

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/17/2025
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring and administering of all drugs to meet the needs for 1 of 4 halls (hall 300) reviewed for controlled medications and 1 of 19 residents rooms reviewed for unsecured medication, and 1 of 1 medication rooms reviewed for expired medications. The facility failed to ensure controlled medications were counted on 12/14/25 between the night and day shift for the 300 hall med cart. The facility failed to ensure controlled medications were counted on 12/15/25 between the day and night shift for the 300 hall med cart. The facility failed to ensure no loose pills were left on the floor of Resident #98's room. The facility failed to ensure the expired fast acting dairy relief lactase supplement (dairy relief) was not in the medication storage room from current supply. This failure could place residents at risk for medication overdose, medication under-dose, ineffective therapeutic outcomes, and drug diversion. Findings included: 1. Record review of the controlled counting sheet for between shifts, indicated the sheet contained shifts without documentation for 300 hall med cart. The sheet was missing nursing signatures for 12/14/25 at 10:00 p.m. and 12/15/25 at 6:00 a.m. During an interview on 12/16/25 at 8:59 a.m., LVN B said she did not count the cart with the 10 p.m.-6 a.m. nurse, and that LVN C had a very bad night. She stated one of the residents was dying and she let the 10 p.m.-6 a.m. nurse leave without counting. She said she had been trained to count all narcotics when coming on her shift and when she was leaving the facility. She said they counted to prevent missing medications and drug diversion. During an interview on 12/16/25 at 2:00 p.m., LVN B said she could not remember if she counted Sunday morning. She said she normally counted unless there was an emergency with her family. She said she had been trained on counting controlled medications and the reason for counting was to prevent drug diversion. 2. Record review of a face sheet dated 12/15/25 indicated Resident #98 was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included hemiplegia affecting the right side (paralysis affecting one entire side of the body resulting from brain or spinal cord damage), liver transplant status (major surgery replacing a diseased liver with a healthy one from a donor), and history of cerebral infarct (death of brain tissue from a lack of blood flow). Record review of the admission MDS dated [DATE] indicated Resident #98 had a BIMS score of 13 indicating she had intact cognition with diagnoses of stroke, hemiplegia and liver transplant status. Record review of the care plan dated 11/25/25 indicated Resident #98 required pain medication (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	therapy related to administration of pain medication. Record of physician's orders dated 12/15/25 indicated Resident #98 was prescribed baclofen 10 mg three times a day related to spasmodic torticollis (a painful neurological disorder causing involuntary neck contractions sometimes caused by a problem with the brain) with a started date of 11/06/25. During an observation and interview on 12/14/25 at 9:00 a.m., Resident #98 was lying in bed, and under Resident #98's bedside table was a small white pill on the floor. In an interview Resident #98 said she must have dropped her baclofen pill when she was trying to take her pills this morning. She said the nurse hands her a cup with her pills and she takes the pills out of the cup and lines them up on her napkin on her bedside table and checks them and then takes the pills. She said MA D gave her medications this morning and she lined them up on her bedside table and must have dropped the baclofen. She said the MA watched her take her pills but went back to her medication cart for a moment but came back to watch her finish. Resident #98 said she must have dropped the pill between that time. During an interview and observation on 12/14/25 at 9:24 a.m., MA D said she gave medication to Resident #98 this morning. She said the white pill under Resident #98's bedside table on the window side of her bed was her baclofen. She said the pill could have been dropped last night. She said she gave Resident #98 her pills this morning but Resident #98 takes all her pills out of the medicine cup and lines them up on her bedside table on a napkin and takes them one at a time, taking a long time to take them sometimes up to an hour. MA D said she watched Resident #98 take all her pills this morning. She said she did walk back to her medication cart at the door and check something while Resident #98 was taking her pills and Resident #98 may have dropped the pill at that time when she was not looking. She said she did not see the pill on the floor until surveyor intervention. MA D said it was the facility policy to give the resident their pills and stand and watch the resident take all the pills before they turned and left the room. She said she had been educated to give a resident all the prescribed pills for a medication pass and stand and watch the resident until all pills were consumed and not leave the resident until the medication pass was completed. The risk of a resident dropping some of their prescribed medication on the floor was the medication may not be as beneficial to the resident if she did not receive all of them. During an interview on 12/15/25 at 1:00 p.m., the DON said the charge nurse or MA that was providing medication to a resident was responsible for ensuring that resident received all medications given on each medication pass. She said the charge nurse or MA giving medication were to stay with the resident until the medications prescribed were all taken and not leave a resident with any medication. The DON said the charge nurses and MAs were all educated on medication administration protocol. She said Resident #98 possibly dropped the medication