident #31 indicated he had bladder incontinence related to neurogenic bladder. Interventions included for incontinent care at least every 2 hours and apply moisture barrier after each episode.</p> <p>During an observation on 9/23/2024 at 3:33 PM, CNA B and CNA C were in the hallway outside of Resident #31's room gathering supplies to provide incontinent care. The supplies were gathered and placed in a plastic bag, both CNA B and CNA C put on gowns. CNA B placed gloves on her hands without washing or sanitizing them and CNA C went into the bathroom and washed her hands. CNA B said she made a mistake, removed her gloves, placed them in the trash and then went into the bathroom to wash her hands. CNA B placed gloves on both hands. CNA C opened Resident #31's brief and pulled it down between his thighs. CNA B removed wipes from the plastic bag and wiped across his abdomen and placed it in the trash. CNA C removed another wipe and wiped down his right thigh and placed it in the trash and then removed another wipe and wiped down his left thigh and placed the wipe in the trash. CNA B removed another wipe and wiped his penis in a circular motion and pushed his foreskin back and cleaned and placed the wipe and gloves in the trash. CNA B washed her hands in the bathroom and applied gloves. CNA C rolled the resident onto his right side. CNA B removed wipes from the plastic bag and wiped his rectal area and placed the wipe in the trash. CNA B grabbed a clean brief and placed it on the bed and removed the dirty brief and placed it in the trash. CNA B removed her gloves and placed them in the trash and put on clean gloves without washing or sanitizing her hands. CNA B placed the brief underneath the resident's buttocks, and he was rolled to his left side and the brief was secured. CNA B and CNA C removed their gloves and gowns and placed them in the trash and washed their hands.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/23/2024 at 4:06 PM, CNA B said she had been employed at the facility for 4 years and worked 6 am-6 pm shift. She said during the care provided to Resident #31, when she went to pull the brief off, she should have removed her glove and washed or sanitized them before she grabbed a clean brief. She said she should have washed or sanitized her hands after she removed her gloves. She said she had recent skills check off on incontinent care and should have had sanitizer in the room. She said staff should wash their hands if soiled in any type of way and get clean gloves. She said when going from dirty to clean, you should change gloves, sanitize, or wash hands whatever was best at the moment and get a clean pair of gloves. She said residents could be at risk for cross contamination and infections.</p> <p>Record review of a competency check off for CNA B dated 8/2/2024 indicated she was satisfactory in perineal care for a male resident and checked off by CNA E.</p> <p>During an interview on 9/25/2024 at 2:19 PM, CNA E said she had been employed at the facility for 7 years and was recently promoted to being the lead CNA. She said she was responsible for overseeing the CNA's to make sure they were doing their jobs and she conducted competency check offs with them every 2-3 months. She said CNA B had a competency check in July 2024 with her. She said staff should perform hand hygiene before they entered the room, after changing gloves, and when changing from dirty to clean. She said hands should be washed or sanitized. She said there could be a risk for cross contamination or spreading infections if staff did not perform hand hygiene properly.</p> <p>During an interview on 9/25/2024 at 2:25 PM, the ADON said hand hygiene should be performed at the beginning of care, after pericare and anal care, when changing gloves and when finished. She said staff should be sanitizing their hands or washing them when going from dirty to clean. She said residents could be at risk for infection if staff did not perform hand hygiene.</p> <p>During an interview on 9/25/2024 at 2:35 PM, the Regional Nurse said the DON and ADON's were responsible for competency check offs with staff. She said the DON just started on 9/23/2024. She said staff should wash or sanitize their hands when going from dirty to clean and should change gloves and wash hands. She said there was a risk for infections and would provide more education with staff and conduct check offs.</p> <p>During an interview on 9/25/2024 at 4:35 PM, the Administrator said staff should perform hand hygiene when they remove dirty or their gloves. She said the DON, ADON and lead CNA helped with educating the staff. She said all staff would be reeducated on how to provide proper pericare on every nurse aide in the facility. She said there was a risk for cross contamination or infections.</p> <p>3. Record review of a facility face sheet dated 9/24/24 for Resident #55 indicated that he was admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: Stage 4 pressure ulcer of sacral region (Full thickness tissue loss with exposed bone, tendon, or muscle located on sacrum), type 2 diabetes mellitus (uncontrolled blood sugars), and hypertension (high blood pressure).