STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675431	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Oak Health and Rehabilitation Center	101 Reese Dr Red Oak, TX 75154

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654 Based on observations, interviews, and record review the facility failed to ensure residents received services in the facility with reasonable accommodations of resident's needs and preferences except when to do so would endanger the health and safety of the resident or other residents for 2 of 9 residents (Residents #1 and #2) reviewed for resident rights. The facility failed to ensure Resident #1 and #2's call lights were within reach on 07/17/24. This failure could place residents at risk of needs not being met. Findings included: Record review of Resident #1's Admission Record dated 07/17/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia (a syndrome associated with many neurodegenerative diseases, characterized by a general decline in cognitive abilities that affects a person's ability to perform everyday activities), anxiety (an emotion which is characterized by an inner turmoil and includes feelings of dread over anticipated events), seizures (uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain), and cerebral infarction (also known as ischemic stroke, pathological process that results in an area of necrotic tissue in the brain). Record review of Resident #1's Quarterly MDS dated [DATE] reflected a BIMS of 00 indicating Resident #1's cognitive level would not allow him to complete the interview. Section GG-Functional Abilities and Goals reflected Resident #1 required substantial/maximal assistance with bathing and was independent with toileting hygiene and personal hygiene. Record review of Resident #1's care plan which initiated on 01/27/23 and was revised on 07/27/23 reflected Resident #1's focus: had an ADL Self Care Performance Deficit r/t Alzheimer's, muscle weakness. Had a history of a right hip fracture, a goal: will be cleaned, well-groomed, appropriately dressed and weight maintained through next review date, and interventions: reflected extensive assistance X2 staff to use toilet, requires extensive assist X1 staff with personal hygiene care, and requires extensive assist X2 staff with transferring. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 07/17/24 at 10:15 AM revealed Resident #1's call light was observed on the floor to the right-hand side of the bed and out of the resident's reach. Resident #1 was lying in bed. Resident #1's sheets were saturated with milk, and it appeared the resident had spilled his milk. Observed an empty carton of milk which was lying on the foot of the bed. Resident #1 opened his eyes only to say hello then he shut them again. Record review of Resident #2's Admission Record dated 07/17/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia (a syndrome associated with many neurodegenerative diseases, characterized by a general decline in cognitive abilities that affects a person's ability to perform everyday activities), hyperlipidemia (abnormally high levels of any or all lipids or lipoproteins in the blood), anxiety (an emotion which is characterized by an inner turmoil and includes feelings of dread over anticipated events), and nontraumatic subdural hemorrhage (a rare condition that occurs when blood collects between the dura mater and arachnoid mater of the meninges surrounding the brain). Record review of Resident #2's Quarterly MDS dated [DATE] reflected a BIMS of 03 indicating Resident #2 had severe cognitive impairment. Section GG-Functional Abilities and Goals revealed Resident #2 required partial/moderate assistance with bathing, toileting hygiene, and personal hygiene. Record review of Resident #2's care plan which initiated on 08/01/23 and was revised on 08/23/23 reflected Resident #2's focus: had an ADL Self Care Performance Deficit r/t DX: Dementia, a goal: will be cleaned, well-groomed, appropriately dressed and weight maintained through next review date, and interventions: requires assistance X1 staff to use toilet, required extensive assistance X1 staff member with personal hygiene care, and requires physical assistance X1 staff member with transferring. In an observation and interview on 07/17/24 at 10:19 AM reveled Resident #2's call light was laying lying on the nightstand, out of the resident's reach. Resident #2 was observed in bed and stated everyone was treating him well. He stated he would just yell out if he needed help. In an interview on 07/17/24 at 10:24am, the ADON , she stated she expected call lights to be at bedside and in reach of residents. She stated staff were educated and in-serviced every month and as needed related to having their call light within reach. She stated if the resident's call lights were out of reach, the residents could fall or have an injury related to not being able to get assistance or not being clean and dry. In an interview on 07/17/2024 at 11:08 AM, LVN A stated residents' call lights should without a doubt be in their residents reach at all times. She stated she had been trained on call light placement. She stated if a call light was not in a resident's reach, it could cause a fall or some kind of trauma. In an interview on 07/17/2024 at 11:22 AM, CNA A stated residents' call lights should be in the residents reach at all times. She stated she had been trained on call light placement. She stated if a call light was not in resident reach, it could cause a resident to fall due to them reaching for it or could cause the resident to be in danger. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/17/2024 at 11:33 AM, CNA B stated residents' call lights should be in the residents reach at all times. She stated she had been trained on call light placement. She stated if a call light was not in resident reach, it could cause a fall. In an interview on 07/17/2024 at 11:42 AM, LVN B stated residents' call lights should be in residents their reach at all times. She stated she had been trained on call light placement. She stated if a call light was not in resident reach, it could cause a fall or harm to a resident. In an interview on 07/17/2024 at 11:42 AM, the DON stated residents' call lights should be in residents their reach at all times. She stated staff had been trained on call light placement. She stated if a call light was not in residents reach, a resident could possibly have a fall. In an interview on 07/17/2024 at 11:48 AM, the ADM stated residents' call lights should be in residents their reach at all times. He stated staff had been trained on call light placement. He stated if a call light was not in the residents reach, it could cause a resident to possibly have a delay in care. Record review of facility's policy titled Answering the Call Light dated 2001 (revised March 2012) revealed The purpose of this procedure is to respond to the resident's requests and needs. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654 Based on observations, interviews, and record review, the facility failed to have all residents receive treatment and care in accordance with professional standards of practice, the comprehensive care plan, for 1 of 7 (Resident # 1) residents reviewed for care. The facility failed to provide a clean comfortable environment for Resident #1 by allowing him to lay in a soiled bed . This failure could place residents at risk for further skin integrity impairment, untreated medical issues, and diminished quality of care. Findings included: Record review of Resident #1's Admission Record dated 07/17/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia (a syndrome associated with many neurodegenerative diseases, characterized by a general decline in cognitive abilities that affects a person's ability to perform everyday activities), anxiety (an emotion which is characterized by an inner turmoil and includes feelings of dread over anticipated events), seizures (uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain), and cerebral infarction (also known as ischemic stroke, pathological process that results in an area of necrotic tissue in the brain). Record review of Resident #1's Quarterly MDS dated [DATE] reflected a BIMS (- Brief Interview for Mental Status) of 00 indicating Resident #1 could not complete the interview. Section GG-Functional Abilities and Goals reflected Resident #1 required substantial/maximal assistance with bathing and was independent with toileting hygiene and personal hygiene. Record review of Resident #1's care plan which initiated on 01/27/23 and was revised on 07/27/23 reflected Resident #1's focus: has an ADL Self Care Performance Deficit r/t Alzheimer's, muscle weakness. Had a history of a right hip fracture, a goal: will be cleaned, well-groomed, appropriately dressed and weight maintained through next review date, and interventions requires extensive assistance X2 staff to use toilet, required extensive assist X1 staff with personal hygiene care, and requires extensive assist X2 staff with transferring. The care plan also reflected Resident #1 requires supervision of 1 staff to eat. A second focus area within the care plan reflected Resident #1 had an actual impairment of the skin with an intervention to Keep the skin clean and dry. Record review of Resident #1's weekly skin review dated 7/15/24 reflected Resident #1 had open wounds to his right buttocks, posterior (back) scrotum, and his lower sacrum. Resident #1 received wound care daily by the nurse and being followed weekly by the wound physician. In an observation on 7/17/24 at 10:15am revealed Resident #1 was lying in bed. His sheets were saturated with fluid, and an empty carton of milk was lying on the foot of the bed. Resident #1 opened his eyes only to say hello then shut them again. His call light was observed on the floor to the right-hand side of the bed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/17/24 at 10:24am with the ADON, she stated she expected call lights to be at bedside and in reach of residents and sheets on the bed should be dry. Staff were educated by in-service every month and as needed related to residents having their call light within reach and keeping residents clean and dry. If the call light were to remain out of reach the residents could fall or have an injury related to not being able to get assistance or not be clean and dry. In an interview on 7/17/2024 at 11:08am with LVN A, she stated she had worked in the facility for about a month. She stated she was in-serviced regularly on abuse and neglect, resident rights, medication administration, ADL care, falls/fall prevention. She stated residents' sheets should be clean and dry. She stated it was common knowledge to ensure residents had clean and dry linens, including sheets. She stated if a resident were to lay in soiled or wet sheets for a period, it could cause bed sores. In an interview on 07/17/2024 at 11:22am with CNA A, she stated residents should be changed, turned, and repositioned every 2 hours and as needed. She stated if a resident was gotten out of bed, they should still be checked and changed every 2 hours and as needed. She stated residents' sheets should be clean and dry. She stated she was trained on linen care and ensuring residents had clean and dry linens, including sheets. She stated if resident were to lay in soiled or wet sheets for a period, it could cause bed sores. In an interview on 07/17/2024 at 11:55am with ADM and DON, they stated if a call light was not in a resident's reach, the resident could possibly have a delay in care or a fall. They stated residents' sheets should be clean and dry. They stated staff were trained on linen care and ensuring residents have clean and dry linens, including sheets. They stated if resident were to lay in soiled or wet sheets for a period, it could cause skin breakdown. Record review of facility policy titled Quality of Life-Dignity dated October 2009 reflected each resident shall be cared for in a manner that promotes and enhances quality of life. Record review of facility policy titled Routine Resident Checks dated December 2007 reflected Staff shall make routine resident checks to help maintain residents' safety. Routine residents check involves entering the resident's room and or identifying the resident elsewhere on the unit to determine the resident's needs are being met identifying any change in the resident's condition, identifying whether the resident has any concerns, and see if the resident is sleeping, needs toileting assistance etc.