

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER The Oaks at Radford Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 725 Medical Dr Abilene, TX 79601	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45458</p> <p>Based on observation, interview and record review, the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment for 2 of 4 residents' rooms reviewed for homelike environment, in that:</p> <ol style="list-style-type: none"> Resident #2's bathroom tile was discolored and covered in multiple dried, dark brown stains, toilet base caulking and tile grout lines were covered in a dark black substance, and the cove base around the wall and floor between the toilet and inside wall had an indentation and had pulled away from the wall, which exposed the drywall. Resident #2's floor in his room was wet and stained with dark streaks; a piece of toilet paper was observed on the floor with a wet, brown substance, and Resident #2's oxygen machine had a dried liquid stain that ran down the front of the machine and several dried splatter spots. Resident #6's bathroom tile around the base of the toilet was broken, cracked, and exposed the bare floor. The toilet base that was caulked to the floor was cracked and the toilet was loose from the foundation. The cove base on the wall by Resident #6's bed was pulled away from the wall and exposed cracked drywall and a pink liquid stain that ran down the wall from the window to the floor that was dry and sticky. <p>These failures could place residents at risk of living in an unsanitary environment, and psychosocial harm due to diminished quality of life:</p> <p>The findings included:</p> <ol style="list-style-type: none"> Record review of Resident #2's Face Sheet, dated 09/10/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included Unspecified atrial fibrillation (irregular heartbeat that occurs when the heart's upper chambers beat irregularly and rapidly), Chronic obstructive pulmonary disease (lung disease that makes it difficult to breath), Candidiasis (fungal infection caused by overgrowth of Candida yeast), Primary open-angle glaucoma, bilateral, stage unspecified (eye disease that occurs in both eyes that damages the optical nerve and vision loss and/or blindness), Glaucomatous optic atrophy, bilateral (a condition that affects the optic nerve, which carries visual information from the eye to the brain), and Type II Diabetes (condition that affects the way the body regulates and uses sugar as a fuel). <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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record Review of Resident #2's Quarterly MDS, dated [DATE], revealed in Section C0500 BIMS a score of 09, which indicated moderate cognitive impairment.</p> <p>Record review of Resident #2's Care Plan, dated 07/17/2024, revealed a category area of Urinary Incontinence, dated 07/16/2024, which indicated the resident had occasional episodes of incontinence related to impaired mobility and impaired communication. The long-term goal, with a target date of 10/16/2024, revealed the resident would be continent of bowel and bladder, be clean, order free, and would maintain dignity. The Care Plan Approaches revealed nursing staff would check for incontinence routinely and PRN, toilet routinely and PRN, and sometimes I may need more help. Monitor my daily abilities and provide me with more assistance as needed.</p> <p>During an interview on 09/07/2024 at 3:45 p.m., Resident #2 said he had a hard time moving items around in his room because he was legally blind. Resident #2 said he had difficulty when he placed his cup on his bed side table because he would drop the cup and spill his drink on the floor. Resident #2 said he had difficulty going to the bathroom by himself and the bathroom would smell bad because he would miss the toilet and urine would fall on the floor.</p> <p>During an observation on 09/10/2024 at 10:09 a.m., revealed Resident #2's bathroom floor around the toilet, approximately one (1) foot from the base was covered in multiple dark brown stains that were dried. The tile was discolored a dark yellowish color. The base of the toilet that sat on the tile was covered in a dark black, thick substance that circled the base of the toilet. The dark black substance was located in grout lines of the tiles around the toilet. The cove base behind the toilet was covered in a thick black substance and pulled out from the wall. The cove base that ran down the wall between the toilet and inside wall had an indentation and had pulled away from the wall, which exposed the drywall. A gray potty chair was placed over the toilet. The handle on the right side of the chair had a dark brown smear, approximately six (6) inches in length, running downwards, which had dried. The floor was covered in small pieces of paper and a smear of a brown substance approximately an inch in length which had dried on the floor by the bathroom door. There was an area approximately one (1) foot by one (1) foot under the sink where the drywall that had been cut out and the area was open and exposed. Resident #2's floor in his room by the bed in an area approximately 4 feet by 4 feet was wet and had black, streaks and marks from Resident #2's wheelchair on the floor. There was a piece of toilet paper, 6 inches in length, approximately two (2) feet from the door of the room on the floor with a wet, brown substance that smelled of feces. Resident #2's oxygen machine had dried liquid stains that ran down the front of the machine and several dried splatter spots.</p> <p>During an interview on 09/10/2024 at 10:19 a.m., CNA A said he did not usually work the hall Resident #2 resided on but on that date, CNA A was working with Resident #2 to clean out his dresser. CNA A said Resident #2 was legally blind and had difficulty seeing where he put his belongings. CNA A said Resident #2 was unorganized. CNA A said Resident #2 would spill his water on the floor because he could not always see to put the cup on his side table. CNA A said when he needed to report a repair, he would notify the maintenance supervisor.</p> <p>During an interview on 09/10/2024 at 3:37 p.m., NA F said she was familiar with the residents' needs and services from information in the care plans in the electronic records. NA F said she would assist Resident #2 with toileting when he asked for help or pulled his call light. NA F said if Resident #2's room needed to be cleaned, she would assist him. NA F said Resident #2's room was dirty often.