</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #55 indicated that he had a BIMS score of 11, which indicated that he had moderately impaired cognition. Section M (Skin Conditions) indicated that he had one Stage 4 pressure ulcer that was present upon admission/entry.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a comprehensive care plan dated 7/30/24 for Resident #55 indicated that he was on enhanced barrier precautions with an intervention that read .Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity .</p> <p>During an observation on 9/24/24 at 2:41 pm RN M did not don a gown while providing wound care to Resident #55.</p> <p>During an interview on 9/24/24 at 2:45 pm RN M said he thought they only had to wear the gown if they were handling his urine because he had MDRO in his urine. He said that he had received training on infection control and enhanced barrier precautions, but the enhanced barrier precautions were new and he just must have misunderstood.</p> <p>Record review of a Nurse Proficiency Audit dated 2/19/24 for RN M indicated that he had demonstrated proficiency with dressing changes and infection control on 2/19/24.</p> <p>4. Record review of an Admission Record for Reisdent #62 dated 9/25/2204 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of paraplegia unspecified, tremor unspecified, protein-calorie malnutrition, iron deficiency anemia, bipolar, depressive disorders, insomnia, stage 4 pressure ulcers right lower back, left lower back, sacral region, bilateral above knee amputations, and other specified bladder disorders.</p> <p>Review of a Quarterly MDS assessment dated [DATE] for Resident #62 indicated he did not have any impairment in thinking with a BIMS score of 13. Resident has an indwelling foley catheter to manage incontinence and assist in healing of pressure ulcers.</p> <p>Record review of a care plan dated 9/20/2024 for Resident #62 indicated interventions for and maintaining the drainage bag off the floor.</p> <p>During an observation of Resident #62 on 09/25/2024 at 8:30 AM revealed that his foley catheter drainage bag was lying on the ground.</p> <p>During an observation of Regional Nurse on 09/25/2024 at 9:00 AM performing wound care for Resident #62 revealed his foley catheter drainage bag was still lying on the ground. CNA F, who was assisting Regional Nurse, stepped on the foley drainage bag twice, but did not pick the bag up off the floor.</p> <p>In an interview on 09/25/2024 at 9:45 AM the Regional Nurse, who was the facility Infection Preventionist, said that all CNA's received training in foley care, and the expectation was to hang the drainage bag where it was not touching the floor. She stated that risks to patient are infection.</p> <p>In an interview on 09/25/2024 at 9:50 AM CNA F said she had received training in foley care and that the drainage bag should be kept off of the floor. She stated that risks to patients include bacteria and infection.</p> <p>A record review on 09/25/2024 of a proficiency audit for CNA F dated 7/31/24 indicated she was successfully checked-off on skills providing foley care to male resident's as satisfactory on 7/31/24.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 09/25/2024 at 10:10 AM the Administrator said that all CNAS receive training in foley care and that the expectation was that foley drain bags are to be hung and kept off the floor. She stated that we have one resident that prefers to have his foley laying on the ground, but it would need to be in a basin and not on the floor. She stated that would need to be ordered and care planned to be implemented.</p> <p>A record review on 09/25/2024 of policy titled Catheter Care dated 2/13/2007 stated .Be sure the catheter tubing and drainage bag are kept off the floor .</p> <p>Record review of a facility policy titled Fundamentals of Infection Control Precautions undated, .A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions. 1. Hand Hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: After contact with a resident's mucous membranes and body fluids or excretions; after removing gloves or aprons .</p> <p>Record review of a facility policy titled Enhanced Barrier Precautions undated indicated, .Enhanced Barrier Precautions (EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are indicated for residents with any of the following: Indwelling medical device examples include urinary catheters. Donning PPE for Residents on EBP Based on Activity Provided / Assistance While in Resident Room: Perform wound care: any skin opening requiring a dressing .Don gloves and gown - YES</p> <p>46273</p> <p>46436</p> <p>50818</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46273</p> <p>Based on interview and record review, the facility failed to ensure the resident's medical record included documentation that indicates the resident received education on the influenza and the pneumococcal immunizations of 4 of 5 residents (Residents #6, #45, #55, #62) reviewed for immunizations.