or knocked them to the floor when MA D went back to her medication cart. She said the risk was that a resident may not receive their medication as prescribed. The DON said her expectation was all medications were given by the MA and charge nurses as prescribed and none left with the resident or on the resident's table. She said the MAs and charge nurses were expected stay and watch the resident take all medication given. During an interview on 12/15/25 at 4:00 p.m., the Administrator said the nurse or MA giving medication to a resident was responsible for ensuring the resident took all medications provided and no medications were dropped on the floor. She said all nurses and MAs had been educated on administration of medication properly. The Administrator said the medication on the floor was possibly overlooked, she said it was possibly dropped by the resident when the MA went back to her medication cart. She said the resident risk of medication dropped on the floor was not following (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician orders. The Administrator said her expectation was all medication administered properly and timely. Record review of a facility policy titled, Medication Administration, revised 2025, indicated, . Medications are administered by licensed nurse, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.18. observe resident consumption of medication. Record review of a facility in-service titled, Medication Administration dated 11/11/12/25 and signed by MA D, indicated,. 2. The 7 rights of Medication Administration. 1. Right person. Before medication prep identify correct patient and their readiness to receive medications. e. ensure that resident swallow medications before walking away and drinks all of the liquid medication/supplement due. F. If a pill drops anywhere, discard in a manner which it cannot be accessed by other residents and prepare the dose again. During an observation of the medication storage room on 12/14/2025 at 10:35 a.m., revealed a box of fast acting dairy relief lactase enzyme supplement (dairy relief) 32 chewable t tablets with an expiration date of 08/25 was in the medication storage room with current supply. During an interview on 12/14/25 at 11:15 a.m., the Interim DON for 12/14/2025 said only non- expired medications should be in the facility for use. She said nursing staff were responsible for ensuring expired medications were removed from current use medications and properly discarded of. During an interview 12/16/25 at 10:50 a.m., the Administrator said the unit manager, charge nurses and the DON were responsible for ensuring expired medications were removed and properly discarded. She said her expectation was not to have expired medication in the facility. She said the potential risk was that the expired medications may not be as effective, and it could potentially be a sanitation issue. Record review of facility policy titled Medication Storage dated 12/1/2025 indicated in part: Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments. c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 1 of 1 treatment cart and 1 of 1 medication storage rooms reviewed for storage of drugs and biologicals. The facility failed to ensure the treatment cart was locked and secured when the Wound Care Nurse left the treatment cart unlocked and unattended on [DATE] at 7:45 a.m. The facility failed to ensure the treatment cart #1 was locked and secured when the Wound Care Nurse left the treatment cart unlocked and unattended on [DATE] at 9:42 a.m. The facility failed to ensure Hall200's medication aides' medication cart was free of loose pills at the bottom of the medication cart on [DATE] at 12:00 p.m. The facility failed to ensure medication carts were free of loose pills at the bottom of the medication cart. These failures could place residents at risk of medication misuse or drug diversion. The findings included: 1. During an observation and interview on [DATE] at 7:45 a.m. revealed the treatment cart was left unlocked and unattended in front of the nurse's station, facing out into the main pathway. The Wound Care Nurse said the cart should not have been left unlocked and unattended. 2. During an observation and interview on [DATE] at 9:42 a.m. on hall 400 the Wound Care Nurse left the treatment cart (drawers facing outward) unattended and unlocked (cart lock button was not pushed in indicating the cart was unlocked). Staff and residents had passed by the treatment cart that was left unlocked by the Wound Care Nurse. She had begun wound care in room [ROOM NUMBER], forgot needed supplies and went back to the treatment cart to retrieve supplies. She did not unlock the lock when she went back to retrieve supplies, nor did she lock the cart after the supplies were retrieved. During an interview on [DATE] at 9:50 a.m. with the Wound Care Nurse she said she did not lock the cart when she left the treatment cart the first time and when she went back to retrieve supplies. She said she should have locked the treatment cart to avoid anyone getting ahead to items that they should not have access to. She said she had been educated on the importance of locking the medication cart. During an interview on [DATE] at 11:10 a.m., the interim DON for [DATE], said the treatment cart should be locked when not in use by the nurse. She said the wound care nurse was responsible for ensuring her cart was locked. The DON said she makes rounds and checks the carts. During an interview [DATE] at 10:50 a.m., the Administrator said the treatment cart should be locked when not within the sight of the nurse assigned to the cart. She said the nurse that was assigned the cart was responsible for ensuring the cart was locked after use. 3. During an observation on [DATE] at 12:00 p.m. revealed Hall 200's medication aides' med cart had a total of 23 loose pills at the bottom of the medication cart: 2 large round white pills 2 white capsules (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 green round pill 1 white square pill 13 small white round pills 1 round orange pill 1 oval white pill 1 crushed orange/ tan pill 1 round orange pill During an interview on [DATE] at 12:10 p.m., the Interim DON for [DATE] said carts should be cleaned at the end of each shift ensuring there are no loose pills anywhere in the cart. During an interview [DATE] at 10:50 a.m., the Administrator said her expectation was for all carts to be locked, tidy, no expired medication, unlabeled meds, or things that did not belong in it. Record review of facility policy titled Medication Storage dated [DATE] indicated in part: Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments. c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. 8. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection control 1 of 4 halls (hall 400) observed for infection control. The facility failed to ensure the Wound Care Nurse wore personal protective equipment (gown) while doing wound care. The facility failed to ensure the Wound Care Nurse performed hand hygiene between glove changes while doing wound care. The facility failed to ensure the Wound Care Nurse sanitized the wound cleanser bottle before putting it back in the treatment cart. These failures could place residents at risk of cross-contamination and development of infections. The findings included: During an observation on 12/14/2025 at 8:45 a.m. revealed the Wound Care Nurse began and ended Resident #74 (on enhanced barrier precautions for wound care.) wound care without personal protective equipment (gown) on. The Wound Care Nurse removed Resident #74's soiled dressings then she changed her gloves and put on new ones without using hand hygiene. At 9:00 a.m. the Wound Care Nurse took the wound cleanser bottle out of Resident #74's room that she used and placed it back in the treatment cart without sanitizing it. During interview on 12/14/2025 at 9:42 a.m. with the Wound Care Nurse said she should have had the personal protective equipment (gown) on. She said wearing personal protective equipment (gown) protected the resident and herself from cross contamination. She said she had been trained and in-serviced on personal protective equipment (gown and gloves) and cross contamination. She said she should have used hand hygiene between glove changes when she did Resident #74's wound care. The Wound Care Nurse said she should have sanitized the wound cleanser bottle before putting the bottle back into the treatment cart. She said she was responsible for wearing personal protective equipment (gown and gloves) during wound care, sanitizing her hands between glove changes, and sanitizing the wound cleanser bottle before putting it back in the treatment cart. She said the associated risk is cross contamination to residents in the facility. During an interview on 12/14/2025 at 12:15 a.m. with the Interim DON, she said it was her expectation for staff to wear personal protective equipment (gown) during wound care and on residents that were on enhanced barrier precautions, sanitizing their hands between glove changes, and sanitizing the wound cleanser bottle before putting it back in the treatment cart. She said the Wound Care Nurse had been in-serviced and trained on enhanced barrier precautions and wearing personal protective equipment during wound care. During an interview on 12/16/2025 at 2:45 p.m. with the Administrator, she said herself and the Infection Preventionist were responsible for all infection control training. She said the Wound Care Nurse was responsible for proper infection control and hand hygiene during wound care. The Administrator said the Wound Care Nurse was educated on infection control. She said the potential associated risk was the spread of infection. She said her expectation was for all staff to follow infection control policies. Record review of facility policy titled Infection Prevention and Control Program revision dated: 12/01/2025 indicated in part: Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Definitions: Staff includes all facility staff (direct and indirect care functions), contracted staff, consultants, volunteers, others who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions. Policy Explanation and Compliance Guidelines: 1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases. 2. All staff are responsible for following all policies and procedures related to the program. 3. Surveillance: a. A system of surveillance is utilized for (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards.b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee.c. The RNs and LPNs participate in surveillance through assessment of residents and reporting changes in condition to the residents' physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections.4. Standard Precautions:a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services.b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures.c. All staff shall use personal protective equipment (PPE) according to the established facility policy governing the use of PPE.d. Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies.e. Environmental cleaning and disinfection shall be performed according to the facility policy. All staff have responsibilities related to the cleanliness of the facility and are to report problems outside of their scope to the appropriate department.5. Equipment Protocol: a. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment.b. Single-use disposable equipment is an alternative to sterilizing reusable medical instruments. Single-use devices must be discarded after use and are never used for more than one resident. c. Reusable items potentially contaminated with infectious materials shall be placed in an impervious clear plastic bag. Label bag as CONTAMINATED and place in the soiled utility room for pickup and processing.d. The central supply clerk will decontaminate equipment with a germicidal detergent prior to storing for reuse.		