

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Silsbee Oaks Health Care LLP		STREET ADDRESS, CITY, STATE, ZIP CODE 920 E Ave L Silsbee, TX 77656	
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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to transmit encoded, accurate, and complete MDS data to the CMS System within 14 days after a facility completes the resident's assessment for 3 of 3 residents reviewed for MDS transmission. (Resident #s #3, #87, and #98) The facility failed to complete and transmit a Discharge MDS assessment for Resident #3 within 14 days of completion. The facility failed to initiate and complete Discharge MDS assessments for Resident #s #87 and #98 within 14 days of discharge. These failures could place residents at risk of not having their assessment and care plan completed timely, which could result in denial of services and/or payment for services. Findings included: 1. Record review of Resident #3's face sheet indicated [AGE] year-old-male admitted to the facility on [DATE] with diagnoses including acute respiratory failure and morbid obesity. Record review of Resident #3's MDS assessments indicated a Discharge assessment -return not anticipated dated 08/30/2025 had been completed but not transmitted to CMS as of 01/28/2026. 2. Record review of Resident #87's face sheet indicated an [AGE] year-old-male admitted to the facility on [DATE] with diagnoses including Alzheimer's disease and diabetes mellitus. Record review of a Transfer/Discharge report indicated Resident #87 was discharged from the facility on 09/29/2025 to a private home with home health services. Record review of the MDS tracking tab in Resident #87's electronic medical record indicated a Discharge MDS was due with an ARD of 9/29/2025. Record review of an MDS tab in Resident #87's electronic medical record indicated there had been no MDS Discharge assessment completed as of 01/28/2026. 3. Record review of Resident # 98's face sheet indicated an [AGE] year-old-female admitted to facility on 09/06/2025 with diagnoses including osteoporosis with fracture to left femur and muscle weakness. Record review of a Transfer/Discharge report indicated Resident #98 was discharged from the facility on 11/05/2025 to a private home with no home health services. Record review of the MDS tracking tab in Resident #98's electronic medical record indicated a Discharge MDS was due with an ARD of 11/05/2025. Record review of an MDS tab in Resident #98's electronic medical record indicated there had been no MDS Discharge assessment completed as of 01/28/2026. During an interview on 01/28/2026 at 10:50 a.m., the DON said the MDS coordinator was responsible for completing and transmitting MDS assessments. She said the role of MDS coordinator had been changed a few times in the last year most likely contributing to the MDS assessments not being completed nor transmitted as required. She said going forward she would be responsible for monitoring and ensuring timely completion and submissions. She said by not being completed, this could hold up billing and potentially cause issues with the former residents receiving services elsewhere. The DON said the discharge MDSs should be completed and transmitted within 14 days of discharge date. During an interview on 01/28/2026 at 11:30 a.m., the Administrator said she expects all MDS assessments to be completed and transmitted to CMS in a timely manner per the RAI guidelines. She said this failure could delay payments to the facility and for the future services of the residents already discharged from facility. Record review of the Assessment Frequency/Timeliness policy dated 06/21/2023 indicated the following: . The purpose of this policy is to provide a system to complete standardized (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
--	-------	-----------

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Silsbee Oaks Health Care LLP		STREET ADDRESS, CITY, STATE, ZIP CODE 920 E Ave L Silsbee, TX 77656	
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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessments in a timely manner, according to the current RAI manual.6. An OBRA discharge assessment will be completed within 14 days of the discharge date .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Silsbee Oaks Health Care LLP		STREET ADDRESS, CITY, STATE, ZIP CODE 920 E Ave L Silsbee, TX 77656	
