STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455626	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Guest Care Center	2712 N Hurstview 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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on interview and record review, the facility failed to notify the resident or the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for one (Resident #1) of three residents reviewed for discharge notices. The facility failed to notify Resident #1 or her representative in writing of her transfer/discharge to the hospital for behavioral reasons, the reason for the transfer, and the right to appeal and they failed to send a copy of the notice to the ombudsman as soon as practicable of the transfer/discharge. This failure could place residents at risk of being transferred or discharged , and not having access to available advocacy services, discharge/transfer options, and appeal processes. Findings included: Record review of Resident #1's face sheet, dated 09/04/24, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and discharged [DATE] to an acute care hospital. Record review of Resident #1's 5-day scheduled MDS assessment, dated 03/26/24, reflected a BIMS score of 12, which indicated moderate cognition impairment. Her diagnosis included encephalopathy (brain dysfunction), legal blindness, acute respiratory failure, and schizophrenia. Record review of Resident #1's Nurses Notes, dated 03/28/24, reflected the following: [Resident #1] was discharged today to the VA Hospital due to her increasing and escalating mental health concerns that were preventing her from fully participating in her rehab here at this facility. VA LCSW confirmed she spoke with the VA physician as well as the VA ER LSW and sent notes stating [Resident #1] had been discharged from the VA CCN Contract program effective today due to her needs not being able to be safely met at this facility. Facility Administrator phoned and notified [Resident #1] guardian, [Guardian Name]. [Guardian Name] stated she and the family would be at this facility at some point this weekend to pick up [Resident #1] personal belongings. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's clinical record reflected there was no documentation of the resident, the resident's responsible party, or the Ombudsman being notified in writing of the resident's discharge or the reason for the resident's discharge. Interview on 09/04/24 at 10:01 AM with Resident #1's POA revealed she had received a phone call on 03/28/24 at around 11 AM stating Resident #1 was going to be transferred to the VA ER to get a mental health evaluation and medication adjustment. Resident #1's POA stated the same day 03/28/24 at around 3 PM she received a call from the Administrator, and he stated the resident was going to be discharged from the facility. Resident #1's POA stated she did not receive any paperwork or discharge information. Interview on 09/04/24 at 4:11 PM with the Ombudsman revealed she was not notified of Resident #1's discharge. Interview on 09/04/24 at 4:32 PM with the Administrator revealed Resident #1 was transferred to the hospital for a mental health assessment and stabilization. He stated Resident #1 was being combative, verbally aggressive, and refusing care. He stated by Resident #1 agreeing to go to the hospital Resident #1 initiated the transfer. The Administrator stated the VA ended Resident #1's contract on 03/28/24 and the resident was discharged . He stated the family was made aware verbally. He stated nothing in writing had been sent with the resident or family explaining the reason for her discharge. The Administrator stated he was not aware the Ombudsman had to be contacted for any discharges other when a resident was issued a 30-day discharge notice. Review of the facility's current Transfer and Discharge, facility - Initiated policy, revised October 2022, reflected the following: Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy. Notice of Transfer or Discharge (Emergent or Therapeutic Leave) 1. When residents who are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfer, NOT discharges, because the resident's return is generally expected. 2. Residents who are sent emergently to an acute care setting, such as hospital, are permitted to return to the facility. Residents who are sent to the acute care setting for routine treatment/planned procedures are also allowed to return to the facility . 3. Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable. 4. Notice of facility bed-hold and return policies are provided to the resident and representative within 24 hours of emergency transfer. 5. Notices are provided in a form and manner that the resident can understand, taking into account the resident educational level, language, communication barriers, and physical or mental impairments.