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Form Approved OMB
No. 0938-0391

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 10/03/2024
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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on interview, and record review the facility failed to inform the resident representative of a significant change in the residents' physical status and the need to significantly alter the resident's treatment for 1 of 3 residents (Resident #1) reviewed for notification. The facility failed to notify Resident #1's representative of hospital transfer on 09/16/2024 resulting in resident not having an advocate the make decisions at the hospital. This failure could affect residents by placing them at risk for not having an advocate, delay in medical treatment, or decline in health. The findings included: Review of Resident #1's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with latest return on 09/19/2024 from hospital with diagnoses to include: diabetes, amputation of left leg, and altered status. Further review of face sheet revealed Resident #1's representative and responsible party was an assigned legal guardian. Review of Resident #1's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 09 which indicated moderate cognitive impairment. Review of Resident #1's Comprehensive Care Plan last reviewed 10/02/2024, revealed: Focus: Resident has difficulty understanding others and impairment making needs know. Review of Resident #1's electronic progress notes revealed: 09/16/2024 10:15 PM Upon arriving at facility, this nurse was notified that resident was needing to be sent out via ambulance related to altered mental status. This nurse prepared all the paperwork while staff remained with resident until EMT's arrived. Signed by LVN B. 09/17/2024 04:06 AM Resident admitted to hospital for UTI and metabolic encephalopathy. Signed by LVN B. Further review of progress notes revealed no evidence of resident representative being notified of hospital transfer. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/03/2024 at 9:30 am, the resident representative for Resident #1 stated she was not notified when Resident #1 went to the hospital in September. She stated the facility was making and cancelling appointments for her residents without notifying her. She is concerned as to who was making the decisions for the residents at these appointments since they were not capable, and she was not being notified. Attempted interview on 10/03/2024 at 10:00 am via phone call with LVN B with no answer. During an interview on 10/03/2024 at 11:15 am, LVN A stated resident representatives should have been notified for falls, all changes in condition, all medication changes, all doctors appointments, and any transfers or hospitalization s. She stated it was the nurse's responsibility to notify the representatives of these things. During an interview on 10/03/2024 at 11:30 am, the DON stated that resident representatives should have been notified of all condition changes, new medications, doctors' appointments, and hospitalization s. She stated when a doctor's appointment was scheduled it was the responsibility of the person who scheduled or received notification of the appointment to notify the resident and the resident representative of the appointment. She stated the failure occurred due to lack of communication between nursing staff. She stated that having agency (contracted) staff and not consistent nursing staff caused a gap in communication. The DON stated this failure could cause residents to be left with no one to advocate for them. She stated she did not know how the residents could communicate and make decisions with the doctors without the representative present. The DON stated it was ultimately her responsibility to ensure that proper notifications were being made. During an interview on 10/03/2024 at 12:45 pm, the Administrator stated resident representatives should have been notified of all change of conditions, doctors' appointments, and especially hospitalization s. He stated he did not know what lead to the failure. Review of facility policy titled, Change in a Resident's Condition or Status, revised February 2021, revealed in part: Policy Statement: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Policy Interpretation and Implementation .4. A nurse will notify the residents representative when: .d. a decision has been made to discharge the resident from the facility; and/or e. it is necessary to transfer the resident to a hospital/treatment center .6. Regardless of the residents current mental or physical condition, a nurse will inform the resident of any changes in his/her medical care or nursing treatments.