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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 kitchen reviewed for essential equipment. The facility did not ensure the gas stove was in safe operating condition. This failure could place the residents at risk of a fire and not receiving their meals in a timely manner. Findings included: During an observation and interview on 01/26/26 at 9:30 a.m., DM turned on the burners on the stove. 2 of 10 burners (front left first burner and the back third burner) did not light using their pilot lights. The stove did not have an odor of escaping gas. DM said sometimes the 2 burners were slow to light but had been lighting and she turned the 2 burners off. She said she would clean the stove today maybe something boiled over this morning during breakfast, and she would have maintenance check the stove. During an observation and interview 01/26/26 at 11:33 a.m., the 2 burners were not being used during the cooking of the lunch meal. There was no odor of escaping gas in the kitchen. The pilot lights were lit on all 10 burners. The stove was clean and free of spills. The DM said we are not using those 2 burners. During an observation and interview 01/27/26 at 11:30 a.m., the 2 burners were not being used during the cooking of the lunch meal. There was no odor of escaping gas in the kitchen. The pilot lights were lit on all 10 burners. The stove was clean and free of spills. The DM said we are not using those 2 burners. During an interview on 01/28/26 at 10:00 a.m., the maintenance supervisor said the pilot lights on the stove are required to be cleaned at times and said she would check the stove today. She said if pilot lights do not light the burners, the stove would not be working properly and could allow gas to escape. During an interview on 01/28/26 at 11:00 a.m., the Administrator said her expectation was for the stove to light with the pilot light. She said the DM should report to her immediately if equipment in dietary was not working properly. She said the facility did not have a policy about equipment however the stove should work properly. She said the two burners were not being used until repaired. She said she would have the stove service company come to the facility and service the stove today. During an interview on 01/28/26 at 11:45 a.m., the Administrator said the stove service company checked the stove and replaced 2 pilot lights and the stove burners all worked. During an observation on 01/28/26 at 12:30 p.m., the 10 burners on the stove were lighting promptly when the DM turned the burners on. Record review of the Sanitation Policy dated 07/18/2025 indicated Policy: It is the policy of this facility as part of the departments of program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations. 5. Inspections will be conducted but not limited to the following areas. i. stove .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Silsbee Oaks Health Care LLP		STREET ADDRESS, CITY, STATE, ZIP CODE 920 E Ave L Silsbee, TX 77656	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all residents had the right to formulate an advance directive for 2 of 12 residents (Resident #5 & #9) reviewed for advanced directives. The facility failed to ensure Resident #5 who was listed as DNR (Do Not Resuscitate) had valid Out-of-Hospital Do Not Resuscitate (OOH-DNR) form that was missing the doctor's medical identification number and did not have the POA's signature at the bottom of the document. The facility failed to ensure Resident #9 who was listed as DNR (Do Not Resuscitate) had valid Out-of-Hospital Do Not Resuscitate (OOH-DNR) form that was not missing required information and did not have Witness sign date or printed name. This failure could place residents at risk of not having their end-of-life wishes honored. Findings included: 1. Record Review of Resident # 5's face sheet, dated [DATE], indicated a [AGE] year-old female, originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included: multiply fractures of the pelvis (hip), osteoarthritis of the hip (deterioration of joints), and Alzheimer's disease (an umbrella term for a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking and behavior). Further review under the advance directive section the resident was listed as a DNR (Do Not Resuscitate). Record review of an admission MDS dated [DATE] indicated Resident #5 had adequate hearing, she had clear speech, she was always able to make herself understood, she was able to always understand others, and she had a BIMS of 10 indicating she was moderately impaired cognitively. Record Review of Resident #5's Care Plan dated [DATE], indicated: problem of MY CODE STATUS: DNR and an intervention of Obtain written DNR. Record Review of Resident #5's physician order dated [DATE] indicated: communication method Verbal, order status Active, description Do Not Resuscitate. Record Review of Resident #5's OOH-DNR dated [DATE] indicated: Under the Physician's Statement section, the physician's license number was blank. Under the All persons who have signed above must sign below, acknowledge that this document has been properly completed. The person's signature and POA's signature line was blank. During an observation and interview on [DATE] at 1:45 p.m. Resident # 5 was lying in her bed in her room. She said she was not on hospice and was a DNR and wanted to remain that way. Record review of Resident #9's face sheet, dated [DATE], indicated a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses that included: essential hypertension (high blood pressure), and unspecified dementia (an umbrella term for a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking and behavior). Further review under the advance directive section the resident was listed as a DNR (Do Not Resuscitate). Record review of an admission MDS dated [DATE] indicated Resident #9 had adequate hearing, she had clear speech, she was able to sometimes make herself understood, she was able to usually understand others, and she had a BIMS score of 3, indicating severe impaired cognitive skills for daily decision making. