

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2025
NAME OF PROVIDER OR SUPPLIER Oak Manor of Commerce Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	

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 0550</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 dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892</p> <p>Based on interview and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 5 residents (Resident #1) reviewed for resident rights.</p> <p>The facility failed to ensure Resident #1 was treated respectfully when CNA B spoke to Resident #1 in a loud manner and patted her hand on 04/14/2025.</p> <p>This failure could place residents at risk of embarrassment, feelings of worthlessness, decreased self-worth, loss of dignity, and a diminished quality of life.</p> <p>Findings included:</p> <p>1. Record review of a face sheet dated 05/08/2025 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Parkinsonism (condition that impacts movement and causes muscle stiffness, slow movement, speech impairment, tremors, slowed reaction time, frequent falls), anxiety disorder (mental illness defined by feelings of uneasiness, worry and fear), and major depressive disorder (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks).</p> <p>Record review of the Quarterly MDS assessment dated [DATE] indicated, Resident #1 was usually understood and usually understood others. The MDS assessment indicated Resident #1 had a BIMS score of 10, which indicated her cognition was intact. The MDS assessment indicated Resident #1 required substantial/maximal assistance with showering/bathing, toileting, and partial to moderate assistance with personal hygiene.</p> <p>Record review of Resident #1's care plan revised 04/15/2025 indicated, she screamed out at staff/other residents during anxious episodes and is at times hard to redirect or console related to anxiety. Resident #1's interventions indicated to maintain a calm environment and approach.</p> <p>Record review of the Provider Investigation Report with incident date 4/14/2025 at 2:25 PM, indicated Description of Allegation CNA B went and told the BOM Resident #1 was hitting her and cussing at her. CNA B stated she smacked Resident #1's hand like you would a toddler. The Provider Investigation Report indicated the conclusion of the investigation was that it was unfounded. CNA B had no intention to harm resident and was only attempting to distract resident from aggressive behavior.</p> <p>(continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/07/2025 at 11:08 AM, when Resident #1 was asked if staff had yelled at her, she said I am sure they have, but was unable to report who it was or when it happened. Resident #1 said she did not remember any staff hitting her or patting her hand. Resident #1 said she felt safe in the facility.</p> <p>During an interview on 05/07/2025 at 12:26 PM, LVN A said she was the nurse when the incident between Resident #1 and CNA B occurred. LVN A said Resident #1 was agitated when CNA B started her shift that day. LVN A said she was sitting at the nurse's station behind the desk and heard CNA B raise her voice at Resident #1, so she told her hey you need to stop doing that, and CNA B walked away. LVN A said she did not see CNA B hit Resident #1. LVN A said CNA B could get loud sometimes, and she had to tell her that was not how she needed to talk to the residents. LVN A said examples were CNA B would tell the residents you are my patient and you are not doing what I want you to do or ma'am we need to go in and get you cleaned up, we need to do it now, and if the they said no CNA B told them yes, we are we are going to go do it now. LVN A said she had to step in and tell CNA B if the resident was agitated, she was not going to be able to care for them. LVN A said CNA B speaking to the residents loudly and making such comments was disrespectful, and she was not treating the residents with dignity. LVN A said she had reported this to management when they asked her to write a witness statement for the incident between CNA B and Resident #1.</p> <p>During an interview on 05/07/2025 at 4:28 PM, CNA B said Resident #1 was in her room and she was trying to change her, and Resident #1 was hitting her and being physically and verbally abusive towards her, so she tapped her hand to try to calm her down, when she saw that she was not deescalating, she walked out of her room and went to get Resident #1's wheelchair. CNA B said she went back into Resident #1's room and got her in her chair and Resident #1 did it again and she said to her stop hitting. CNA B said after this, she went to the BOM and told her Resident #1 was hitting her and she tapped her hand because she was hitting. CNA B said she had not gotten loud with Resident #1, and she had removed herself from the situation. CNA B said when a resident was aggressive, she should stop providing care, and return later. CNA B said she had made comments to the residents such as they were her patients and they needed to do things now. CNA B said speaking to the residents this way could make them feel like poop and that their rights did not matter. CNA B said she had received training on how to handle residents with behaviors and how to speak to the residents when she first started, but she had not received any training since then.</p> <p>During an interview on 05/07/2025 at 5:34 PM, the BOM said CNA B went in her office and told her Resident #1 was pushing and hitting her. The BOM said she told CNA B Resident #1 could not swing that far so she needed to just back up. The BOM said CNA B told her she got Resident #1's hand and tapped it. The BOM said she told CNA B to hold on and got the DON to takeover.