

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/31/2025
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)		
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved flavor and ensured food and drink were palatable for 3 of 3 residents receiving puree diets. Services. The facility failed to ensure that meals served to residents were palatable on 12/29/25 at 11:00 a.m. when excessively pureed spicy pork chop was served to residents. This failure could place residents at risk of weight loss and diminished quality of life. Findings included: During an interview on 12/29/25 at 1:15 p.m., the CDM said cooks were responsible for preparing pureed foods and were expected to follow recipes as provided. The CDM were expected to taste the food after seasoning to ensure it was palatable. CDM said she tasted the puree of pork chops from the 12/29/25 meal service after being made aware of the concern of it being too spicy and found the food to be too spicy. CDM said she had already conducted an in-service with kitchen staff regarding pureed diets texture and following recipes. CDM said the risks to residents of being served unpalatable food is that the residents won't eat it. During an interview on 12/31/25 at 10:00 a.m., the ADM said he was responsible for oversight of all staff including kitchen staff. The ADM said he tasted the puree of pork chops served for the 12/29/25 lunch service and it was too spicy. The ADM said he expected cooks to follow recipes when preparing food. The ADM said the risk of serving unpalatable food to residents would be unwanted weight loss. The ADM said he had already begun in-servicing kitchen staff on pureed foods and following recipes. Record review of an in-service training attendance roster titled Pureed - Texture/Taste, dated 12/29/25 at 2:15 p.m., indicated dietary staff and the CDM attended. During an observation and sample tasting of a pureed diet tray on 12/29/25 at 12:00 p.m., this surveyor tasted the pureed pork chops and found them to be spicy. During an interview on 12/29/25 at 1:00 p.m., [NAME] A said she prepared the pureed food for the 12/29/25 lunch service. [NAME] A said she added additional spices to the pureed pork chops including black pepper and a commercial spice blend. [NAME] A said, going forward, she planned to follow the recipes. [NAME] A said she tasted the puree of pork chops and found them to be a little too spicy. [NAME] A said she should have discarded the puree and prepared more. [NAME] A said the risk of serving unpalatable food to residents was that residents wouldn't be able to eat the food. Record review of an undated facility policy titled Texture Modified Diets indicated .How to prepare texture modified diet. The recipes must be out and must be followed! .		

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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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. Based on observation, interview, and record review the facility failed to store food in accordance with professional standards for food service safety for 1 of 1 facility kitchens reviewed for food storage. The facility failed to store food in accordance with professional standards when frozen apple pies were observed stored in a ripped, opened, and undated bag in a freezer in the facility kitchen. The facility failed to store food in accordance with professional standards when pork chops were observed stored in an undated plastic bag in a freezer, and when ham was observed stored in an undated plastic bag in a refrigerator in the facility kitchen. This failure could place residents at risk of food-borne illness and diminished quality of life. Findings included: During an observation in the facility kitchen on 12/29/25 at 8:50 a.m., a freezer was observed to contain a plastic bag of frozen apple pies. The plastic bag was ripped, opened, and undated. During an observation in the facility kitchen on 12/29/25 at 8:55 a.m., a freezer was observed to contain a plastic bag of pork chops which were undated. A refrigerator contained a plastic bag of ham which was undated. During an interview on 12/31/25 at 8:45 a.m., [NAME] B said all food stored in the facility refrigerators and freezers should be labeled and dated. [NAME] B said it was the responsibility of all kitchen staff to check the freezers and refrigerators for undated and opened food. [NAME] B said any food found undated or opened in the refrigerators or freezers should be disposed of. [NAME] B said risks from improperly stored and/or labeled food was serving the residents expired food. During an interview on 12/31/25 at 9:00 a.m., the CDM said it was the responsibility of all kitchen staff to inspect the freezers and refrigerators for opened, undated, or unlabeled food which should be discarded. The CDM said she had signs posted in the kitchen to remind all staff to look for opened, undated, or unlabeled food when checking daily refrigerator and freezer temperatures. The CDM said she thoroughly checked all food in the facility freezers and refrigerators on Monday and Wednesday to remove any unlabeled or open food. The CDM said the risk of improperly stored and/or labeled food was serving freezer-burned or expired food to residents. The CDM said, going forward, she planned to conduct an in-service with all kitchen staff covering proper storage and labeling of food and implement a monitoring plan. During an interview on 12/31/25 at 11:00 a.m., the ADM said the CDM was responsible for supervising kitchen staff directly and he was responsible for oversight of all staff. The ADM said the facility policy was all food stored in the facility freezers or refrigerators were dated and sealed. The ADM said his expectation was that all staff follow the facility policy regarding labeling and storing food. The ADM said the risks to residents would be serving unpalatable food to residents which Review of a facility policy titled Food Storage and Supplies, dated 2012, indicated .Open packages of food are stored in closed containers with covers or in sealed bags, and dated as when opened.