

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/18/2025
NAME OF PROVIDER OR SUPPLIER  Oak Manor Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for residents, staff and public for one (room # 411 vent) of seven vents observed and reviewed for environment. The facility failed to ensure the vent in room [ROOM NUMBER] was clean and free of dust particles. These deficient practices placed residents at risk for illness and decreased quality of life. Findings included: During an interview on 10/13/2025 at 2:03 pm the Maintenance Director stated the vent/AC register was responsible for directing the air. The Maintenance Director looked at the picture of the vent from room [ROOM NUMBER], and he stated that it was probably dust and needed to be cleaned. The Maintenance Director stated he would think it would have an impact on the residents, dust in their room, but was not sure of medical issues. The Maintenance Director said the dust in the vent of room [ROOM NUMBER] was not brought to his attention. During an interview on 10/13/2025 at 2:50 pm the DON looked at the picture of the vent in room [ROOM NUMBER] and stated that it was a vent with all dust and it could cause respiratory problems. She stated that meant the facility was not cleaning the vents. The DON stated Housekeeping and Maintenance were responsible for cleaning the vents in the building. The DON stated the managers should be checking the vents during their morning rounds. During an interview on 10/13/2025 at 3:34 pm the housekeeping supervisor stated she gives her staff a daily schedule. Housekeeping supervisor stated cleaning the vent was part of their daily cleaning schedule, with the duster on the surface, but they couldn't get thorough cleaning. The Housekeeping supervisor stated they have to get maintenance to open the vent for thorough cleaning. The Housekeeping supervisor stated she has climbed on the ladder and taken the vent cover out to clean thoroughly but that was about a year ago. The Housekeeping supervisor stated she was not sure if cleaning the vent had an impact on the residents' health. During an interview on 10/13/2025 at 4:03 pm the Administrator stated the facility had been working on the vents in the facility but did not know the vent in room [ROOM NUMBER] was that dirty. The Administrator stated the dirty vent could potentially cause respiratory issues, but she had not had complaints regarding vents. Review of facility's policy revised June 2011 titled cleaning and disinfecting non-critical Resident -Care items reflected: Purpose--The purpose of this procedure is to provide guidelines for disinfection of non-critical resident-care items. Preparation--Assemble the equipment and supplies as needed. Review of facility's policy dated revised 06/30/2025 titled Cleaning and Disinfection of Resident-Care Items and Equipment reflected: Policy Statement --Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interviews 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 of each resident for one resident (Resident #1) of four residents reviewed for medication administration in that: Resident #1 was not administered her Clonazepam 0.5 MG (anti-anxiety medication-- is a benzodiazepine medication used to treat panic disorders, certain seizure disorders, and movement disorders) for 3 days from 09/23/2025 to 09/25/2025 due to the facility not obtaining medication from the pharmacy. This failure could place residents on anti-anxiety medication at risk for increased anxiety and depression and change in ADLs. Findings included:Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted on [DATE] with the following dx. Major Depressive Disorder, recurrent, moderate (a mood disorder that causes a persistent feeling of sadness and loss on interest), Panic Disorder [episodic paroxysmal anxiety] (a panic disorder is a sudden episode of intense fear that triggers severe physical reactions when there is no real danger or apparent cause), Generalized Anxiety Disorder (a condition characterized by excessive or unrealistic anxiety about two or more aspect of life), Bipolar Disorder, recurrent episode mixed (a condition where a person experiences episodes that contain both manic and depressive symptoms at the same time and that these episodes happen repeatedly).Review of Resident #1's quarterly minimum data set (MDS) assessment dated [DATE] reflected a brief interview for mental status (BIMS) score of 15, indicating no cognitive impairment. Section I, Active Diagnoses reflected: Anxiety Disorder, Depression, Bipolar Disorder. Section N, Medications reflected antidepressant and Anticonvulsant medications were given in the last 7 days. Antianxiety and antipsychotic were not checked.Review of Resident #1's care plan initiated 12/24/2024 reflected Resident #1 required staff assistance for meeting emotional, intellectual, physical and social needs related to physical limitations. Care plan initiated 09/25/2024 reflected, resident uses anti-anxiety medications Clonazepam and Hydroxyzine related to Anxiety with intervention to administer ANTI-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Review of complaint file with HHSC dated 10/02/2025 reflected: From 09/19/2025 to 09/24/2025, The Resident [Resident #1] was without her CLONAZEPAM, for anxiety, because the facility was unable to get her medication from the pharmacy.Review of Resident #1's physician orders reflected an order dated 09/22/2025 for Clonazepam Tablet 0.5 MG Give 1 tablet by mouth at bedtime related to BIPOLAR DISORDER, CURRENT EPISODE MIXED, MILD, to start 09/23/2025.Review of Resident #1's Narcotic count sheet reflected 30 pills of Clonazepam Tablet 0.5 MG was delivered for Resident #1 on 08/18/2025, started taking on 8/19/2025 and was completed on 09/22/2025, zeroing out. It was also revealed that Resident #1's next Clonazepam Tablet 0.5 MG pills were delivered on 09/26/2025.Review of Resident #1's MAR for the month of September reflected:Clonazepam Tablet 0.5 MG Give 1 tablet by mouth at bedtime related to BIPOLAR DISORDER, CURRENT EPISODE MIXED, MILD and for the dates of 09/23/205, 09/24/2025 and 09/25/2025 signed by RN A, it indicated the number 6. The meaning for the number #6 on the MAR reflected: other/see progress notes.Review of Resident #1's progress