</p> <p>The facility failed to document education offered for the influenza and pneumococcal vaccination to Residents #6, #45, #55, #62.</p> <p>These failures could place residents at risk for contracting a viral disease that could spread through the facility and cause respiratory complications, and potential adverse health outcomes.</p> <p>Findings include:</p> <p>Resident #45</p> <p>Record review of a facility face sheet dated 9/23/24 for Resident #45 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: cutaneous abscess of buttock (a localized collection of pus in the skin that may occur on any skin surface), seizures, and hypertension (high blood pressure).</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #45 indicated that he had a BIMS score of 14, which indicated he was cognitively intact. Section O (Special Treatments, Procedures, and Programs) indicated that resident did not receive his influenza vaccine in the facility for this year's influenza season because it was offered and declined. He was not up to date on his pneumonia vaccination. He did not receive the pneumonia vaccine because it was offered and declined.</p> <p>Record review of a comprehensive care plan dated 8/5/24 for Resident #45 indicated that he had no interventions for flu and pneumonia vaccinations.</p> <p>Record review of a physician order summary report dated 9/23/24 for Resident #45 indicated that he had the following orders: Influenza Vaccination Annually, dated 1/15/21.</p> <p>Record review of Resident #45's immunization tab in his electronic medical record indicated that he had refused the flu and pneumonia vaccination with no date of refusal listed.</p> <p>Resident #55</p> <p>Record review of a facility face sheet dated 9/24/24 for Resident #55 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: pressure ulcer of the sacral region (a medical condition that involves tissue damage or necrosis in the area of the sacrum due to prolonged pressure), type 2 diabetes mellitus (uncontrolled blood sugars), and hypertension (high blood pressure).</p> <p>(continued on next page)</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a quarterly MDS assessment dated [DATE] for Resident #55 indicated that he had a BIMS score of 11, which indicated he had moderate cognitive impairment. Section O (Special Treatments, Procedures, and Programs) indicated that resident did not receive his influenza vaccine in the facility for this year's influenza season because it was offered and declined. He was not up to date on his pneumonia vaccination. He did not receive the pneumonia vaccine because it was offered and declined.</p> <p>Record review of a comprehensive care plan dated 7/30/24 for Resident #55 indicated that he was at risk for signs and symptoms of Covid-19 and had interventions that read: .educate staff, resident, family and visitors of Covid-19 signs and symptoms and precautions .</p> <p>Record review of a physician's order summary report dated 9/24/24 for Resident #55 indicated that he had the following orders: Influenza vaccination Annually, dated 5/4/22, and Pneumonia vaccine per CDC recommendations, dated 7/5/24.</p> <p>Record review of Resident #55's immunization tab in his electronic medical record indicated that he had not received the flu vaccine for this influenza season and had not received the pneumonia vaccine due to refusal. There was no date of refusal listed.</p> <p>Resident #62</p> <p>Record review of a facility face sheet dated 9/25/24 for Resident #62 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: paraplegia, iron-deficiency anemia, and bipolar disorder.</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #62 indicated that he had a BIMS score of 13, which indicated that he was cognitively intact. Section O (Special Treatments, Procedures, and Programs) indicated that resident did not receive his influenza vaccine in the facility due to not being in facility during this year's influenza season. He was not up to date on his pneumonia vaccination. He did not receive the pneumonia vaccine because it was offered and declined.</p> <p>Record review of a comprehensive care plan dated 9/20/24 for Resident #62 indicated that he was at risk for signs and symptoms of Covid-19 and had interventions that read: .educate staff, resident, family and visitors of Covid-19 signs and symptoms and precautions .</p> <p>Record review of a physician's order summary report dated 9/25/24 for Resident #62 indicated that he had the following orders: pneumonia vaccine per CDC recommendations, dated 5/31/24.</p> <p>Record review of Resident #62's immunization tab in his electronic medical record indicated that he was not eligible for the flu vaccine, and his pneumonia vaccine was not given due to refusal, with no date of refusal listed.</p> <p>Resident #6</p> <p>Record review of a facility face sheet dated 9/25/24 for Resident #6 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: dementia, hypertension, and schizophrenia.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Twin Oaks Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1123 N Bolton St Jacksonville, TX 75766	
