STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675330	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Radford Hills Healthcare Center	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat residents with respect, dignity, and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life for 3 of (Resident #1, Resident #2, and Resident #3) 4 residents reviewed for dignity. The facility failed to ensure staff treated Resident #1 with dignity by not assisting resident with a brief change when asked on 11/22/2025. The facility failed to ensure staff treated Residents #1, #2, and #3 with dignity by not providing showers 3 times a week from 11/01/2025 until 11/30/2025. This failure could place residents at risk of a diminished quality of life and lead to a loss of self-esteem and isolation. The findings included: Record review of Resident #1's electronic face sheet dated 12/02/2025 revealed a [AGE] year-old male admitted into facility on 08/16/2025 with diagnoses to include: heart failure, urinary tract infection, diabetes, and diarrhea. Record review of Resident #1's admission MDS dated [DATE] revealed Resident #1 had a BIMS score of 06 which indicated severe cognitive impairment. Further review of the MDS indicated Resident #1 used a wheelchair and required partial/moderate assist with hygiene. Resident #1 was frequently incontinent of bowel and always incontinent of urine. Record review of Resident #1's care plan last revised on 12/02/2025 revealed: Problem: resident was at risk for pressure ulcers related to incontinence. Interventions: keep clean and dry as possible, minimize skin exposure to moisture. Record review of Resident #1's POC documentation for the month of November 2025 revealed no evidence that Resident #1 had bath / shower on his preferred shower days Tuesday, Thursday, or Saturday for 11/1/2025, 11/04/2025, 11/06/2025, 11/08/2025, 11/11/2025, 11/13/2025, 11/15/2025, 11/18/2025, 11/20/2025, 11/22/2025, 11/25/2025, 11/27/2025, and 11/29/2025. During an interview on 11/30/2025 at 12:00 pm, Resident #1's family member stated that Resident #1 called her at 11:45 a.m. on 11/22/2025 and said that he had wheeled himself up to the nurses' station 15-30 minutes before that, to tell them that he had diarrhea and had a soiled brief that needed to be changed but that they had blown him off. She stated that he told her there were two nurses sitting up there and that no one had come to change him yet and he was asking her if she could come up there to change him. She stated that she asked him if he had pulled the cord yet and he said he hadn't because he wheeled himself up there to tell them. Resident #1's family member stated that she told him to pull that cord right then because she was going to come up there and she wanted to see if that light to his room was still on when I got there. She stated that she got to the facility 45 minutes later, at exactly 12:30. Family member stated that she walked up to the nurses' station and there LVN-A and LVN-D were sitting up there and another lady leaning against the counter. She stated that Resident #1's call-light was lit up and ringing. She stated that when she asked the nurses why they had not helped Resident #1, LVN-D stood up and went to find a CNA to help him. She stated that CNA-B came to his room and changed his brief. Family member stated that the resident was supposed to get a shower 3 times per week, but he did not get one yesterday 11/06/2025, because they only had 1 CNA working so they were too short-staffed to do it. He was supposed to get one last Saturday too, on 11/1 but did not get it that day either because they also only had 1 CNA working. During an observation and interview on 12/01/2025 at 4:45 p.m., Resident #1 had on a dirty brief. Resident #1 stated that he always had on dirty briefs because everyone refused to change him. He stated that his call light was never answered and that he had to go to the nurses' station and beg for help. He stated that him and his family member had reported their concerns to the DON and Administrator and that nothing had been done about it. He stated that he felt ignored, and embarrassed. He stated that he had never refused a shower. Resident #2 Record review of Resident #2's electronic face sheet dated 12/02/2025 revealed a [AGE] year-old male admitted into facility on 06/16/2023 with diagnoses to include: diabetes, chronic kidney disease, and anxiety. Record review of Resident #2's quarterly MDS dated [DATE] revealed Resident #2 had a BIMS score of 11 which indicated moderate cognitive impairment. Further review of the MDS indicated Resident #2 used a wheelchair and required partial/moderate assist with hygiene. Resident was occasionally incontinent of bowel and urine. Record review of Resident #2's care plan last revised on 10/11/2025 revealed residents preferred bath/shower on Tuesday, Thursday, and Saturday. Record review of Resident #2's POC documentation for the month of November 2025 revealed no evidence that Resident #2 had a bath/shower on his preferred shower days Tuesday, Thursday, or Saturday for 11/1/2025, 11/04/2025, 11/06/2025, 11/08/2025, 11/11/2025, 11/13/2025, 11/15/2025, 11/18/2025, 11/20/2025, 11/22/2025, 11/25/2025, 11/27/2025, and 11/29/2025. During an observation and interview on 12/02/2025 at 11:00 a.m., Resident #2