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Silsbee Oaks Health Care LLP		STREET ADDRESS, CITY, STATE, ZIP CODE 920 E Ave L Silsbee, TX 77656	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #9's Care Plan dated [DATE], indicated: problem of MY CODE STATUS: DNR and an intervention of Obtain written DNR. Record review of Resident #9's physician order dated [DATE] indicated: communication method prescriber written, order status Active, description Do Not Resuscitate. Record review of Resident #9's OOH-DNR record dated [DATE] indicated there was no date of when witness #1 signed and Witness #1 printed/typed name section was left blank. During an observation and interview on [DATE] at 1:30 p.m. Resident #9 was sitting in her wheelchair in her room. She said she was doing fine. She indicated she did not want anyone to do CPR on her. During an interview on [DATE] at 1:00 p.m., the SW said if a DNR form was not completed correctly with accurate dates and signatures, the DNR could be considered invalid. The SW said it was the social worker's responsibility to ensure the top portion of the DNR forms were completed accurately to include signatures and dates. The SW said she must have probably overlooked Resident #9 witness had not signed or dated the DNR, and for Resident #5 the physician's license number was blank and the POA's signature line was blank she said she must have not looked in detail like she should be. The SW said the nursing administration nurses are responsible for the bottom half of the DNR for completeness to include the doctor's information. The SW said she would check all the DNRs for proper completeness of signatures and dates. The SW said a resident's wishes may not have been followed if their advance directive was not completed. During an interview on [DATE] at 1:30 p.m. the DON said Advance Directives were reviewed by the admitting nurse and social worker to ensure accuracy. The DON said the SW fills out the top half of the DNR to include resident or POA signatures and witnesses' signatures. The DON said she or the ADON would make sure the bottom half of the DNR was complete to include the doctor's information. The DON said Advance Directives should be completed thoroughly to include dates that the document was witnessed sign and doctors' information. The DON verified there were no additional advance directives for Resident #9 or #5. The DON verified the current Advance Directives for Residents #9 and #5 were not completed. The DON said Resident #9's DNR #1 Witness did not have a date or signature, and Resident #5 the physician's license number was blank and the POA's signature line was blank. The DON said it was important for Advance Directives to be completed thoroughly to ensure the documents were legally binding. The DON said if an advance directive was not completed, the resident's wishes may not be honored. The DON said she would ensure the advance directives for Resident #9 and #5 was updated as soon as possible. During an interview on [DATE] at 2:00 p.m. the Administrator said if a DNR form was not completed correctly with accurate dates and signatures, the DNR would not be accepted. She said that in such a case, staff would be required to initiate CPR, which would go against the resident's expressed wishes. The Administrator said she believed it was the social worker's responsibility to ensure DNR forms top part was signed and complete and the nursing administration were responsible for making sure the doctor signed it and that the overall DNR was completed accurately and in accordance with requirements before it would be uploaded to the resident's medical record. Record review of a Do Not Resuscitate Order back page instructions read, .the OOH-DNR order Must be signed and dated by two competent adult witnesses .The form must be signed and dated by two witnesses except when executed by two physicians only.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Silsbee Oaks Health Care LLP		STREET ADDRESS, CITY, STATE, ZIP CODE 920 E Ave L Silsbee, TX 77656	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an environment that was free from accident hazards and provide assistive devices to each resident to prevent avoidable accidents. 