

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  10/24/2024
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944</b></p> <p>Based on observations, interviews and record review, the facility failed to ensure the medical record was complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for resident records.</p> <p>The facility failed to ensure CNA B documented the accurate dinner meal intake for Resident #1.</p> <p>These failures could place residents at risk of weight loss and a decline in health status.</p> <p>Findings included:</p> <p>Record review of Resident #1's Face Sheet revealed she was a [AGE] year-old female who was admitted on [DATE], with the following diagnoses: epilepsy (a condition associated with abnormal electrical activity in the brain that is marked by convulsions episodes of sensory disturbance, or loss of consciousness, hypertension (high blood pressure), and schizoaffective disorder ( a mental disorder that includes symptoms of schizophrenia such as delusions, and of mood disorders such as high and low mood swings).</p> <p>Record review of Resident #1's OSA MDS with an ARD date of 8/7/24 documented her BIMS score was 00, which indicated severe cognitive impairment. Resident #1 required extensive assistance of 2 people for bed mobility and toileting, and extensive assistance of 1 person to eat, and she was dependent on 2 people for transfers.</p> <p>Record review of Resident # 1's care plan reflected:</p> <p>Eating amount of assist: Supervision with Set-Up</p> <p>Created: 04/29/2024</p> <p>Approach Start Date: 4/29/224.</p> <p>Record review of the Order Summary Report dated 10/1/24 indicated Resident #1 had orders for:</p> <p>Admit to hospice. DX: unspecified sequelae cerebral infarction; Notify hospice for changes and prior to sending to hospital.</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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Code Status: Do Not Resuscitate (DNR)</p> <p>Diet: Regular fortified food item Texture: Puree</p> <p>Fluid Consistency: Thin</p> <p>Use Plate-guard.</p> <p>Special Instructions: Offer Additional Puree Dessert with Lunch</p> <p>Offer 2.0 Supplement Give 90ml TID Special Instructions: Offer 2.0 Supplement Give 90ml TID.</p> <p>Three Times A Day</p> <p>08:00 AM, 12:00 PM, 04:00 PM.</p> <p>During an observation on 10/22/24 at 5:40 PM revealed Resident # 1 was fed by the ADON and ate only 1-2 bites. She did not swallow her food and it was removed from her mouth by the ADON. Resident #1 unable to drink through a straw or drink from a cup. Resident #1 was only able to take drops of water in her mouth from a sponge mouth cleaner or dropped into her mouth from a straw.</p> <p>Record review of Resident #1's meal intake log which was signed by CNA B and had an entry date and time of 10/23/24 at 3:29 AM indicated Resident #1 ate 75-100 percent of her dinner.</p> <p>During an interview on 10/23/24 at 10:30 AM the ADON stated Resident #1 did not eat more than 2 bites of her dinner meal on 10/22/24. She stated it should have been marked refused due to her condition. She stated she did not document the diet after she fed her. She stated she should have done the documentation herself and that failure to document diets accurately could result in the resident not receiving needed care and treatment to prevent a decline in their health.</p> <p>During an interview on 10/23/24 at 10:40 AM the DON stated Resident #1's diet should have been marked refused due to her condition if she was unable to eat. She stated her expectation was for the diets to be documented in a timely and accurate manner by the person that did the care. She stated the ADON should have done the documentation herself, and the failure to document diets accurately could result in the resident not receiving needed care and treatment to prevent a decline in their health.</p> <p>During an interview on 10/23/24 at 3:16 PM, the Administrator said he expected for nurses to document accurately and completely. The Administrator said it was important for diets to be documented accurately to prevent weight loss.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with CNA C on 10/24/24 AT 4:45 pm he stated he did document the diet on 10/23/24 at 3:29 AM He stated he usually did pick Resident #1's stray up on the 6 PM to 6 AM shift and sometimes fed her on that shift if the trays were late coming out. He stated she hadn't been eating due to a recent decline in her health. He stated he was in a hurry and just made a mistake. He stated he tries to be very meticulous about documenting diets and always tries to pass his snacks and document them accurately. He stated it is important to be accurate when documenting diets and snacks, because a resident might be a diabetic and it could make them sick if the nurse thought they ate and they really didn't. He stated he didn't intentionally document inaccurately, and that the incident has taught him to be more careful.</p> <p>Record review of the facility's policy dated July 2017, titled, Charting and Documentation, indicated:</p> <p>All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.</p> <p>Documentation of procedures and treatments will include care-specific details, including:</p> <ol style="list-style-type: none"> <li>a. The date and time the procedure/treatment was provided.</li> <li>b. The name and title of the individual(s) who provided the care.</li> <li>c. The assessment data or any unusual findings obtained during the procedure/treatment.</li> <li>d. How the resident tolerated the procedure/treatment.</li> <li>e. Whether the resident refused the procedure/treatment.</li> <li>f. Notification of family, physician, or other staff, if indicated; and</li> <li>g. The signature and title of the individual documenting</li> </ol> <p>Documentation in the medical record may be electronic, manual or a combination.</p> <p>2. The 'following information is to be documented in the resident medical record: a'. Objective observations; Medications administered; Treatments or services performed; Changes in the resident's condition.</p> <p>e. Events, incidents or accidents involving the resident; Progress toward or changes in the care plan goals and objectives.</p> <p>3 Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.</p>		