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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a quarterly MDS assessment dated [DATE] for Resident #6 indicated that BIMS should not be completed due to resident rarely/never being understood. He had moderate cognitive impairment. Section O (Special Treatments, Procedures, and Programs) indicated that resident received his influenza vaccine in the facility on 9/28/23. He was not up to date on his pneumonia vaccination. He did not receive the pneumonia vaccine because it was offered and declined.</p> <p>Record review of a comprehensive care plan dated 7/3/24 for Resident #6 indicated that he was at risk for signs and symptoms of Covid-19 and had interventions that read: .educate staff, resident, family and visitors of Covid-19 signs and symptoms and precautions .</p> <p>Record review of a physician's order summary report dated 9/25/24 for Resident #6 indicated that he had the following orders: Influenza Vaccine Annually, dated 6/25/19.</p> <p>Record review of Resident #6's immunization tab in his electronic medical record indicated that he last received the flu vaccine on 9/28/23, and did not receive pneumonia vaccine due to refusal, with no refusal date listed.</p> <p>During an interview on 9/25/24 at 4:07 pm the Regional Nurse said she could not provide documentation of resident education for immunization refusals. She said the nurses were supposed to have them sign a declination form after being educated if the resident refused. But there was no documentation of that in the facility. She said the DON would be responsible going forward to ensure that residents were educated on immunizations and providing documentation. She said residents could be at risk of not knowing what they were refusing if they were not provided education.</p> <p>During a joint interview on 9/25/24 at 4:12 pm the DON said she and the ADON both would be responsible for immunizations going forward. The ADON said the old DON had been responsible before she left. The DON said residents could be at risk of contracting infections, severe respiratory problems and even death if they were not properly educated and did not receive vaccinations. She said they would be providing education and have consent/declination forms signed going forward.</p> <p>During an interview on 9/25/24 at 4:19 pm Administrator said she would make the DON responsible for immunizations and ensure that she enforced it. She said that residents could get sick if they were not educated on the risks/benefits of immunizations.</p> <p>Record review of a facility policy titled Resident Influenza and Pneumonia Vaccine dated 2019 and revised 3/2024 read: .The following must occur prior to administering the immunization: * Provide a Vaccine Information Statement (VIS) to the resident and/or resident representative that corresponds to the influenza vaccine being administered to the recipient. The VIS will outline education, benefits and</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>potential risks of the immunization. * The facility will maintain documentation of influenza vaccinations or refusals of the influenza immunization in the Point Click Care clinical record and will include: ^That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization or did not receive the influenza immunization due to medical contradiction or refusal . and .The following must occur prior to administering the immunization: *Provide a Vaccine Information Statement (VIS) to the resident and/or resident representative that corresponds to the pneumonia vaccine being administered to the recipient. The VIS will outline education, benefits, and potential risks of the immunization. *The facility will maintain documentation of pneumonia vaccinations or refusals of the pneumonia immunization in the Point Click Care clinical record and will include: ^That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumonia immunization; and ^That the resident either received the pneumonia immunization or did not receive the pneumonia immunization due to medical contraindication or refusal .</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46273</p> <p>Based on interview and record reviews, the facility failed to implement their policy to ensure the residents, or their responsible party, received education of the benefits and risks, or potential side effects of Covid-19 immunizations, receipt of Covid-19 immunizations, or the residents did not receive the Covid-19 immunizations, due to medical contraindication, or refusal, for 4 of 5 residents who were reviewed for immunizations. (Residents #6, #45, #55, #62).</p> <p>The facility failed to document education offered for the covid-19 vaccination to Residents #6, #45, #55, #62.</p> <p>These failures could place residents at risk for contracting a viral disease that could spread through the facility and cause respiratory complications, and potential adverse health outcomes.