1 of 6 residents (Resident #117), reviewed for accidents and hazards. The facility failed to ensure Resident #117 had fall mats in place bedside while she was in bed. These failures could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health. The findings included: Record review of Resident # 117's face sheet dated 01/28/2026 indicated an [AGE] year-old male admitted to the facility on [DATE]. Resident #117 had diagnoses of anxiety disorder (group of mental health conditions that cause fear, dread) and muscle weakness (refers to a reduced ability of one or more muscles to generate force). Record review of Resident #117's Quarterly MDS assessment dated [DATE] indicated she had a BIMS score of 9, which indicated moderate cognitive impairment. In section J1800- Any Falls Since Admission/Entry or Reentry or Prior Assessment indicated she had falls since admission. In Section V - Care Area Assessment (CAA) Summary indicated that falls were triggered, and a care planning decision was made. Record review of Resident #117's care plan dated 01/29/2026 indicated she had falls on 08/13/25, 11/21/25, 11/24/25, 12/30/25, 01/19/26. The care plan had fall mats on floor bedside listed as an intervention. During an observation on 01/27/2026 at 11:15 a.m. Resident #117 had no fall mats in place when she was in bed. During an interview on 01/27/2026 at 12:00 p.m., LVN G said she was not aware that Resident #117's fall mat was not bedside nor in the room. She said the fall mat was there earlier but had to be cleaned. She said she was responsible for ensuring Resident #117's fall mat was bedside. She said she did not follow up to ensure the fall mat was returned to Resident #117's bedside after cleaning. She said the purpose for the fall mat was to cushion her fall if she ever fell from bed. She said all staff that enter the room should be aware if her floor mat was in place at her bedside. During an interview on 01/27/2026 at 12:15 p.m., the DON said Resident #117's should have had her fall mat bedside. She said it was in there earlier that day. She said she did not know where it was at that time. She said it was her expectation that all staff would ensure her fall mats all bedside while in bed due to Resident #117 being a high risk for falls. She said staff should communicate to the charge nurse or herself when fall mats are not bedside. She said the associated potential risk would be the resident falling with nothing to break her fall. She said she would reeducate all staff on the process as not using fall mats on high fall risk residents could lead to an injury. During an interview on 01/27/2026 at 1:00 p.m., the Administrator said all residents that require fall mats should have them. She said it was her expectation for all staff walking into Resident #117's room to be observative and ensure the fall mat was bedside. She said the associated potential risk was falls. Record review of the facility policy and procedure titled, Fall Prevention Program, dated 10/17/2023, indicated in part, . Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines:3. The nurse will indicate on the resident's fall risk and initiate interventions on the resident's level of fall risk.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Silsbee Oaks Health Care LLP		STREET ADDRESS, CITY, STATE, ZIP CODE 920 E Ave L Silsbee, TX 77656	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 10 residents (Resident #90) reviewed for respiratory therapy. The facility failed to keep the oxygen concentrator filter clean for Resident #90. This failure could place residents at risk of receiving incorrect or inadequate oxygen support which could result in a decline in health. Findings include: Record review of Resident #90's face sheet dated 01/28/2026, indicated she was a [AGE] year-old female readmitted on [DATE] with a diagnosis of systolic and diastolic heart failure (condition in which the heart does not pump blood as well as it should). Record review of Resident #90's most recent admission MDS assessment dated [DATE] indicated she had a BIMS score of 10 which indicated moderately impaired cognition. The assessment indicated medical diagnoses of systolic and diastolic heart failure and no shortness of breath. The assessment did not indicate respiratory therapy during the lookback period. Record review of Resident #90's care plan with a target date of 05/13/2026 indicated she received oxygen therapy for ineffective gas exchange related to shortness of breath with interventions including provide oxygen as ordered. Record review of Resident #90's Physicians Order Summary dated 01/26/2026 indicated she was prescribed *oxygen at 2 liters per nasal canula (a thin flexible tube that delivers supplemental oxygen through your nose) every shift with a start date of 11/12/2026 and *Oxygen at 2 liters per nasal