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	11/21/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 of 5 residents (Resident #1) reviewed for care plans. The facility failed to ensure Resident #1's care plan addressed activities of daily living. This failure could place residents at risk of not receiving the care required to meet their individual needs. Findings included: Record review of Resident #1's Face Sheet, dated 11/21/24, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #1's quarterly MDS assessment, dated 10/30/24, reflected her diagnoses included cirrhosis (severe scarring) of liver, hypertension, pain, muscle weakness, and need for assistance with personal care. Resident #1 had a BIMS score of 07, which indicated severe cognitive impairment. The MDS further revealed Section GG - Functional Abilities indicated resident was totally dependent on staff to assist with getting personal hygiene and getting dressed. Record review of Resident #1's care plan, revised 11/18/24, reflected: Focus: [Resident #1] has a terminal prognosis r/t alcoholic cirrhosis of the liver. She has chosen [Hospice Name] hospice for her end-of-life care provider. Goal: [Resident #1] comfort will be maintained through the review date. Interventions/Tasks: Adjust provision of ADLs to compensate for resident's changing abilities. The care plan did not address Resident #1's ADL care. (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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/21/24 at 9:39 AM with Resident #1 revealed she had some concerns regarding her toenails. Resident #1 stated her toenails were long, and they were bothering her. She stated she was on hospice but was discharged about two days ago. She stated hospice would assist with showers and getting her ready, but now that she was no longer on hospice the facility staff would assist. She stated she had asked several staff to cut her toenails, but staff would not do it. She stated she was told by staff the the Podiatrist would need to cut her toenails. She stated she the Social Worker informed her the Podiatrist would see her on 10/09/24, but she was never seen by the Podiatrist. Interview on 11/21/24 at 11:49 AM with RN A revealed the MDS Coordinators and DON were responsible for updating care plans. He stated ADLs should be care planned because it was part of a resident's daily care. RN A stated he was unable to see the residents' care plans. Interview on 11/21/24 at 11:51 AM with the MDS Coordinator revealed the MDS Coordinators were responsible for creating and updating care plans. She stated ADLs should be care planned for residents. The MDS Coordinator stated Resident #1's care plan was on her to-do list to be revised. The MDS Coordinator reviewed Resident #1's care plan and stated ADLs were not care planned, but they should be. She stated it was missed. She stated there was no potential risk to Resident #1 for the lack of ADL care planning since the resident was now more independent in performing her ADLs. Interview on 11/21/24 at 2:19 PM with the DON revealed the MDS Coordinators were responsible for creating care plans, and nursing staff could update care plans. She stated ADLs should be part of the comprehensive care plan. The DON reviewed Resident #1's care plan and stated ADLs were not care planned for the resident. Record review of the facility Care Plans - Baseline policy, revised March 2022, reflected the following: .The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident .C. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, and record review, the facility failed to ensure residents received proper treatment and care to maintain good foot health by providing foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition for 1 of 5 residents (Resident #1) reviewed for foot care. The facility failed ensure foot care, specifically trimming of toenails, was provided for Residents #1. This failure could result in residents developing fungal infections or other podiatric problems. Findings included: Record review of Resident #1's Face Sheet, dated 11/21/24, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #1's quarterly MDS assessment, dated 10/30/24, reflected her diagnoses included cirrhosis (severe scarring) of liver, hypertension, pain, muscle weakness, and need for assistance with personal care. Resident #1 had a BIMS score of 07, which indicated severe cognitive impairment. The MDS further revealed Section GG - Functional Abilities indicated resident was totally dependent on staff to assist with getting personal hygiene and getting dressed. Record review of Resident #1's care plan, revised 11/18/24, reflected: Focus: [Resident #1] has a terminal prognosis r/t alcoholic cirrhosis of the liver. She has chosen [Hospice Name] hospice for her end-of-life care provider. Goal: [Resident #1] comfort will be maintained through the review date. Interventions/Tasks: Adjust provision of ADLs to compensate for resident's changing abilities. The care plan did not address Resident #1's ADL care or nail care. Record review of the facility's podiatry visits for 10/09/24 and 11/05/24 reflected Resident #1 had not been seen by the Podiatrist. Resident #1 was also not scheduled to see the Podiatrist on 12/09/24. Interview on 11/21/24 at 9:39 AM with Resident #1 revealed she had some concerns regarding her toenails. Resident #1 stated her toenails were long and they were bothering her. She stated the second and third toe from her right foot bother her the most. She stated since being admitted she had never seen a Podiatrist, and her toenails had not been cut but staff. She stated she had attempted to cut her own toenails a few weeks ago, but she was not able to cut them. She stated she had asked several staff to cut her toenails, but staff would not do it. She stated she was told by staff the Podiatrist would need to cut her toenails. She stated the Social Worker informed her the Podiatrist would see her on 10/09/24, but she was never seen by the Podiatrist. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 11/21/24 at 11:34 AM with RN A revealed the second and third toenails on Resident #1's right foot were long and curving in. RN A stated Resident #1's toenails were overgrown and needed to be cut. Resident #1 stated her toenails bothered her. RN A stated he would notify the Social Worker and request that she put in a Podiatry referral for Resident #1. RN A stated he was able to cut Resident #1 toenails, but the second toenail might need to be cut by the Podiatrist. RN A stated if residents were not diabetic, the nurses or CNAs would be able to cut them; otherwise, the Podiatrist would have to cut their toenails. RN A stated he could not recall if the resident had been seen by the Podiatrist or when her toenails were last cut. He stated he was not aware Resident #1 toenails needed to be cut. He stated the resident was able to make her needs known, and she never mentioned it to him. RN A stated neither facility staff nor the hospice aide had mentioned anything about cutting Resident #1's toenails. He stated the potential risk of not cutting the resident's toenails was that it could lead to ingrown toenail or the toenail cutting into the skin. Interview on 11/21/24 at 11:43 AM with CNA B revealed she was the CNA assigned to Resident #1. She stated Resident #1 was a hospice patient, and the hospice aide would come daily to give the resident a shower and get the resident ready for the day. She stated at times she would assist the resident with putting her socks on. She stated she had seen Resident #1's toenails and they were long; however, Resident #1 had not mentioned anything to her about wanting them cut. She stated she had not asked if she wanted her toenails cut. CNA B stated the nurses or the Podiatrist were responsible for cutting residents' toenails. She stated the risk of not trimming residents' toenails was that it could lead to discomfort or the toenails cutting into the skin. Interview on 11/21/24 at 12:16 PM with the Social Worker revealed she was responsible for completing referrals, and today (11/21/24) she sent a referral for podiatry for Resident #1. She stated prior to today Resident #1 had not been referred to the Podiatrist nor had she been seen by Podiatrist. She stated no one had mentioned to her that Resident #1 needed to be seen by the Podiatrist. She stated Resident #1 had not mentioned anything to her about wanting to see a Podiatrist. She stated the Podiatrist last visited the facility on 10/09/24 and 11/05/24, and the next visit would be 12/09/24. Interview on 11/21/24 at 1:20 PM with the ADON revealed podiatry was responsible for cutting residents' toenails. She stated if a resident needs a podiatry referral, the staff would notify the Social Worker, who would then send a referral. She stated she was unsure if Resident #1 had ever been seen by the Podiatrist. She stated Resident #1 had not mentioned anything regarding her toenails and had not asked to be seen by the Podiatrist. Interview on 11/21/24 at 2:19 PM with the DON revealed all the residents' toenails were cut by the Podiatrist. She stated during morning meetings they verbally talked about referrals that were needed. She stated no one had mentioned to her that Resident #1 needed to be seen by the Podiatrist. She stated Resident #1 was able to make needs known, and she had not mentioned anything regarding her toenails. She stated the potential risk of not keeping toenails trimmed was that it could lead to pain or skin issues. Interview on 11/21/24 at 2:33 PM with the Administrator revealed not all residents were seen by the Podiatrist. He stated if podiatry was needed, the Social Worker would send a referral. He stated residents' needs were communicated during clinical meetings and by report. He stated Resident #1 had not mentioned her toenails to anyone nor had she requested needing podiatry. He stated Resident #1 was capable of making her needs known and had a daily opportunity to report to staff that she needed podiatry care. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Foot Care policy, revised October 2022, reflected the following: Residents receive appropriate care and treatment in order to maintain mobility and foot health. -Residents are provided with foot care and treatment in accordance with professional standards of practice. -Trained staff may provide routine foot care (e.g., toenail clipping) within professional standards of practice for resident without complicating disease processes.