</p> <p>Findings include:</p> <p>Record review of a facility face sheet dated 9/23/24 for Resident #45 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: cutaneous abscess of buttock (a localized collection of pus in the skin that may occur on any skin surface), seizures, and hypertension (high blood pressure).</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #45 indicated that he had a BIMS score of 14, which indicated he was cognitively intact.</p> <p>Record review of a comprehensive care plan dated 8/5/24 for Resident #45 indicated that he was at risk for signs and symptoms of Covid-19 and had interventions that read: .educate staff, resident, family and visitors of Covid-19 signs and symptoms and precautions . and .following facility protocol for Covid-19 screening/precautions .</p> <p>Record review of a physician order summary report dated 9/23/24 for Resident #45 indicated that he had the following orders: may have Pfizer Covid Vaccine, dated 1/24/21.</p> <p>Record review of Resident #45's immunization tab in his electronic medical record indicated that he had refused the Covid booster with no date of refusal listed.</p> <p>Record review of a facility face sheet dated 9/24/24 for Resident #55 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: pressure ulcer of the sacral region (a medical condition that involves tissue damage or necrosis in the area of the sacrum due to prolonged pressure), type 2 diabetes mellitus (uncontrolled blood sugars), and hypertension (high blood pressure).</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #55 indicated that he had a BIMS score of 11, which indicated he had moderate cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a comprehensive care plan dated 7/30/24 for Resident #55 indicated that he was at risk for signs and symptoms of Covid-19 and had interventions that read: .educate staff, resident, family and visitors of Covid-19 signs and symptoms and precautions . and .following facility protocol for Covid-19 screening/precautions .</p> <p>Record review of a physician's order summary report dated 9/24/24 for Resident #55 indicated that he did not have an order for Covid vaccination.</p> <p>Record review of Resident #55's immunization tab in his electronic medical record indicated that he had not received the covid-19 vaccine due to refusal, with no date of refusal listed.</p> <p>Record review of a facility face sheet dated 9/25/24 for Resident #62 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: paraplegia, iron-deficiency anemia, and bipolar disorder.</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #62 indicated that he had a BIMS score of 13, which indicated that he was cognitively intact.</p> <p>Record review of a comprehensive care plan dated 9/20/24 for Resident #62 indicated that he was at risk for signs and symptoms of Covid-19 and had interventions that read: .educate staff, resident, family and visitors of Covid-19 signs and symptoms and precautions . and .following facility protocol for Covid-19 screening/precautions .</p> <p>Record review of a physician's order summary report dated 9/25/24 for Resident #62 indicated that he had no order for Covid vaccination.</p> <p>Record review of Resident #62's immunization tab in his electronic medical record indicated that he was not eligible for the flu vaccine, and his pneumonia vaccine was not given due to refusal and covid-19 vaccine was not given due to refusal, with no date of refusal listed.</p> <p>Record review of a facility face sheet dated 9/25/24 for Resident #6 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: dementia, hypertension, and schizophrenia.</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #6 indicated that BIMS should not be completed due to resident rarely/never being understood. He had moderate cognitive impairment.</p> <p>Record review of a comprehensive care plan dated 7/3/24 for Resident #6 indicated that he was at risk for signs and symptoms of Covid-19 and had interventions that read: .educate staff, resident, family and visitors of Covid-19 signs and symptoms and precautions . and .following facility protocol for Covid-19 screening/precautions .</p> <p>Record review of a physician's order summary report dated 9/25/24 for Resident #6 indicated that he had the following orders: may have Pfizer covid vaccine, dated 1/5/21.</p> <p>Record review of Resident #6's immunization tab in his electronic medical record indicated that he did not receive the covid booster due to refusal, with no refusal date listed.</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/25/24 at 4:07 pm Regional Nurse said she could not provide documentation of resident education for immunization refusals. She said the nurses were supposed to have them sign a declination form after being educated if the resident refused. But there was no documentation of that in the facility. She said the DON would be responsible going forward to ensure that residents were educated on immunizations and providing documentation. She said residents could be at risk of not knowing what they were refusing if they were not provided education.