

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 225 S Main St Vidor, TX 77662	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported, immediately but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or bodily injury, to the administrator of the facility and to other officials, including the State Survey Agency in accordance with State law through established procedures for 1 of 8 residents (Resident #1) reviewed for reporting allegations of abuse. The facility failed to ensure MA A reported an allegation of abuse to the Abuse Coordinator immediately when Resident #1 told them on 3/12/26 that CNA B was rough during care. The facility failed to ensure MA E and CNA B reported an allegation of abuse, made by Resident #1, to the Administrator immediately when they learned of the allegation on 03/18/26. MA E reported the allegation to CNA B and CNA B then reported the allegation to LVN D. These failures could place residents at risk of further incidents of abuse, neglect, exploitation, and a decreased quality of life. Findings included: Record review of Resident #1's face sheet dated 03/21/26 indicated she was [AGE] years old, admitted on [DATE] and her diagnoses included metabolic encephalopathy (brain dysfunction), Alzheimer's (type of dementia that affects memory, thinking and behavior), anxiety (uncontrollable worry), wedge compression fractures of the T11-T12 vertebra (spinal injuries), wedge compression fracture of the first lumbar vertebra (spinal injury), pain, and bipolar disorder (mental health condition). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated she was able to make herself understood and understood others. She had intact cognitive function (BIMS-14). Record review of Resident #1's care plan dated 07/07/25 indicated she had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's. Interventions included to administer medications as ordered and keep the resident's routine consistent. Record review of Resident #1's care plan dated 03/19/26 indicated Resident #1 had verbal behavior symptoms directed toward others and alleged staff attacked her then reported she loved the same staff. Interventions included to allow time for the resident to express themselves and feelings and psychiatric consultation as indicated. Record review of the facility investigation dated 03/24/26, completed by the Administrator indicated an incident occurred on 03/07/26. The facility became aware of the incident on 03/18/26 at 4:40 p.m. and reported to HHS on 03/18/26 at 5:52 a.m. The allegation was noted as abuse. The APs were identified as CNA B and CNA C. CNA B and CNA C were suspended on 03/18/26. The allegation of abuse was not confirmed. Resident #1 was assessed on 03/18/26 with no injuries. The report indicated on 03/18/26 at approximately 4:40 p.m., Resident #1 reported to LVN D (typo-error; should read MA B) that about a week ago, CNA B and CNA C were giving her a bed bath, twisted her leg, and jumped on the bed. Resident #1 was being treated for a UTI. Resident #1 said she reported to her (family member). Family Member H indicated Resident #1 never reported any incident with staff and her leg pain was chronic. The allegation of abuse was not confirmed. Abuse and Neglect training (included reporting) began on 03/18/26 and included MA A, CNA B, and CNA C. Record review of CNA B's undated statement indicated On March 7th 2026 (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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Saturday 6 [AM]-7 [AM] in the morning Resident #1 was the last bed bath [CNA C] and I had to do. [CNA C] and I never have done [Resident #1's] bath before, so we decided to do it together. We started her bed bath and bathed her like we normally do our bed baths. There was no complaints the whole time we were giving her her a bed bath. Monday (03/09/26) came and I worked on the same hall and there was still wasn't any complaint. [CNA C] and I worked Sunday (03/08/26) morning and everything was fine. [Resident #1] never said anything even after giving her tray or just going in her room to take care of her roommate. Four days had gone by that I didn't work and when I came to work Thursday March 12th, 2026 [MA A] told me that [Resident #1] was saying all this stuff about me and [CNA C]. I was off for four days after that and worked Tuesday March 17th, 2026 and today March 18th, 2026. When [MA E] told me a different story of what [Resident #1] said. The whole time [CNA C] and I gave [Resident #1] a bath was normal. She was a little cold but we told her we were trying to hurry. [MA E] that told me [Resident #1] complained to her that we got her wet when we gave her a bath. Record review of CNA C's statement dated 03/18/26 indicated On Saturday March 7th 2026 [CNA B] and I came to work and started on bath. [Resident #1] was the last bath given before breakfast trays were served. We had never done her bath before so we decided to do her bath together. We got her soap, lotion, deodorant, and clean clothes out to begin her bath. During her bath she didn't complain about any pain but complained she was wet. We did her bath like we would do any other resident here. After this event happened, nothing was told to me or [CNA B] until four days after it happened. I was not notified of any of this until March 18th almost two weeks after this happened. In between her bath and today [Resident #1] has never told me a complaint from her bath . Record review of MA E's undated statement indicated On March 18th [Resident #1] told me that [CNA B] was rough when giving her bath and she could (not) remember the other aides name, and she said that her legs were hurting really bad because they were jumping up and down on her legs. I then let [CNA B] know and she reported it to [LVN D] she told me this around 4:30 to 5:00 PM. There was no statement in the investigation from MA A for available for review. Record review of MA A's statement obtained by the facility on 03/31/26 indicated Resident #1 reported that CNA B was rough with her. She was unsure what day this occurred or which nurse she told. She did not remember the date. Record review of CNA B's time card indicated she worked 03/07/26, 03/08/26, 03/12/26, 03/17/26 and 03/18/26. Record review of CNA C's time card indicated she worked 03/07/26, 03/08/26, 03/09/26, 03/10/26, 03/13/26, 03/14/26, 03/15/26, and 03/16/26. During an interview on 03/31/26 at 8:55 a.m., the Administrator said she was the abuse coordinator. She said allegations of abuse were reportable to her or her designees immediately and to HHSC within 2 hours. She said she was informed of Resident #1's allegations on 03/18/26 at approximately 4:40 p.m. She said it was determined the allegations came from 03/07/26 when CNA B and CNA C gave her a bed bath. Resident #1 said they hurt her leg and jumped on her bed. She