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident and determined by considering the number, acuity, and diagnoses of the facility's resident population with accordance for 2 (11/01/2025 and 11/06/2025) of 4 days reviewed for sufficient staffing. The facility failed to maintain nurse staffing at the level indicated by the PPD budget on 11/01/2025 and 11/06/2025. This failure could place the residents at risk of resident's needs, safety and psychosocial well-being not being met.Findings included: Record review of timesheets dated 11/01/2025 revealed 63.55 hours worked by direct care staff. Per facility PPD and census of 48 residents, 80. 64 direct care staff hours were needed for 24-hour period. Record review of timesheets dated 11/06/2025 revealed 62.86 hours worked by direct care staff. Per facility PPD and census of 47 residents, 78.96 direct care staff hours were needed for 24-hour period. Record review of Resident #1's electronic face sheet dated 12/02/2025 revealed a [AGE] year-old male admitted into facility on 08/16/2025 with diagnoses to include: heart failure, urinary tract infection, diabetes, and diarrhea. Record review of Resident #1's admission MDS dated [DATE] revealed Resident #1 had a BIMS score of 06 which indicated severe cognitive impairment. Further review of the MDS indicated Resident #1 used a wheelchair and required partial/moderate assist with hygiene. Resident #1 was frequently incontinent of bowel and always incontinent of urine. Record review of Resident #1's care plan last revised on 12/02/2025 revealed: Problem: resident was at risk for pressure ulcers related to incontinence. Interventions: keep clean and dry as possible, minimize skin exposure to moisture. Record review of Resident #1's POC documentation for the month of November 2025 revealed no evidence that Resident #1 had bath / shower on his preferred shower days Tuesday, Thursday, or Saturday for 11/1/2025, 11/04/2025, 11/06/2025, 11/08/2025, 11/11/2025, 11/13/2025, 11/15/2025, 11/18/2025, 11/20/2025, 11/22/2025, 11/25/2025, 11/27/2025, and 11/29/2025. During an interview on 11/30/2025 at 12:00 p.m., Resident #1's family member stated that on 11/06/2025, Resident #1 had soiled his brief (several times) and wheeled himself up to the nurses' station to ask them for help changing him. They gave the same response they always gave which is that they said a CNA would come help him as soon as all the breakfast trays had been picked up. No one came for 2 hours and in that period, he went several more times (in the toilet this time) but he had to put on the same dirty diaper that he had already soiled because no one had come to change him yet. She stated that he had to wheel himself back up there to the nurses' station to ask again. Family member stated that the resident was supposed to get a shower 3 times per week, but he did not get one yesterday 11/06/2025, because they only had 1 CNA working so they were too short-staffed to do it. He was supposed to get one last Saturday too, on 11/1 but did not get it that day either because they also only had 1 CNA working. During an observation and interview on 12/01/2025 at 4:45 p.m., Resident #1 had on a dirty brief. Resident stated that he always had on dirty briefs because everyone refused to change him. He stated that his call light was never answered and that he had to go to the nurses' station and beg for help. Record review of Resident #2's electronic face sheet dated 12/02/2025 revealed a [AGE] year-old male admitted into facility on 06/16/2023 with diagnoses to include: diabetes, chronic kidney disease, and anxiety. Record review of Resident #2's quarterly MDS dated [DATE] revealed Resident #2 had a BIMS score of 11 which indicated moderate cognitive impairment. Further review of the MDS indicated Resident #2 used a wheelchair and required partial/moderate assist with hygiene. Resident was occasionally incontinent of bowel and urine. Record review of Resident #2's care plan last revised on 10/11/2025 revealed residents preferred bath/shower on Tuesday, Thursday, and Saturday. Record review of Resident #2's POC documentation for the month of November 2025 revealed no evidence that Resident #2 had a bath/shower on his preferred shower days Tuesday, Thursday, or Saturday for 11/1/2025, 11/04/2025, 11/06/2025, 11/08/2025, 11/11/2025, 11/13/2025, 11/15/2025, 11/18/2025, 11/20/2025, 11/22/2025, 11/25/2025, 11/27/2025, and 11/29/2025. During an observation and interview on 12/02/2025 at 11:00 a.m., Resident #2 was up in his wheelchair in his room. A foul smell was noted coming from the resident and his room. Resident #2 stated he only received a shower once every 2 weeks. He stated he was supposed to receive showers on Tuesday, Thursday, and Saturday. He stated the staff always said that they were short-staffed and could not give him a shower. He stated the call-lights were never answered. Record review of Resident #3's electronic face sheet dated 12/02/2025, revealed a [AGE] year-old male admitted into the facility on