</p> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/08/2025 at 3:54 PM, the DON said the BOM had gone to her and told her CNA B just told her she hit Resident #1 on the hand. The DON said she asked CNA B to explain what happened with Resident #1. CNA B said Resident #1 was hitting and flinging her arms and CNA B could not get Resident #1's attention so she grabbed Resident #1's hand and patted it to get her attention. The DON said she did not allow CNA B to return to provide care. The DON said she sent CNA B home. The DON said CNA B had no history of abuse. The DON said if the residents refused care they should not continue and get the social worker involved. The DON said she was not aware CNA B was loud with the residents, and LVN A had not reported the comments CNA B made to the residents to her. The DON said the residents should be treated respectfully, and CNA B speaking to them in such way could make them feel pressured into doing what she wanted them to, and it could be misconstrued by the residents as the staff being confrontational.</p> <p>During an interview on 05/08/2025 at 4:51 PM, the Administrator said she was not aware CNA B was loud with the residents or of her speaking to the residents disrespectfully. The Administrator said she expected for the staff to speak to the residents gently and encourage them to be assisted. The Administrator said if the resident was refusing, the staff should leave and return later. The Administrator said she expected for the staff to explain what they were doing to the residents, and not just tell them they were going to do something. The Administrator said if the residents were spoken to loudly and told what to do this could make them feel like they were pressured to do things right then and there and like they were on a time schedule.</p> <p>Record review of an Inservice Attendance Record dated 04/17/2025, indicated the subject was Abuse/Neglect-Dealing with resident behaviors, the instructors were the Administrator and the DON, and for the name of attendee it indicated, by phone with CNA B prior to returning----verbalizes understanding. Summary of Meeting indicated reviewed abuse/neglect policy discussed ways to deal with dementia and other resident behaviors such as distraction, activities, offering snacks or getting a different caregiver.</p> <p>Record review of the facility's policy titled, Resident Rights, revised February 2021, indicated, Employees shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity .</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>46892</p> <p>Based on interview and record review, the facility failed to provide sufficient number of nursing staff on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans and the facility assessment for 1 of 1 facility reviewed for care and services.</p> <p>The facility failed to provide sufficient CNAs according to the facility assessment on 02/01/2025, 02/04/2025, 02/05/2025, 02/06/2025, 02/07/2025, 02/08/2025, 03/01/2025, 03/07/2025, 03/10/2025, 03/12/2025, 03/25/2025, 03/29/2025, 04/01/2025.</p> <p>This failure placed residents at risk of inadequate supervision, an unsafe environment, falls, serious harm and injury, exacerbations of disease processes, abuse, and death.</p> <p>Findings included:</p> <p>During an interview Anonymous Staff Member #1 said they had been working short staffed for a while, but it was getting better. Anonymous Staff Member #1 said there were multiple nights where there was one CNA for the whole building. Anonymous Staff Member #1 said they worked as a team to care for the residents. Anonymous Staff Member #1 said they provided care to the residents as they could that it might not be as timely as the residents required but the care was provided. Anonymous Staff Member #1 said the residents had to wait until they could get to them. Anonymous Staff Member #1 said not having enough staff placed the residents at risk of not receiving the care they needed. Anonymous Staff Member #1 said management was aware that they were short, and it was difficult to provide timely care to the residents.</p> <p>During an interview Anonymous Staff Member #2 said the facility was short staffed, and some of the residents required the use of a mechanical lift. Anonymous Staff Member #2 said at times they had used a mechanical lift without the assistance of another staff member because the nurses were not helping. Anonymous Staff Member #2 said they had made management aware of the difficulty completing tasks due to the staffing shortage and was told they were trying to get more help.</p> <p>During an interview Anonymous Staff Member #3 said there had been nights when they were the only CNA for the entire building. Anonymous Staff Member #3 said they were not able to round on the residents every 2 hours. Anonymous Staff Member #3 said nobody could provide the care the residents needed on their own. Anonymous Staff Member #3 said management was aware they were unable to complete all the resident care as the only CNA for the building. Anonymous Staff Member #3 said this placed the residents at risk for being neglected.