canula as needed for shortness of breath with a start date of 11/12/2025. *Oxygen concentrator filters cleaned every week on Sundays on the night shift with a start date of 11/16/2025. During an observation and interview on 01/26/2026 at 10:05 a.m., Resident #90 was lying in bed with oxygen per nasal canula set at 2 liters/minute to an oxygen concentrator with a black filter on the back soiled with a thick grayish/ white powdery substance. Resident #90 said the staff changed the oxygen tubing every Sunday but she was unsure if they cleaned the oxygen concentrator filter. During an observation and interview on 01/28/2026 at 8:00 a.m., Resident #90 was lying in bed with oxygen in use per nasal canula set at 2 liters/minute to an oxygen concentrator with a black filter on the back soiled with a thick grayish/ white powdery substance. Resident #90 said the staff change the oxygen tubing every Sunday, but she was unsure if they clean the oxygen concentrator filter. During an observation and interview on 01/28/2026 at 8:05 a.m., LVN D said she was providing care for Resident #90 this week Monday (01/26/2026) through today (01/28/2026). She said Resident #90's filter was soiled and she immediately cleaned it. She said the 10/6 shift nurses were responsible for cleaning the oxygen concentrator filters every Sunday night and the day and evening nurses were the back up to ensure all oxygen concentrator filters were cleaned. LVN D said Resident #90's oxygen concentrator filter was overlooked. She said the nurses were educated on cleaning oxygen concentrator filters. LVN D said the resident risk of a soiled oxygen concentrator filter was potential infection and decrease in delivery of oxygen through the oxygen concentrator. During an observation and interview on 01/28/2026 at 8:14 a.m., the SW said she was not sure who was responsible for ensuring oxygen concentrator filters were cleaned. She said she was a hall monitor for Resident #90's hall and did not notice Resident #90's oxygen concentrator filter was soiled. The SW said she was not in-serviced on cleaning oxygen concentrator filters, she was in-serviced to notify nursing if she found a soiled oxygen concentrator filters for them to clean it. The SW said the resident risk of a soiled oxygen concentrator filter was that the oxygen concentrator may not work properly. During an observation and interview on 01/28/2026 at 8:16 a.m., Activity Director E said the hall monitors were responsible for ensuring all oxygen concentrator's filters were cleaned weekly. She said she was the other hall monitor for Resident #90's hall. She said the nurses were the back up to ensure all oxygen concentrator filters were cleaned weekly and as needed. Activity Director E said she overlooked Resident #90's oxygen concentrator filter. She said (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Silsbee Oaks Health Care LLP		STREET ADDRESS, CITY, STATE, ZIP CODE 920 E Ave L Silsbee, TX 77656	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she normally checks the oxygen concentrator filters, but she did not this week. She said she was in-serviced on notifying nursing if she found a soiled oxygen concentrator filter for them to clean it. The Activity director said the resident risk of a soiled oxygen concentrator filter was it could potentially make the resident sick or the oxygen concentrator did not work as well as it should. During an observation and interview on 01/28/2026 at 8:35 a.m., The DON said the 10/6 shift nurses were responsible for ensuring all oxygen concentrator filters were cleaned weekly on Sunday nights and as needed. She said Resident #90's oxygen concentrator filter was overlooked. The DON said the nurses working the halls were the backup and responsible for ensuring all oxygen concentrator filters were cleaned weekly and as needed. She said the staff were educated on ensuring all oxygen concentrator filters were cleaned weekly and as needed. The DON said the resident risk of an oxygen concentrator with a soiled filter was the potential of low oxygen intake. She said her expectation was oxygen concentrator filters were cleaned on schedule and if staff see a soiled filter to clean it. During an observation and interview on 01/28/2026 at 11:18 a.m., LVN F said she was the nurse that worked Sunday night (01/25/2026) and was responsible for cleaning Resident #90's oxygen concentrator filter. She said she overlooked it. LVN F said the day nurses were the back up to double check and ensure all oxygen concentrator filters were cleaned. She said she was in-serviced recently on ensuring oxygen concentrator filters were cleaned weekly. LVN F said the resident risk of an oxygen concentrator with a soiled filter was that the resident may potentially get sick from it. During an interview on 01/28/2026 at 11:27 a.m., the Administrator said the hall monitors were responsible for ensuring oxygen