</p> <p>During a joint interview on 9/25/24 at 4:12 pm DON said she and the ADON both would be responsible for immunizations going forward. ADON said the old DON had been responsible before she left. DON said residents could be at risk of contracting infections, severe respiratory problems and even death if they were not properly educated and did not receive vaccinations. She said they would be providing education and have consent/declination forms signed going forward.</p> <p>During an interview on 9/25/24 at 4:19 pm Administrator said she would make the DON responsible for immunizations and ensure that she enforced it. She said that residents could get sick if they were not educated on the risks/benefits of immunizations.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43994</p> <p>Based on observation, interview, and record review, the facility failed to be equipped to allow residents to call for staff through a communication system which relays the call directly to a centralized staff work area for 3 of 18 residents (Resident #68, #63, #29) reviewed for call lights.</p> <p>The facility failed to ensure Resident #68, #63, and #29's emergency call button in the bathroom had a pull cord from 9/24/2024-9/25/2024.</p> <p>These failures could place residents at risk of injury, pain, hospitalization, and a diminished quality of life.</p> <p>Findings included:</p> <p>1. Record review of an Admission Record for Resident #68 dated 9/25/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia, hypertension, and BPH (enlarged prostate).</p> <p>Record review of a Quarterly MDS Assessment for Resident #68 dated 8/12/2024 indicated he had severe impairment in thinking with a BIMS score of 5. He required supervision with toileting and was always continent of bowel/bladder.</p> <p>Record review of a care plan for Resident #68 dated 5/9/2024 indicated he was at risk for falls with interventions to be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed.</p> <p>2. Record review of an Admission Record for Resident #63 dated 9/24/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnosis of other cerebrovascular disease (stroke), hypertension and BPH with lower urinary tract symptoms (enlarged prostate).</p> <p>Record review of a Quarterly MDS Assessment for Resident #63 dated 8/9/2024 indicated he had severe impairment in thinking with a BIMS of 4. He required setup or clean up assistance with toileting hygiene. He was occasionally incontinent of urine and always continent of bowel.</p> <p>Record review of a care plan for Resident #63 dated 5/21/2024 indicated he had bladder incontinence related to confusion. Interventions included to ensure resident has unobstructed path to the bathroom.</p> <p>3. Record review of an Admission Record for Resident #29 dated 9/25/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnosis of schizophrenia (mental health condition that affects how people think, feel, and behave), major depressive disorder (persistent sadness or loss of interest) and BPH.</p> <p>Record review of a Quarterly MDS Assessment for Resident #29 dated 7/15/2024 indicated he had moderate impairment in thinking with a BIMS score of 12. He was independent with toileting and was occasionally of urine and always continent of bowel.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a care plan for Resident #29 dated 1/16/2017 indicated he had an ADL self care performance deficit with interventions for toilet use was independent with toilet use.</p> <p>During an observation on 9/24/2024 at 7:58 AM, the bathroom for Resident's #68, #63 and #29 share a bathroom between two rooms and the call light in the bathroom did not have a pull string.</p> <p>During an observation on 9/25/2024 at 2:09 PM, the bathroom for Resident's #68, #63, and #29 had a call light string but was wrapped around the call light and would not reach the floor.</p> <p>During an interview on 9/25/2025 at 2:35 PM, the Regional Nurse and DON said the call lights in the bathrooms were the responsibility of the Maintenance Supervisor who was not at the facility and unavailable for an interview as he was on vacation. The Regional nurse said she noticed on yesterday 9/24/2024 that there were some call lights wrapped up and she unwrapped them, so they were long enough to reach close to the floor. She said she was not aware of the bathroom where Resident #68, #63 and #29 shared did not have a bathroom call light string until yesterday 9/24/2024 and one had been installed. She said if the call light strings were not attached or if they were wrapped, residents would not be able to reach them.</p> <p>During an interview on 9/25/2024 at 4:35 PM, the Administrator said the Maintenance Supervisor was responsible for ensuring the call lights in the bathrooms had strings and the staff were to ensure they were not wrapped around the bars. She said it was a collaborative effort by staff. She said maintenance had a program that staff utilized to tell what inspections and checks he had due. She said the Maintenance Supervisor was on vacation and not available for interview. She said the call light strings in the bathrooms should be hanging down from the wall and not short or wrapped around anything and easily accessible. She said residents may not be able to call for assistance, if too short may not be able to reach, which could result in an injury, and no one knew until someone made rounds.</p> <p>Record review of a Maintenance Task List dated 9/25/2024 indicated the nurse call system test: conduct a test of the nurse call system created on 9/17/2024. There was not a task list for checking the call light strings.</p> <p>A facility policy for call lights was requested, but none was provided as the facility said they did not have a policy for call lights.</p>		