said Resident #1 was being treated for a UTI and her diagnoses included bipolar and hallucinations. She said Resident #1 would receive continued psychiatric services after treatment for the UTI was completed. She said Resident #1 never made any previous allegations against staff. She said Resident #1 indicated she never had any issues and stated she really liked CNA B and CNA C. She said CNA B and CNA C were suspended immediately pending the investigation. The allegation was not substantiated and they returned to work. She said the risk of not reporting allegation immediately placed residents at risk of further abuse. During an interview on 03/31/26 at 10:09 a.m., Resident #1 said CNA A and CNA B were rough when they gave her bath, twisted her leg and jumped on the bed. She said she did not remember exactly what day it was, but she did not want them in her room or to give her care or a bath. She said she was hurt. She said she believed it was done on purpose but did not know if it was abuse. She said she was not afraid of any of the staff. She said she told someone about the incident but could not remember the name of the staff or what date. During an interview on 03/31/26 at 10:17 a.m., LVN D said on 03/18/26 CNA B came to her and reported someone had told her Resident #1 said CNA B had attacked her and put too much water on her. She said she had to report the allegation to the (continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administrator. She said she called and texted the Administrator and then told the ADON because she could not reach the Administrator. She said CNA B was not allowed to continue any resident care and had to write a statement. She said CNA B was suspended immediately and left the facility. She said MA A did not report any allegations of staff being rough or abusive on 03/12/26. She said the risks of not reporting immediately could be continued abuse. During an interview on 03/31/26 at 10:46 a.m., CNA B said she had not provided Resident #1 a bath previously and asked CNA C to assist on 03/07/26. She said Resident #1 complained she was getting wet and they explained they would get her dry and dressed and then changed her sheets. She said Resident #1 was normally a bed bath because she did not get up for showers. She said she came to work on the 03/17/26, and she was not made aware of any issues or complaints. She said she returned to work on 03/18/26 and MA E told her Resident #1 said she was jumping on her bed and legs. She said she told LVN D immediately and LVN D said she had to report to the Administrator immediately. She said she wrote a statement and went home. She said she did not hurt Resident #1 and did not jump on her bed. She said staff being rough could be abuse. She said the risk of not reporting immediately could be further abuse. She said she was previously trained on abuse and reporting and was retrained upon her return to work after the investigation. During an interview on 03/31/26 at 11:01 a.m., CNA C said she was not aware of any allegations until she was called on 03/18/26 to make a statement. She said she and CNA B provided Resident #1 a bed bath on 03/07/26. She denied she or CNA B hurt Resident #1 or jumped on the bed or her legs. She said staff being rough could be abuse. She said the risk of not reporting immediately could be further abuse. She said she was previously trained on abuse and reporting and was retrained upon her return to work after the investigation. During an interview on 03/31/26 at 11:36 a.m. MA A said Resident #1 said on 03/12/26 (she could not recall the exact time) that CNA A was rough with her during care. She said she told Resident #1 that she did not think CNA A would be rough. She said Resident #1 did not say she was hurt or complain of pain. She said she went on the give medications to the next resident. She said she believed she told LVN D or whoever the nurse was on duty on 03/12/26 of Resident #1's allegation of staff being rough but she could not recall who she told. She said staff being rough could be abuse. She said abuse was reportable immediately to the nurse, DON, ADON, or Administrator. She said she did not report immediately to the Administrator. She said the risk of not reporting immediately could be further abuse. She said she was previously trained on abuse and reporting ad was retrained upon her return to work after the investigation. During an interview on 03/31/26 at 12:25, the ADON said MA A did not report to her on 3/12/26 the allegation CNA B was rough with Resident #1. She would have reported any allegation to the Administrator immediately. She said staff being rough could be abuse. She said she assessed Resident #1 on 03/18/26 and there were no injuries. During an interview on 03/31/26 at 1:03 p.m., TX LVN F said MA A did not report to her on 3/12/26 the allegation CNA B was rough with Resident #1. She would have reported any allegation to the Administrator immediately. She said staff being rough could be abuse. During and Interview on 03/31/26 LVN G said MA A did not report to her on 3/12/26 the allegation CNA B was rough with Resident #1. She would have reported any allegation to the Administrator immediately. During a clarification interview on 04/01/26 at 11:46 a.m., MA E said she was taking Resident #1's BP on 03/18/26 at approximately 4:30 -5:00 p.m. and Resident #1 reported CNA B and another CNA were rough during care. She said Resident #1 could not remember the second CNA's name. She said Resident #1 said her legs were hurting because the aides were jumping up and down on her legs. She said she told CNA B what Resident #1 said and CNA B reported to LVN D immediately. She said she did not report the allegation to the LVN D or the Administrator immediately. She said she should have reported immediately and had no excuses. She said residents were at risk of abuse if allegations were not reported immediately to the charge nurse or Administrator. Record review of the facility's Abuse Protocol dated 04/2019 indicated . 8. Any person observing an incident of Patient Abuse or suspecting Patient Abuse must immediately report such incidents to the Charge Nurse. The following information should be reported to the Charge Nurse: a. The name of the Patient (continued on next page)</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	involved; b. The date and time that the incident occurred; c. Where the incident took place; d. The name(s) of the person(s) committing the incident, if known; e. The name(s) of any witnesses to the incident; f. The type of abuse that was committed (i.e., verbal, physical, sexual, etc.); and g. Other information that may be requested by the Charge Nurse. 9. The Charge Nurse will immediately examine the Patient and notify the Abuse Prevention Coordinator upon receiving reports of mental, physical or sexual abuse.		