STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675445	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Manor Nursing Center	624 N Converse St Flatonia, TX 78941

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the residents were free from physical abuse for two (Resident #2 and Resident #3) of six residents reviewed for abuse. 1. The facility failed to ensure Resident #2 was not attacked by Resident #1 with a pencil on 08/11/25 causing slight bleeding and the facility failed to ensure Resident #2 was not hit over the head by Resident #1 with a metal object on 08/15/25, no physical injury, causing Resident #2 to be afraid of Resident #1.2. The facility failed to ensure Resident #1 did not slap Resident #3 on the back on 08/20/25.3. The facility failed to ensure a nurse, on 09/01/25, when pushing Resident #3 in her wheelchair to her room, did not tell the resident it hurt the nurses her back to push her and the nurse was going to need a forklift to move Resident #3An Immediate Jeopardy (IJ) situation was identified on 08/30/25. While the IJ was removed on 09/02/25, the facility remained out of compliance at a scope of isolated that with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of continued abuse, injury, hospitalization, trauma, and psychosocial injury.The findings include:Review of Resident #1's face sheet dated 08/30/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including schizophrenia (a chronic mental illness characterized by a combination of positive, negative, and cognitive symptoms that significantly impair a person's daily functioning and social relationships), schizoaffective disorder, bipolar type (a mental health condition that combines symptoms of schizophrenia and bipolar disorder (a chronic mental health condition characterized by extreme mood swings between episodes of mania (highs) and depression (lows)), and unspecified dementia (a general term for a group of conditions that cause a progressive decline in cognitive abilities, such as memory, thinking, reasoning, and judgment), severe, with anxiety (a severe form of unspecified dementia with the added symptom of anxiety).Review of Resident #1's care plan reflected focus;1. 07/08/25 Resident #1 had a behavior problem aggressive r/t schizophrenia and had potential to be physically aggressive r/t schizophrenia2. 07/08/25 Resident #1 had potential to be physically aggressive r/t schizophrenia3. 07/08/25 Resident #1 had potential to be verbally aggressive r/t schizophrenia and DementiaResident #1's MDS Nursing Home Comprehensive dated 06/16/25 reflected a BIMS score of 00 indicating severe cognitive impairment. Section A1510 Level II Preadmission Screening and Resident Review (PASRR) Conditions reflected serious mental illness. Section A1805 Entered From reflected Inpatient Psychiatric Facility (psychiatric hospital or unit). Review of Resident #2's face sheet dated 08/30/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline), schizophrenia, unspecified dementia, unspecified severity, with other behavioral disturbance (a description combining symptoms of schizophrenia with unspecified dementia and a behavioral disturbance). Review of Resident #2's care plan reflected focus;1. 07/30/24 Resident #2 was PASRR level 2 d/t schizophrenia and major depressive disorder, recurrent2. 12/26/24 Resident #2 had potential to be physically aggressive (throwing cups, trash) r/t schizophrenia and TBI3. 12/26/24 Resident #2 had potential to be verbally aggressive calling staff bitches and niggers r/t schizophrenia and TBI4. 01/15/24 Resident #2 had a communication problem r/t HOH and used an amplifier. 5. 01/15/24 Resident #2 had a mood problem r/t schizoaffective disorder. Resident #2's Quarterly MDS dated [DATE] reflected a BIMS score of 12 indicating moderate cognitive impairment. Review of Resident #3's face sheet dated 09/02/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including major depressive disorder (mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life), unspecified psychosis not due to a substance or known physiological condition (psychotic symptoms (like hallucinations or delusions) but a specific diagnosis cannot be made because there isn't enough information or the symptoms don't fit another established category), and schizoaffective disorder, depressive type (a mental health condition that combines symptoms of schizophrenia with those of major depression).Review of Resident #3's care plan reflected focus dated 08/31/25 reflected Resident #3 had potential to be verbally aggressive, shouting at staff or other residents r/t dementia, mental or emotional illness. Resident #3's MDS Quarterly assessment dated [DATE] reflected in section A1805 Resident #3 entered the facility from inpatient psychiatric hospital. Review of Resident #3's brief interview for mental status reflected a BIMS score of 00, indicating severe cognitive impairment

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to ensure based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one of five residents (Resident #4) reviewed for quality of care.The facility failed to ensure that Resident #4 was taken to her MD referred pulmonary and dermatology appointments referral date 02/24/25.These failures could place residents at risk for unassessed changes in conditions that could lead to permanent impairment, including decreased quality of life.Findings included:Record review of Resident #4's MD orders dated 02/24/25 reflected, refer to pulmonology DX COPD and refer to dermatology for rash.Interview on 09/01/25 at 4:26 pm with Resident #4 reflected she had not been taken to her specialist appointments of either the dermatologist or the pulmonologist.Interview on 09/02/25 at 5:29 pm with the LPN A reflected it was the responsibility of the charge nurse to follow up on scheduling specialist appointments when the MD made an order for the resident to see a specialist. She said the appointments should be made within the next couple of days of receiving the order from the MD. She said it was the responsibility of the ADON and DON to make sure that the doctor's orders for specialists were followed up with and scheduled. She said the possible negative effects of not following through the MD order for specialist appointments was that Resident #4's breathing would not get better. She said Resident #4 had sensitive and it tore really easily, and it was important to see a dermatologist for her thin skin.Interview on 09/02/25 at 5:48 pm LVN C reflected either the MDSC, or the DON were responsible for making sure residents' specialist appointments were scheduled. She said it was not good practice for MD orders for resident specialist appointments not to be scheduled. It is important to follow through with all MD orders. The possible negative consequences for not following up with specialty appointments for resident orders to go to a specialist was they could become ill.Interview on 09/02/25 at 6:02 pm with the ADON reflected if the MD wanted Resident #4 to see a specialist, it was the responsibility of everyone to make sure the appointment was schedule and Resident #4 was taken to see the specialist. The negative consequences for no follow through with scheduling specialist appointments would be Resident #4 could potentially suffer medically and it was not good quality of care to not to follow up with the MD. Interview on 09/02/24 at 4:35 pm with the facility MD reflected Resident #4 should have been taken to her specialist pulmonary and dermatologist appointments. She said she was not too worried that Resident #4 did not go to the dermatologist. She was more concerned because she did not go to the pulmonary specialist because she was wheezing more than she had been. She said Resident #4 had reactive airway disease and she needed her medications adjusted by a pulmonary MD. She said her current medications were not working as well as they should have and people who have reactive airway disease often needed medication adjustments. She said anytime an order was given for a resident, and it was not acted upon she was concerned about it. Interview on 09/02/25 at 7:24 pm with the DON reflected the MD orders for Resident #4 to go to a dermatologist and pulmonary specialist were not carried out. She said, the ball got dropped. She said it was the responsibility of the person who put the order into the eMAR to schedule the appointment, but they did not have a system and no one person was responsible. She said the possible negative consequences of Resident #4 not attending her specialist appointments were that she could die from pulmonary complications. She said Resident #4 wanted to go to the dermatologist for cosmetic reasons only. Interview on 09/02/25 at 6:22 pm with the Administrator reflected they did not take Resident #4 to her specialty pulmonary appointment because they could not find a pulmonologist for Resident #4 and there was a transportation issue. She said it was the responsibility of the nursing staff arrange for resident specialist appointments. She said she did not know how the ball was dropped. She said the possible negative consequences of not getting Resident #4 to a specialist could be that she might have had a worsening medical condition, or the disease process could accelerate. Review of facility policy Medication and Treatment Orders dated July 2016 reflected order for medications and treatment will be consistent with principles of safe and effective order writing.