| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455626 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oakmont Guest Care Center | 2712 N Hurstview<br>Hurst, TX 76054 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791<br><br>Based on observation, interview and record review, the facility failed to maintain an infection control program for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for 1 of 5 residents (Resident #1) reviewed for infection control.<br><br>Housekeeper A picked popcorn off the floor and placed it back into Resident #1's bag and was subsequently eaten by Resident #1.<br><br>This failure could place residents at risk of exposure to pathogens from the floor.<br><br>The noncompliance was identified as PNC. The noncompliance began on 03/20/24 and ended on 03/21/24. The facility corrected the noncompliance before the survey began.<br><br>Findings included:<br><br>Review of Resident #1's undated Admission Record revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included pelvic fracture, history of falls, and dementia.<br><br>Review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS score of 10 indicating mild cognitive impairment.<br><br>Review of Resident #1's care plan, dated 05/13/24, revealed he had impaired cognitive function related to dementia, he suffered from depression related to being in the nursing home, and he is on anti-anxiety medications.<br><br>Interview on 06/06/24 at 9:10 AM with Resident #1 revealed he had no recall of the event. Resident #1 stated he liked popcorn, and his family brought him popcorn as a snack.<br><br>Interview on 06/06/24 at 11:00 AM with Resident #1's family member revealed the family reviewed video footage of Resident #1's room from 03/20/24. The video footage showed a female staff member, they assumed a housekeeper, cleaning the resident's room. The video also showed this staff member [Housekeeper A] picked some popcorn off the floor and placed it in the resident's bag of popcorn sitting at his bedside. The family member stated Resident #1 returned to his room later and continued to eat his popcorn, consuming the entire bag. The family notified the Administrator on 03/21/24 and supplied the video footage.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455626 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oakmont Guest Care Center | 2712 N Hurstview<br>Hurst, TX 76054 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 06/06/24 at 12:00 PM with Housekeeper B revealed she had been helping Housekeeper A with Resident #1s room. She stated she had seen Housekeeper A pick popcorn off the floor and place it in a bag of popcorn on the resident's bedside table. Housekeeper B stated she thought Housekeeper A was going to throw the whole bag away, and she did not know she had not until she spoke with the Administrator the next day.<br><br>Interview was attempted on 06/06/24 at 12:45 PM with Housekeeper A via telephone; however, the attempt was not successful and Housekeeper A did not return the call.<br><br>Interview on 06/06/24 at 3:30 PM with the Administrator revealed the family of Resident #1 contacted him via telephone about the incident. When he reviewed the video footage, he stated it was very clear what Housekeeper A had done. He stated Housekeeper A was called to his office to discuss the incident and was then terminated.<br><br>Review of the facility's policy Resident Rights, dated February 2021, revealed:<br><br>Employees shall treat all residents with kindness, respect, and dignity. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455626 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oakmont Guest Care Center | 2712 N Hurstview<br>Hurst, TX 76054 |

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 0914<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide bedrooms that don't allow residents to see each other when privacy is needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791<br><br>Based on observation, interview and record review, the facility failed to ensure resident rooms were equipped with privacy curtains the assured full visual privacy for 11 of 53 rooms (Rooms 201, 202, 205, 207, 211, 302, 305, 306, 307, 406, and 409) reviewed for visual privacy.<br><br>1. LVN C and CNA D failed to ensure Resident #2 had full visual privacy while providing care.<br><br>2. The facility failed to ensure the residents in the A beds in Rooms 201, 202, 205, 207, 211, 302, 305, 306, 307, 406, and 409 had privacy curtains to assure full visual privacy.<br><br>This failure could place residents at risk of being exposed to the hallway during cares.<br><br>Findings included:<br><br>Review of Resident #2's undated Admission Record revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (brain chemical imbalance), muscle weakness, and reduced mobility.<br><br>Review of Resident #2's quarterly MDS, dated [DATE]. revealed a BIMS score of 3 indicating severe cognitive impairment. Her Functional Status indicated she required total assistance with all of her ADLs.<br><br>Review of Resident #2's care plan, dated 02/20/24, revealed she had a self-care deficit requiring assistance with her ADLs, impaired cognitive function and impaired thought processes, and was a high fall risk.<br><br>Observation on 06/06/24 at 1:40 PM revealed LVN C and CNA D were assisting Resident #2 back to bed from her wheelchair, using the lift device. LVN C closed the resident's door, blocking the view from the hallway. After the resident was in bed, during her skin assessment, the door to the hallway popped open slightly. There was not a privacy curtain around Resident #2's bed.<br><br>Interview on 06/06/24 at 1:50 PM LVN C stated privacy for residents in A bed was created by closing the door and pulling the curtain between the beds. LVN C agreed the door was not secured to prevent someone from walking in during care when the resident was exposed. LVN C stated they yelled Cares! when someone knocked on the door or walked in, but that would not stop another resident from coming in. LVN C stated being exposed during care could lead to decreased feelings of self-worth by the resident.<br><br>Observation on 06/06/24 from 1:55 PM-2:20 PM of Halls 100, 200, 300, and 400 revealed 11 (Rooms 201, 202, 205, 207, 211, 302, 305, 306, 307, 406, and 409) of 53 rooms had no privacy curtain for residents of the A bed. Residents of the B bed only had a curtain between the beds, no curtain across the end of the bed.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455626 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oakmont Guest Care Center | 2712 N Hurstview<br>Hurst, TX 76054 |

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 0914<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 06/06/24 at 3:15 PM with the DON revealed residents needed privacy when they were receiving care. She was not aware the rooms did not have the appropriate privacy curtains installed. She stated it was a dignity issue for the residents.<br><br>Interview on 06/06/24 at 3:30 PM with the Administrator revealed he was not aware there were not appropriate curtains for the resident's privacy. He stated it was a dignity issue of someone walked in on a resident receiving care.<br><br>Interview on 06/06/24 at 4:00 PM with the Administrator revealed the facility did not have a policy addressing privacy curtains specifically. |