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<p>F 0924</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Put firmly secured handrails on each side of hallways.</p> <p>46273</p> <p>Based on observation, interview and record review, the facility failed to equip corridors with firmly secured handrails for 1 of 4 hallways (hall 400) reviewed for environmental conditions.</p> <p>The facility did not ensure a handrail found on 400 hall was firmly affixed to the wall.</p> <p>This failure could place residents at risk for avoidable accidents and decreased quality of life due to environmental hazards.</p> <p>Findings include:</p> <p>During an observation on 9/23/24 at 12:00 pm a handrail was observed loose in the hallway. It was detached from the wall on the end. The bracket was not secured to the wall.</p> <p>During an interview on 9/23/24 at 3:50 pm DON said the handrail being loose could cause residents to fall if it was not securely attached to the wall.</p> <p>During an interview on 9/25/24 at 3:06 pm Administrator said going forward she would ensure the maintenance supervisor inspected the handrails weekly. She said she would also be in-servicing the staff to use the computer system to put maintenance issues in the system that the maintenance supervisor needed to correct. She said maintenance supervisor was responsible for ensuring the handrails were securely attached to the wall. She said maintenance supervisor was off on vacation this week and was unavailable by phone. She said residents could be at risk of falls if they were using it to hold on to and it came off. She said they also could be at risk of being cut by the sharp edge.</p> <p>Record review of a facility policy titled Resident Rights dated 2003 and revised on 11/28/16 read Safe environment - The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely .</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43994</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program and ensure it was free of pests for 1 of 4 halls (Hall 300) reviewed for pest control.</p> <p>The facility failed to ensure an effective pest control program was in place to keep roaches out of the bathrooms for Resident # 42 and Resident #37.</p> <p>This failure could place residents at risk for injury due to an ineffective pest control program at the facility.</p> <p>Findings included:</p> <p>1. Record review of an Admission Record for Resident #42 dated 9/25/2024 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of schizoaffective disorder, bipolar (a condition that causes hallucinations and delusion with mood swings), hypothyroidism (when the thyroid gland does not make enough thyroid hormones to meet the body's needs), and fibromyalgia (widespread muscle and bone pain).</p> <p>Record review of a Quarterly MDS Assessment for Resident #42 dated 9/8/2024 indicated she had moderate impairment in thinking with a BIMS score of 8. She required set up/clean up assistance with toileting and was always continent of bowel/bladder.</p> <p>2. Record review of an Admission Record for Resident #37 dated 9/25/2024 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of COPD (a group of lung disease that affect breathing), malignant neoplasm of retroperitoneum (cancer that is in the hidden space behind the abdominal cavity that contains vital organs) and type 2 diabetes.</p> <p>Record review of a Quarterly MDS Assessment for Resident #37 dated 8/10/2024 indicated she had moderate impairment in thinking with a BIMS score of 11. She required supervision with toileting and was always continent of bladder and bowel.</p> <p>During an observation on 9/23/2024 at 10:12 AM, the bathroom of Resident #42 and Resident #37 had missing baseboards along the walls and two brown bugs were noted crawling on the floor when the light was turned on and went underneath the wall.</p> <p>During an observation and interview on 9/23/2024 at 10:14 AM, Resident #42 was in her room sitting on the side of her bed. She said she noticed some water bugs in the bathroom a couple days ago.</p> <p>During an interview on 9/23/2024 at 10:19 AM, Resident #37 was sitting up in a wheelchair in her room. She said she had been at the facility for 4 years. She said she noticed cockroaches in the bathroom at night and said she saw someone spray the facility a couple of weeks ago or last month some time.