notes dated 09/23/2025 at 10:54 pm, 09/24/2025 at 10:46 pm and 09/26/2025 at 00:02 am written by RN A reflected: Clonazepam Tablet 0.5 MG Give 1 tablet by mouth at bedtime related to BIPOLAR DISORDER, CURRENT EPISODE MIXED,on order.Review of Resident #1's progress notes dated 09/25/2025 at 3:19 pm written by LVN B reflected: Spoke with [XXX] at Pharmacy, to send Clonazepam today.Review of Resident MAR indicated behavior monitoring dated 09/24/2025 which reflected : Behavior monitoring Anti- Psychotic Q Shift: 0.None 1.Afraid 2.Agitated 3.Angry 4.Anxious 5.Mood change 6.Noisy 7.Restless 8. Withdrawn/crying 9.Crying 10. Combative 11. every shift related to BIPOLAR DISORDER, CURRENT EPISODE MIXED, MILD. There were no monitoring done on 09/24/2025 and the nurses indicated 0 on 09/25/2025 meaning no behavior noted. Review of Resident #1's progress notes from 09/22/2025 through 09/26/2025 did not reflect staff notifying Resident 's NP/MD for Clonazepam Tablet 0.5 MG.During an interview on 10/13/2025 at 10:31 am Resident #1 stated the staff usually do not give her medication and would say she refused her medication.Observation on 10/13/2025 at 1:55 pm reflected there were 13 pills of Clonazepam Tablet 0.5 MG left on the blister packet of pills for Resident #1 which was delivered on 09/26/2025.During an interview on 10/13/2025 at 2:25 pm, LVN B stated she called the local pharmacy on 09/25/2025 regarding Resident #1's Clonazepam Tablet 0.5 MG to be delivered. LVN B stated she was not sure if Resident #1 was out of Clonazepam Tablet 0.5 MG</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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Findings included: Observation on 10/13/2025 at 10:02 am reflected the water dispenser/drinking fountain in the main dining area had brown-colored liquid in the drip tray that looked slimy with tiny particles. Observation on 10/13/2025 at 10:05 am the kitchen sink was brown-colored and there were two small brown pellets on the drain strainer. The sink had black area at the back directly under the faucet. Observation on 10/13/2025 at 10:07 am kitchen vent without cover and the other vent was cover with dust. Observation on 10/13/2025 at 10:08 am the countertop of the drinks area had brown stains. Observation on 10/13/2025 at 10:09 am revealed there were cracked tiles in the kitchen under the sinks which created tripping hazard for staff. During an interview on 10/13/2025 at 12:34 pm, the Administrator stated the water dispensers were checked at least daily and she checked it daily on her daily morning rounds. The Administrator stated she expected the water dispenser to be clear, clean, no residual. The Administrator stated housekeeping staff was supposed to make sure the water dispenser was clean. The Administrator stated most of the Residents drink from the water dispenser due to the hard water system in the city. During an interview on 10/13/2025 at 12:55 pm the Dietary aide said everybody in the kitchen was responsible for the cleaning. The Dietary aide looked at the picture of the kitchen sink and counter area and stated she had never seen an area like that. She also stated she did not know who was responsible for cleaning the water dispenser in the dining area. The Dietary aide stated one of the vents in the kitchen had been open for a while, but she couldn't recall how long. During an interview on 10/13/2025 at 1:05 pm the [NAME] stated everyone was responsible for cleaning certain things in the kitchen. The [NAME] stated the Dietary aide was responsible for cleaning the drinks area. The aide was responsible for cleaning that sink because that was her area. The [NAME] said the Dietary manager was responsible for ensuring tasks were completed in the kitchen based on the cleaning list. The [NAME] stated dietary staff had to initial once their cleaning task was completed. The [NAME] stated the vent in the kitchen had been opened since she started working at the facility about 3 months ago. The [NAME] stated she spoke with the Dietary Manager about the vent being opened. The [NAME] stated the vent was supposed to have a filter to prevent dust or anything else from coming in. The [NAME] also stated the cracked tiles had been like that since she started working at the facility and the Administration was aware. During an interview on 10/13/2025 at 1:22 pm the Dietary Manager stated she started a cleaning log in August 2025 to make sure the staff were cleaning their work areas. The Dietary Manager stated she checked the cleaning log daily. The Dietary Manager looked at the picture from the kitchen sink and the drinks area and stated the drinks area was [NAME], and the sink had mold, and it was like that when she started her position and had gotten better. The Dietary Manager stated the mold was not supposed to be in the sink, it was gross, it could cause sickness to the residents. The Dietary Manager stated the Dietary aide was responsible for cleaning the sink and the drinks area and she was responsible for ensuring the cleaning was completed. The Dietary Manager stated the vent in the kitchen had been open for a while and it was not ok to remain open because anything like debris could come in. The Dietary Manager stated the Maintenance Director was aware of the open vent. The Dietary Manager stated she was told the Maintenance Director and the Housekeeping Supervisor were responsible for cleaning the water dispenser. The Dietary Manager stated she checked the water dispenser in the dining area at about lunchtime, and it had coffee in the drip tray. When the Dietary Manager looked at the pictures and stated, no, this is not what I saw, this is not coffee, this was dirt. The Dietary Manager stated the water dispenser was clean now, she had cleaned it. During an interview on 10/13/2025 at 2:03 pm the Maintenance Director stated there were 2 water dispensers in the facility, 1 in the dining area and 1 in the lobby. The Maintenance Director stated he checked the water dispensers every morning and when they were dirty and he let the housekeeper know to clean it. The Maintenance Director stated he checked the water dispenser in the lobby and the Dietary Manager checked this morning and it didn't seem dirty. The Maintenance Director looked at the picture of the</p>