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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>675379 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>12/11/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>The Oaks at Longview |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>111 Ruthlynn Dr<br>Longview, TX 75601 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.<br><br>(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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| <p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure residents received therapeutic diets that were prescribed by the attending physician for 1 of 4 residents (Resident #1) reviewed for therapeutic diets. The facility failed to ensure Resident #1 received a diabetic diet (CCHO). This failure could place residents at risk for altered nutritional status and decreased quality of life. Findings included: Record review of Resident #1's electronic face sheet indicated a [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #1 had diagnoses which included type 2 diabetes mellitus (high blood sugars), noninfective gastroenteritis and colitis (inflammation of the digestive tract), and gastrointestinal hemorrhage (bleeding from the digestive tract). Record review of Resident #1's Quarterly MDS assessment, dated 12/2/2025, indicated she usually understood others and was sometimes understood by others. Resident #1 had a BIMS score of 03, which indicated her cognition was severely impaired. Resident #1 required setup or clean-up assistance for eating. The MDS assessment did not indicate Resident #1 required a therapeutic diet. Record review of Resident #1's electronic Order Summary Report indicated she had an order for a regular diet with regular texture and thin consistency with a start date of 7/2/2024. Record review of Resident #1's care plan, last reviewed 5/12/2025, indicated she had the potential for nutritional problem/malnutrition related to diabetes mellitus with interventions that included: 2. Provide, serve diet as ordered. Monitor intake and record every meal. 3. RD to evaluate and make diet change recommendations PRN. Record review of Resident #1's care plan, last reviewed 5/12/2025, indicated she had GERD (gastroesophageal reflux disease) with interventions that included: .Avoid overeating. Provide small frequent meals rather than 3 large ones. Record review of Resident #1's electronic health record indicated the last nutrition assessment was completed was on 04/25/2025, and it did not address Resident #1's requirement of small frequent meals or diabetes mellitus. The nutrition assessment was signed completed on 04/25/2025. Record review of Resident #1's electronic health record indicated Resident #1 had a HGBA1C (blood test showing your average blood sugar levels over the past 2-3 months) level on 2/6/2025 of 7.3 (normal levels 4.7-5.7). Record review of Resident #1's electronic health record indicated Resident #1 had a HGBA1C (blood test showing your average blood sugar levels over the past 2-3 months) level on 11/21/2025 of 9.6 (normal levels 4.7-5.7). Record review of the facility's Concern/Grievance Report, dated 12/1/2025, filed by Resident #1's family member indicated Resident #1's family member was concerned about Resident #1's HGBA1C level had increased. The grievance indicated the report was received by the Administrator and did not include a resolution regarding Resident #1's family member's concern of Resident #1's HGBA1C level. The grievance indicated a care plan meeting would be scheduled to address concerns. During an observation on 12/11/2025 at 12:39 PM, LVN A showed the state surveyor her phone text messages to Resident #1's MD. At 10:35 AM, after state surveyor intervention, LVN A asked Resident #1's MD if Resident #1 could have a diabetic order diet. Resident #1's MD responded to the request and said yes, she could have an order for Resident #1 to have a diabetic diet. During an interview on 12/11/2025 at 9:45 AM, Resident #1's family member said Resident #1 had diabetes mellitus and GERD and was told she was supposed to have frequent small meals and a diabetic diet. Resident #1's family member said Resident #1 was supposed to have a diabetic diet and the facility could not accommodate her. She said she called the facility on 11/21/2025 and inquired about Resident #1's blood sugars and was told her HGBA1C level was a 9.6 (normal levels 4.7-5.7). She said when she asked about Resident #1 getting a diabetic diet, the ADON told her the facility did not offer a diabetic diet, and everybody received the same diet. During an interview on 12/11/2025 at 10:00 AM, Resident #1's family member #2 was at the facility and said when Resident #1 was at home they had always eaten healthy. He said they were able to control Resident #1's diabetes at home with her diet. He said since Resident #1 had been in the facility her blood sugars have been out of control. He said they feed Resident #1 hamburgers, hot dogs and all kinds of things a diabetic should not be eating. He said he addressed it with the facility, and nothing had changed. Resident #1's family member #2 said he had not been invited to attend any care plan meeting since Resident #1's family member had addressed concerns regarding her HGBA1C level. During an interview and record review on 12/11/2025 at 11:50 AM, the Dietary Manager said if a resident required a special diet the nursing staff notified dietary, and they tried to accommodate the diet. The Dietary Manager said a diet order should be completed and given to the kitchen. The Dietary Manager said she was not aware Resident #1 requested a diabetic diet and required</p> |  |  |