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	03/13/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen reviewed for dietary services.The facility failed to ensure food was safely stored, labeled, and dated in the walk-in refrigerator on 03/11/2026.The facility failed to ensure food was safely stored, labeled, and dated in the kitchen pantry on 03/11/2026.These failures have the potential to affect the residents who ate food from the facility's kitchen, placing them at risk of foodborne illness. Findings include:Observation of the kitchen pantry on 03/11/2026 at 9:28 AM revealed:1.One plastic bag with a box of quick creamy wheat. There was no ?open date or ?use by date' documented.2. One gallon of BBQ sauce with an open date of 03/02/2026. There was no 'use by date documented.3. One opened gallon of apple cider vinegar with an ?open date' of 09/15/2025. There was no ?use by date' documented.4. One opened gallon of soy sauce with a date of 10/09 and an open date of 11/03/2026. There was not a ?use by date' documented.5. One opened plastic jar of peanut butter with an open date of 02/27/2026. There was no 'use by date documented.6. One opened gallon of liquid smoke that did not have an ?open date' or ?use by date' documented.7. One gallon of molasses unsulphured original that had an open date of 12/01/2025. There was no 'use by date' documented.8. One plastic bag of chips with a date of 03/02/2026 and did not have a ?use by date' documented.9. One plastic bag of wafer cookies with an open date of 02/10/2026 and did not have a ?use by date' documented.10. One plastic container with graham crackers that did not have an ?open date' or a ?use by date' documented.11. One plastic container with saltine crackers that had an open date of 02/09/2026. There was no ?use by date' documented.12. One opened package of elbow macaroni that was covered with plastic wrap and did not have an ?open date or ?use by date' documented.13. One opened package of spaghetti noodles that was covered with plastic wrap and had an ?open date' of 01/26. There was no 'use by date' documented.14. One opened plastic bottle of dill weed that had a received date of 08/07/2025. There was not an ?open date' or ?use by date documented.15. One opened package of brown gravy mix that was covered with plastic wrap and had an ?open date' of 03/02/2026. There was no 'use by date documented.16. One opened plastic bag of yellow cake mix that had an ?open date' of 03/05/2026. There was no 'use by date documented.17. One opened plastic bag of chocolate cake mix that had an ?open date' of 03/05/2026. There was no 'use by date documented.During an interview with the PC on 03/11/2026 at 9:36 AM, she stated that once food was opened, there should be an ?open date' and a ?use by date' documented on each container. She stated that not properly dating and labelling the food would put residents at risk of food-borne illnesses.Observation on 03/11/2026 at 9:40 AM revealed a sign (undated) posted on the walk-in refrigerator that reflected the following in capital letters: EVERYTHING MUST BE LABELED AND DATED BEFORE IT HITS THE COOLER/FREEZER!!! ALL COOKED ITEMS MUST BE discharged WITHIN 48 HOURS!!! NO EXCEPTIONS!!!!Observation on 03/11/2026 at 9:44 AM of the walk-in refrigerator in the kitchen revealed the following:1. One opened plastic bag of garlic bread that had an ?open date' of 03/09/2026. There was no 'Use by date documented.2. One opened plastic container of apples that had an ?open date' of 03/09/2026. There was no 'Use by date documented.3. One opened (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	carton of thickened lemon-flavored water that had an ?open date' of 03/02/2026. There was no 'use by date' documented.4.One opened plastic container of peaches that had an ?open date' of 03/10/2026. There was no ?use by date' documented.5. One opened metal pan of ham that had an ?open date' of 03/04/2026. There was no ?use by' date documented.6. One metal pan of lettuce and tomatoes that had an ?open date' of 03/06/2026. There was no 'use by date' documented.7. One opened plastic bag of potato wedges that had an ?open date' of 03/03/2026. There was no 'Use by date documented.8. One opened plastic bag of hash browns that had an ?open date' of 03/05/2026. There was no 'use by date' documented.9.One opened plastic container of strawberries with a red gel-like substance on the side of container. There was not an ?open date' or ?use by date' listed on the container.During an interview on 03/11/2026 with the PC at 9:52 AM, she stated food items that were placed in the refrigerator should have an ?open date' and a ?use by date' (the used by date was 48 hours from the open date). The PC advised that not having these dates listed could place residents at risk of foodborne illnesses.During an interview on 03/13/2026 at 1:57 PM with the RPM, she stated food items that were stored in the pantry should be dated when received. The RPM said the container should have an ?open date' and a ?use by date' once it was opened. The RPM stated that refrigerated items should be dated when opened and the used date was 48 hours from the ?open date'. The RPM advised that not safely storing and dating food items could place residents at risk of food borne illnesses.Record review revealed there was an in-service that covered the topic Label-N-Dating on 02/25/26 facilitated by the PC. Record review revealed the following undated policies were reviewed and reflected the following: Food receiving Policy and Procedure - Policy statement: This policy establishes guidelines for the safe handling of all food items during transport, delivery, and storage, with a focus on maintaining strict time and temperature controls to ensure food safety.5. Labeling and Dating: All food items must be clearly labeled and dated, using either the manufacturer's packaging information or manual staff entries, to ensure traceability and freshness Dry Goods Storage Policy and Procedures - Policy statement: This policy ensures that all dry goods are stored in compliance with the FDA Food Code standards to maintain their quality and safety.6. Organization: Storage area shall be organized and maintained in a manner that allows for easy identification and access to items, with all good appropriately date labeled.During an interview on 03/13/2026 at 2:20PM with the ADM, he stated he did not know that staff did not properly date all food items properly. He stated an in-service was completed in February 2026 regarding dating and labeling food in the kitchen. He advised that not properly dating and labeling food in the kitchen could put residents at risk of foodborne illnesses. He concluded that this would be monitored more closely.