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure assessments accurately reflected the residents' status for 2 of 7 residents reviewed for assessments. (Resident #2 and Resident #55)The facility failed to ensure Resident #2's MDS, dated [DATE], was coded for receiving IV medications.The facility failed to ensure Resident #55's MDS, dated [DATE], was coded for the resident having a diabetic foot ulcer.These failures could place residents at risk of not having individual needs met.Findings included:1. Record review of a facility face sheet, dated 12/30/25, for Resident #2 indicated he was a [AGE] year-old male, admitted on [DATE], with diagnosis including congestive heart failure and bipolar disorder.Record review of a quarterly MDS assessment, dated 11/24/25, for Resident #2 indicated a BIMS score of 14, which indicated he had intact cognition. Assessment Reference Date was 11/24/25. He was not coded for receiving IV medications during the 14-day lookback period (11/11/25 through 11/24/25). Record review of a comprehensive care plan, dated 11/11/25, for Resident #2 indicated he had a pressure ulcer and an intervention to administer medications as ordered. Record review of a Treatment Administration Record, dated 11/1/25 through 11/30/25 for Resident #2 indicated he received an IV infusion for wound and skin healing support on 11/18/25 consisting of 250ml of Normal Saline with Vitamin C 5g, B Complex 1ml, Zinc 10mg, Biotin 5mg, Magesium Chloride 1g, and Amino Blend 5ml.During an observation and interview on 12/30/2025 at 9:43 AM Resident #2 was observed sitting up in a geri-chair in his room. He had heel protectors on both feet. He had a dressing in place to right lower extremity. He said they took good care of his foot with the wound and had no complaints.2. Record review of a facility face sheet, dated 12/30/25, for Resident #55 indicated she was a [AGE] year-old female, admitted on [DATE], with diagnoses including Alzheimer's disease and type 2 diabetes mellitus. Record review of a Quarterly MDS assessment, dated 12/1/25, for Resident #55 indicated a BIMS score of 00, which indicated severe cognitive impairment. Assessment Reference Date was 12/1/25. She was not coded for diabetic foot ulcer or having application of dressings to feet (with or without topical medications). Record review of a comprehensive care plan, dated 10/12/25, for Resident #55 indicated she had a diabetic foot ulcer related to diabetes. Record review of a Treatment Administration Record, dated 11/1/25 through 11/30/25, for Resident #55 indicated she received daily treatments for diabetic ulcer to left foot during lookback period. Treatment consisted of cleaning, application of a topical medication, and covering with a dressing (a cover for the wound).During an interview on 12/31/25 at 9:30 a.m., the MDS Coordinator said she had been doing MDSs for about seven years and realized yesterday (12/30/25) that Resident #55's MDS was inaccurately coded for her diabetic foot ulcer. She said she was in the process of getting that corrected. She said she must have missed coding the IV medications on Resident #2's MDS. She said diabetic foot ulcers and IV medications should be correctly coded on MDS assessments. She said if MDS assessments were not accurate, it could affect the plan of care for residents. She said, going forward, she would double and triple check her work to ensure accurate coding.During an interview on 12/31/25 at 10:07 a.m., the DON said the MDS Coordinator was responsible for ensuring assessments were completed accurately. She said she, along with corporate, provided oversight . She said she would be holding an in-service with MDS Coordinator and providing further education to ensure accuracy. She said she expected her staff to accurately code the MDS assessments. She said inaccurate MDS assessments could affect the residents' care plan, and they could miss out on the care they needed.During an interview on 12/31/25 at 10:12 a.m., the Administrator said he expected accuracy with MDS assessments. He said residents could have their care affected if MDS assessments were inaccurate. He said they did not have a specific MDS policy, they just went by the RAI manual.Record review of CMSs RAI Version 3.0 Manual, dated October 2025, read: .code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port. and .coding instructions.check all that apply in the (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	last 7 days.M1040B, Diabetic foot ulcer(s). and .coding instructions.check all that apply in the last 7 days.M1200I, application of dressing to feet (with or without topical medications).		