concentrators filters were cleaned and the nurses working the hall were the back up to double check the oxygen concentrators to ensure the oxygen concentrator filters were clean. She said Resident #90's oxygen concentrator filter was overlooked. The Administrator said the staff were in-serviced on ensuring oxygen concentrator filters were cleaned. She said the resident risk of an oxygen concentrator with a soiled filter was that the oxygen concentrator may potentially not be as effective. The Administrator said her expectation was all oxygen concentrators filters be monitored and cleaned routinely. Record review of a facility in-service dated 11/01/2025, titled, Concentrators/ Oxygen indicated, .Every Sunday night: change all oxygen tubing and humidifiers and date; check filters and clean or change Q Sunday and as needed . OXYGEN: Air filters. The air filter should be cleaned at least once a week. To clean, follow these steps: 1/ Remove the air filter, located on the back of the unit. Remove the oxygen outlet connector (if used). 2. Wash in a solution of warm water and soap. 3. Rise thoroughly with warm tap water and towel dry. The filter should be completely dry before reinstalling. Record Review of a facility policy dated 06/28/2023, titled, Oxygen Administration indicated, .OXYGEN: Air filters. The air filter should be cleaned at least once a week. To clean, follow these steps: 1/ Remove the air filter, located on the back of the unit. Remove the oxygen outlet connector (if used). 2. Wash in a solution of warm water and soap. 3. Rise thoroughly with warm tap water and towel dry. The filter should be completely dry before reinstalling.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Silsbee Oaks Health Care LLP		STREET ADDRESS, CITY, STATE, ZIP CODE 920 E Ave L Silsbee, TX 77656	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 30 residents (Resident #10) observed for infection control. The facility failed to ensure CNA A and CNA B followed the EBP and infection control procedures for Resident #10 on 01/28/26. This failure could place the residents at risk of cross-contamination and the development of infection. Findings included: Record review of the admission record dated 01/28/26 indicated Resident #10 was [AGE] years old female admitted on [DATE] with diagnoses which included dementia and generalized muscle weakness. Record review of Resident #10's quarterly MDS assessment dated [DATE] indicated she required with assistance of 1-2 staff for incontinence care. The MDS indicated Resident #10 indicated she had memory problems with short term and long term. Resident #10 was always incontinent with Bladder and Bowels. Record review of Resident #10's care plan dated 12/05/25 indicated she had bladder incontinence. She had a history of UTI and was at risk for septicemia (a serious, life-threatening infection) with a goal of will be minimized/prevented via prompt recognition and treatment of symptoms of UTI through the review date. Resident #10's care plan indicated she required Enhanced Barrier Precautions related to gastric tube to minimize risk and exposure to infectious disease. Record review of Resident #10's physicians indicated EBP (enhanced barrier precautions) was initiated on 08/20/2025 related to her gastric tube and EBP was initiated on 12/11/2025 for her wound. During an observation on 01/28/26 at 9:20 a.m. CNA A and CNA B provided incontinent care for Resident #10. CNA A used wipes after wiping her front peri area and used more wipes on her coccyx area. CNA A removed her gloves and did not use hand sanitizer or wash her hands prior to putting on a clean pair of gloves. The CNAs completed care and CNA B walked down the hall and put the package of the wipes in the supply closet of wipes into the closet. During an interview on 01/28/26 at 9:45 a.m., CNA A said she should have washed her hands before she applied clean gloves. CNA A said we are to wash our hands to prevent spread of germs. CNA B said she should have placed the package of the wipes into Resident #10's drawer or night side table. The supplies that we bring in the room can only be used by that resident to prevent spread of germs. During an interview on 01/28/26 at 10:24 a.m., LVN C said hands were to be washed or sanitized after removing gloves and the wipes should have been left in the residents' night side table. He said washing hands and not sharing supplies can prevent the spread of germs. During an interview on 01/28/26 at 10:45 a.m., the DON said hands are to be sanitized before and after glove use. She said supplies should not be brought out of the room and used on other residents. Record review of Hand Hygiene policy dated 03/23/2021 indicated Policy: All staff will perform proper hand hygiene procedure to prevent the spread of infection to other personnel, residents, and visitors. 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.		