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 09/11/2024 at 9:56 a.m., observed Resident #2's oxygen machine had a dried liquid stain that ran down the front of the machine and several dried splatter spots that were observed on 09/10/2024 at 10:09 a.m. Observed the machine had not been cleaned.</p> <p>During an interview on 09/11/2024 at 10:35 a.m., Housekeeping Director B said he cleaned Resident #2's room earlier that morning. Housekeeping Director B said he swept, mopped, cleaned the toilets, wiped the blinds, cleaned the refrigerator, and changed sheets. Housekeeping Director B said he cleaned the potty chair in Resident #2's bathroom and observed the brown substance on the handle, which he removed. Housekeeping Director B said the housekeeping staff would clean Resident #2's room but Resident #2 would mess the room up again because the Resident #2 was blind and would immediately make a mess. Housekeeping Director B said the housekeepers go into Resident #2's room daily and clean. Housekeeping Director B said he had not had the housekeeping staff clean more often than daily to accommodate Resident #2's blindness.</p> <p>2. Record review of Resident #6's Face Sheet, dated 09/11/2024, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #6 had diagnoses which included Paroxysmal tachycardia (a type of irregular heartbeat, or arrhythmia, that causes a rapid and regular heartbeat that starts and stops suddenly), Primary pulmonary hypertension (serious lung disease that causes high blood pressure in the pulmonary arteries), Dementia, mild a group of brain disorders that cause a decline in cognitive abilities, such as thinking, remembering, and reasoning), with psychotic disturbance-clarified, and Type 2 diabetes mellitus (condition that affects the way the body regulates and uses sugar as a fuel).</p> <p>Record Review of Resident #6's Quarterly MDS, dated .07/12/2024, revealed in Section C0500 BIMS a score of 03, which indicated severe cognitive impact.</p> <p>During an interview and observation on 09/11/2024 at 11:01 a.m., revealed Resident #6 was in bed. Resident #6 said staff helped him change his brief in bed. Resident #6's bed was pulled from the wall approximately 2 feet. The cover base was pulled back at the bottom of the wall under the window, approximately one (1) foot in length, which exposed the drywall that was cracked. There was a pink liquid stain that ran down the wall from the window to the floor that was dry and sticky.</p> <p>During an observation on 09/11/2024 at 11:05 a.m., revealed the tile around Resident #6's toilet in the bathroom was broken and cracked. The toilet base sat on four square tiles with the front left tile cracked and a piece approximately 4 inches by 4 inches was cracked in multiple pieces and an area approximately 2 inches by 2 inches was missing. The toilet base that was caulked to the floor was cracked and the toilet was loose from the foundation. The tile was discolored a dark yellowish color. The base of toilet that sat on the tile was covered in a dark black, thick substance that circled the base of the toilet. The cove base that covered the base board that was parallel to the toilet and sink was pulled away from the wall, which exposed the drywall that was cracked.</p> <p>During an interview on 09/11/2024 at 11:05 a.m., Administrator C entered Resident #6's room and bathroom and said the condition was unacceptable and needed repaired. Administrator C said the wall needed to be cleaned.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/11/2024 at 11:52 a.m., Maintenance Supervisor E said the tiles in the bathroom in Resident #2's bathroom were discolored due to being worn and unclean. Maintenance Supervisor E said the area around the toilet could be cleaned to remove the stains and the caulking around the base of toilet could be redone. Maintenance Supervisor E said the state and cleanliness of the bathroom and toilet was unacceptable and he would not live at home with a bathroom in the same condition. Entered Resident #6's bathroom and Maintenance Supervisor E said he was not aware the tile was cracked around the base of the toilet or toilet base that was caulked to the floor was cracked and the toilet was lose from the foundation. Maintenance Supervisor E said he felt there was a breakdown in the communication of work orders. Maintenance Supervisor E said the facility used an electronic platform to report needed repairs. Maintenance Supervisor E said employees would scan a code that was placed around the facility and send him a message directly to report the issue. Maintenance Supervisor E said the issue was the facility was low of staff and used agency staff that were not trained to use the workorder system consistently. Maintenance Supervisor E said the condition of Resident #6's bathroom was unacceptable, and the residents deserved better.</p> <p>During an interview on 09/11/2024 at 1:16 p.m., DON D said the stains that ran down Resident #2's oxygen concentrator was unacceptable. DON D said the nursing staff should monitor the machine for cleanliness and even though Resident #2 was blind, staff should protect his dignity. DON D said not keeping Resident #2's medical equipment clean could be unsanitary. DON D observed Resident #2's bathroom and said the condition and appearance was unacceptable and she would not keep her bathroom at her home in the deplorable manner.</p> <p>During an interview on 09/11/2024 at 2:07 p.m., Administrator C said the conditions of Resident #2 and Resident #6's bathrooms were unacceptable and needed work. Administrator C said the state of the bathrooms could cause a negative effect by exposing the residents to unsanitary conditions. Administrator C said the physical condition was unpleasant and not acceptable. Administrator C said he had been in the position of administrator for approximately two (2) weeks and was still in the process of learning his responsibilities.</p> <p>Record review the facility's Maintenance Policies & Procedures, Maintenance Logbook, not dated, revealed the facility would:</p> <ol style="list-style-type: none"> 1. Always keep the maintenance logbook in a designated place in the maintenance shop or work area unless it was requested by the Administrator or other authorized person. 2. Keep the maintenance log up to date. Note and initial all required repair jobs, service jobs, service visits, and daily, weekly, monthly, and annual checks and inspections as soon as possible after they were completed. <p>Record review the facility's Resident Rights Policy, dated 02/2021, revealed employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right to: a dignified existence.</p>		