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure individuals identified with MI, DD, or ID were evaluated for services for 1 of 6 residents (Residents #2) reviewed for PASARR. The facility failed to ensure Resident #2 had a PASARR evaluation after being admitted to the facility on [DATE] with a mental illness diagnoses of bipolar disorder. This failure could place residents at risk of not receiving individualized specialized services to meet their needs. Findings included: Record review of a facility face sheet, dated 12/30/25, for Resident #2 indicated he was a [AGE] year-old male admitted on [DATE] with diagnosis including congestive heart failure and bipolar disorder. Record review of a quarterly MDS assessment, dated 11/24/25, for Resident #2 indicated a BIMS score of 14, which indicated he had intact cognition. He had a diagnosis of bipolar disorder. Record review of a PASSR level I screening form, dated 10/23/24, for Resident #2 indicated question C0100, which read: .Is there evidence or an indicator this is an individual that has a mental illness. was answered .No. Record review on 12/30/25 indicated there was no PASSR level II evaluation for Resident #2. During an interview on 12/31/2025 at 9:30 a.m., the MDS Coordinator said she was responsible for PASSR and was not informed of Resident #2's bipolar diagnosis and it just got missed. She said, going forward, she would run a report and review for new diagnoses added so it did not happen again. She said if a new screening was not done for residents, they could miss out on needed therapies and mental health services. During an interview on 12/31/2025 at 10:07 a.m. the DON said the MDS Coordinator was responsible for PASSR. She said she would be monitoring PASSR for residents as they were admitted and providing in-services for MDS. She said residents could miss out on needed care, medications and treatments if PASSR procedures were not followed appropriately. During an interview on 12/31/2025 at 10:12 a.m., the Administrator said he expected better communication between staff and would like to discuss in the morning meeting any new residents and diagnoses. He said if PASSR screenings were not conducted accurately, it could affect the resident's plan of care and residents could miss out on needed therapies. He said he expected PASSR would be handled right away, and diagnoses should be communicated to staff handling PASSR. He said the facility did not have a specific PASSR policy.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to ensure nurse staffing data was posted daily and readily accessible to residents and visitors with all required information for 2 of 2 days reviewed (12/29/2025 and 12/30/2025) for nurse staffing posting. The facility failed to post the daily staffing information in a prominent place on 12/29/2025 and 12/30/2025. This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts. Findings included: During an observation on 12/29/2025 at 11:00 a.m., the daily staff posting was not in or around the front entrance or by the nurse's desk. During an observation on 12/29/2025 at 12:39 p.m., the daily staff posting was not in or around the front entrance or by the nurse's desk. During an observation on 12/30/2025 at 9:59 a.m., the daily staff posting was not in or around the front entrance or by the nurse's desk. During an interview on 12/30/2025 at 10:06 a.m., the Staffing Coordinator said she was responsible for putting up the daily staff posting. She said she forgot to post it on 12/29/2025 and 12/30/2025 because she was working on the floor as a nurse aide. She said the posting was put up to inform residents, families, and visitors of how many residents to staff were in the facility for the day. She said if the staffing information was not put up daily then the visitors and families would not have the information about the staff in the facility. She said the staff posting was placed by the nurses' desk on the wall in a plastic placard. During an observation on 12/31/2025 at 10:10 a.m., a plastic placard was on a wall behind the nurses' desk by the front entrance but did not contain the staff posting. During an interview on 12/31/2025 at 9:14 a.m., the DON said the Staffing Coordinator was responsible for putting up the staff posting daily. She said the posting showed how many nurses and nurse aides were scheduled each day. She said the posting was placed by the nurses' desk so everyone could see it. She said if the posting was not present, then no one would know the number of staff in the facility each day. During an interview on 12/31/2025 at 10:11 a.m., the Administrator said the Staffing Coordinator was responsible for putting up the staff posting daily. He said the purpose of the posting was to show everyone how the facility was staffed. He said, going forward, the department heads would review and check to make sure it was posted daily. He said the Staffing Coordinator was in-service yesterday, 12/30/2025. He said the facility did not have a policy for the daily staff posting and they just followed the regulation. Record review of a facility in-service, dated 12/30/2025, indicated the Staffing Coordinator received training on the daily staffing sheet.		