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure all drugs and biological were stored in locked compartments for 1 of 6 residents (Resident #111) reviewed for medications storage. During medications administration, MA A left Resident #111 without ensuring medications were swallowed. This deficient practice could place residents at risk of misappropriation of medications or harm due to accidental ingestion of medications.The findings included: Record review of Resident #111's face sheet, dated 03/13/26, reflected an admission date of 06/16/23, with diagnoses which included: cerebral infarction (a pathologic process that results in an area of necrotic tissue in the brain), hypertension (high blood pressure), atrial fibrillation (a common heart arrhythmia that causes the upper chambers of the heart to beat irregularly and often rapidly), and dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities). Record review of Resident #111's Quarterly MDS dated [DATE] reflected Resident #111's had a BIM's score of 05 which indicated she was severely cognitively impaired. Review of MDS reflected Resident #111 required supervision or touching assistance with eating and toileting, substantial/maximal assistance with showers, and partial or moderate assistance with personal hygiene. MDS reflected Resident #111 was diagnosed with hypertension. Record review of Resident #111's physician's orders dated 11/20/25 reflected an order for Lisinopril Oral Tablet 20 MG (Lisinopril) Give 1 tablet by mouth one time a day for HTN hold for SBP less than 100 or DBP less than 60. The physician's order's reflected Resident #111 did not have an order for Aspirin. Record review of Resident #111's MAR dated 11/20/25 reflected Lisinopril Oral Tablet 20 MG (Lisinopril) Give 1 tablet by mouth one time a day for HTN hold for SBP less than 100 or DBP less than 60 -Start Date11/20/2025 0600. Resident #111's MAR reflected medication was given on 03/11/26 and Resident #111's BP was 126/63. Review of Resident #111's care plan, dated 01/26/26, revealed a focus of Resident #111 had the potential for s/sx and complication r/t hypertension, a goal of Will remain free from s/sx of hypertension, and interventions that included give anti-hypertensive meds as ordered. Observe for side effects such as orthostatic hypotension (an increase in blood pressure with standing typically in relation to kidney diseases), and increased heart rate. In an interview and observation on 03/11/26 at 12:11 PM, revealed Resident #111 had a round light orange pill beside her arm in her bed. She stated she did not know what the pill was or who gave it to her. She stated she did not feel like being bothered. Resident #111 moved the pill from her bed to her bedside table. She stated she did not know whose pill that was or if someone brought it to her. Resident #111 appeared pleasantly confused and stated the surveyor had the wrong person because she was not getting any surgery today. The Surveyor explained to the resident they were not at the facility for her to have surgery. Resident #111 turned her back toward the surveyor. In an interview on 03/11/26 at 12:20 PM, MA A stated she thought that the medication found on Resident #111's bedside was an aspirin and she believed Resident #111 took that medication every morning. She stated she had given Resident #111 her medication that morning and she watched the resident take and swallow the medication. She stated she was trained on watching and ensuring residents took their medications and that they swallowed the medications before she left the room. She stated if a resident had a medication left lying on the bed or they had not swallowed their medication, another resident could have come in and taken the medication or the resident that did not take the medication could have gotten a headache or not have the desired effect from the medication. In an interview on 03/12/26 at 4:03 PM, MA A stated on the previous day when she was asked about the medication found on the resident's bed that she thought was aspirin, she went back and looked at the resident's MAR and found that resident did not take aspirin. She stated she found that the medication was Lisinopril (medication given to lower blood pressure) and she went and told her nurse. She stated her nurse came back and told her to go ahead (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and give the medication and she went and gave the resident her medication. She stated she checked the resident's blood pressure and pulse prior to giving resident the medication and everything was in parameters to give the medication. She stated that was about 12:40 PM when she gave the medication and there were no adverse reactions or effects from the medication being given late. In an interview on 03/13/26 at 9:45 AM with the ADON, she stated MA A came to her yesterday and she could not remember exactly what time, but MA A told her there was a medication that was found by the surveyor in Resident #111's bed. She stated MA A thought that the medication was an aspirin but they went and looked at Resident #111's MAR to find out what the medication was. She stated they found that the medication was a Lisinopril 20 mg tab. She stated the MD was in the facility at that time and she informed the MD about the medication being found in Resident # 111's bed. She stated the MD told them to give Resident #111 the medication. She stated she and MA A disposed of the medication that was found and MA A went and checked Resident #111's BP, prepared the medication, and administered the medication. She stated nurses and medication aides were trained on staying with residents when medications were administered and ensuring residents swallowed their pills. She stated if a medication was not taken correctly and remained out in the open such as on a residents bed, another resident or roommate could have taken the medication and the resident that did not swallow them medication properly could have had an increased blood pressure. In an interview on 03/13/26 at 1:17 PM, the DON stated the nurses and medication aides were responsible for administering medications to the residents. She stated when medications were administered to the residents the staff who administered the medication should have stayed with the resident until all of the medications were swallowed. She stated the nurses and medication aides had been trained on medication administration and ensuring residents had swallowed their medications before they left the residents room. She stated if medications were left out in the open or on a resident's bed, another resident could have taken the medication. She stated the resident could have missed a very important medication or a resident's blood pressure could have risen. In an interview on 03/13/26 at 1:21 PM, the ADM stated the licensed nurses and medication aides were responsible for administering medications to the residents. He stated it was his expectation that when medications were administered to the residents, the staff who administered the medication should have stayed with the resident until all of the medications were swallowed. He stated the nurses and medication aides had been trained on medication administration and ensuring the resident had swallowed their medications before they left the residents room. He stated if medications were left out in the open or on a resident's bed, another resident could have taken the medication or in this case, it could have caused a spike in blood pressure. Record review of the facility's policy titled, Storage of Medication, dated April 2007, reflected Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.