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation an interview on 9/24/2024 at 3:45 PM, Pest Control technician was in the facility and said he had been going to the facility for 9 years and visited on a monthly and prn basis. He said he was notified to visit the facility that day to treat the bathroom between the rooms of 303 and 305. He said during his monthly visits, he treated the exterior and interior of the facility for roaches. He said monthly they alternated the chemicals used. He said prior to 9/24/2024, he had not been told of the facility having a problem with roaches. He said he had a log at the nurse station for staff to indicate if they had any issues and during his visits would review and treat the areas indicated on the log. He said the facility never used the log. He said he was not sure what the problem was with roaches in room [ROOM NUMBER] and 305 but would inspect and treat.</p> <p>Record review of a facility pest control log undated indicated the facility did not complete the form, form was completed by the pest control technician.</p> <p>Record review of a pest control invoice dated 9/16/2024 indicated an additional service was requested for reports of little black ants. Treatment of Alpine WSG-BASF was used in target areas closets, laundry room and resident room.</p> <p>Record review of a pest control invoice dated 7/10/2024 indicated the kitchen was treated for roaches in the dish pit. Treatment used was Alpine WSG-BASF, Gentrol IGR-Zoecon, Bifen I/T-[NAME] to treat American Roaches and German Roaches, target areas were bathrooms, common areas, crack and crevice, dish pit, kitchen.</p> <p>During a follow-up interview on 9/24/2024 at 4:05 PM, Pest Control technician said he had treated the bathroom of 303 and 305 and said the problem was the issue of it not having baseboards. He said without baseboards, pests could come into the facility.</p> <p>During an interview on 9/25/2024 at 4:35 PM, the Administrator said pest control came to the facility monthly and prn and no one was aware about the facility having roaches. She said pest control came out on yesterday 9/24/2024 and treated bathroom for room [ROOM NUMBER] and the baseboards were replaced in the bathroom as well. She said residents could be at risk of infections if they did not have an effective pest control program.</p> <p>Record review of a facility policy undated titled Inset and Rodent Control indicated, .The facility will maintain an effective pest control program in order to provide an insect and vermin free food service department. 2. Facility will maintain appropriate screens, close fitting doors, properly sealed water/sewer pipes, structurally maintained walls, baseboards, etc. to prevent entrance access of insects and rodents .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/25/2024
NAME OF PROVIDER OR SUPPLIER  Twin Oaks Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1123 N Bolton St Jacksonville, TX 75766	
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 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>46273</p> <p>Have policies on smoking.</p> <p>Based on observations, interviews, and record review, the facility failed to follow their own established smoking policy for 1 of 1 smoking area reviewed for smoking.</p> <p>The facility failed to follow their policy on smoking on 9/23/24 when cigarette ashes and multiple cigarette butts were observed in a trash can in smoking area.</p> <p>These failures could place residents at risk of injury, burns, and an unsafe smoking environment.</p> <p>Findings include:</p> <p>During an observation on 9/23/24 at 3:36 pm a silver metal trash can was observed in smoking area, it was lined with a clear plastic liner and ashes were observed on the liner. When the lid to trash can was opened, multiple cigarette butts were observed along with soda cans. One cigarette butt was observed still smoking.</p> <p>During an interview on 9/23/24 at 3:45 pm DON said there was risk for a fire if cigarette butts were not properly disposed . The DON said that today was her first day, but going forward they would be reworking their smoking policy to ensure this did not happen again.</p> <p>During an interview on 9/23/24 at 3:50 pm the ADON said the maintenance man was responsible for cleaning the ashtrays in the smoking areas. She said he was on vacation this week and unavailable by phone.</p> <p>During an interview on 9/25/24 at 3:06 pm the Administrator said the maintenance supervisor was responsible for checking the smoking area. She said she would be ordering more ashtrays for the smoking area and was considering removing the trash can altogether. She said there could be a risk for fire if cigarette butts were disposed of in the trash can.</p> <p>Record review of a facility policy titled Smoking Policy dated 11/1/17 read . ashtrays on noncombustible materials and safe design will be provided in all areas where smoking is permitted. Ashtrays will be a metal container with a self-closing cover device into which ash trays may be emptied. Ashtrays will be readily available in all areas where smoking is permitted .</p>		