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 05/08/2025 at 3:54 PM, the DON said staffing had been better that they were having a lot of people all in. The DON said to cover the shifts she had worked the floor, her previous ADON had work, and they had CNAs stay over. The DON said their goal was to have 3 CNAs on the 6 AM-2 PM shift, 3 CNAs on the 2 PM-10 PM shift, and 2 CNAs on the 10 PM-6 AM shift. The DON said she thought the facility assessment said something different. The DON said they had worked with 2 CNAs on the 6 AM-2 PM shift, 2 CNAs on the 2 PM-10 PM shift, and 1 CNA on the 10 PM-6 AM shift. The DON said she believed the 10 PM-6 AM shift could be covered with 1 CNA. The DON said there were 2 nurses during that shift, and the nurses could help the CNAs. The DON said when they first started having 1 CNA on the night shift one of the CNAs had reported to her, she did not know how she was going to do it, and then she did not hear anymore complaints after that. The DON said typically their census was 44-45 residents. The DON said if they did not have enough nursing staff they would be slower getting to the residents' needs.</p> <p>During an interview on 05/08/25 at 4:51 PM, the Administrator said the staff had not made her aware they were having difficulties providing care with 1 CNA on the 10 PM-6 AM shift. The Administrator said they had 2 nurses on the night shift, and they had a lot of independent residents. The Administrator said they started hiring agency staff to fill in for the staffing shortage. The Administrator said according to their facility assessment they could have 1-2 CNAs on the night shift. The Administrator said where the facility assessment indicated direct staff ratio 1:30 it was referring to the number of CNAs required, so if their census was more than 30, they required 2 CNAs on the night shift. The Administrator said she thought they ultimately were providing the care the residents needed because the CNA had the support of the nurses.</p> <p>Record review of the Facility Assessment with date of assessment or update 01/31/2025 indicated, Direct care staff, Plan 1: 30 ratio Nights. This indicated 1 CNA was necessary per 30 residents for the night shift (10 PM-6 AM).</p> <p>Record review of the Daily Census Report indicated:</p> <p>02/01/2025, the census was 47.</p> <p>02/04/2025, the census was 48.</p> <p>02/05/2025, the census was 48.</p> <p>02/06/2025, the census was 49.</p> <p>02/07/2025, the census was 49.</p> <p>02/08/2025, the census was 48.</p> <p>03/01/2025, the census was 45.</p> <p>03/07/2025, the census was 47.</p> <p>03/10/2025, the census was 48.</p> <p>03/12/2025, the census was 47.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>03/25/2025, the census was 47.</p> <p>03/29/2025, the census was 49.</p> <p>04/01/2025, the census was 49.</p> <p>Record review of the time sheets indicated only 1 CNA worked on the 10 PM-6 AM shift on the following dates:</p> <p>02/01/2025</p> <p>02/04/2025</p> <p>02/05/2025</p> <p>02/06/2025</p> <p>02/07/2025</p> <p>02/08/2025</p> <p>03/01/2025</p> <p>03/07/2025</p> <p>03/10/2025</p> <p>03/12/2025</p> <p>03/25/2025</p> <p>03/29/2025</p> <p>04/01/2025.</p> <p>Record review of the facility's policy titled, Staffing, revised September 2023, indicated, Our center provides sufficient nursing staff with the appropriate skills and competencies necessary to provide care and related services to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with resident care plans and the facility assessment.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>46892</p> <p>Based on observation, interview, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 1 of 2 medication carts (South Hall Nurse Medication Cart) reviewed for drugs and biologicals.</p> <p>The facility failed to ensure LVN C secured the South Hall Nurse Medication Cart, when it was not in use on 05/07/2025.</p> <p>This failure could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion.</p> <p>Findings included:</p> <p>During an observation on 05/07/2025 starting at 1:22 PM, there was an unlocked medication cart next to the nurse's station. The housekeeper was cleaning and moved the unlocked medication cart to the opposite side of the hallway. The nurse was not observed near the medication cart or in the hallway. The housekeeper said she thought the nurse, LVN C, was at break.</p> <p>During an interview on 05/07/2025 at 1:27 PM, LVN C said she was on break, and the medication cart was hers. LVN C said she guessed she got distracted and did not realize she did not lock it. LVN C said the nurse should ensure the medication cart was locked when not in use. LVN C said it was important for the medication cart to be locked because they had dementia patients, and someone could go and inject themselves or someone could take stuff. LVN C said that is was super dangerous for the medication cart to be left unlocked.</p> <p>During an interview on 05/08/2025 at 3:54 PM, the DON said the medication cart needed to be locked at all times when not in use. The DON said she conducted rounds daily to check to ensure the medication carts were locked. The DON said the nurses were responsible for ensuring the medication carts were locked. The DON said if the medication cart was left unlocked somebody could access the medications or treatments in it.</p> <p>During an interview on 05/08/2025 at 5:12 PM, the Administrator said she expected for the medication carts to be locked anytime the nurses were not in front of them. The Administrator said if the medication cart was left unlocked a resident could get into the medication cart.</p> <p>Record review of the facility's policy, titled, Security of Medication Cart, revised April 2007, indicated, 4. Medication carts must be securely locked at all times when out of the nurse's view.</p>		