

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455626	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/31/2025
NAME OF PROVIDER OR SUPPLIER  Oakmont Guest Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</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 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice for 1 resident (Residents #1) of 7 residents reviewed for respiratory care. -The facility failed to ensure that Residents #1, who required continuous oxygen therapy, received adequate oxygen when his portable oxygen tank ran out of oxygen while the resident was in the community at an appointment on 10/29/2025. Resident #1 was transported to the local hospital and diagnosed with acute hypoxia (low levels of oxygen) The non-compliance was identified as past non-compliance (PNC). The Immediate Jeopardy began on 10/29/25 and ended on 10/30/25. The facility had corrected the non-compliance before the state's investigation began. This failure could place residents who receive oxygen therapy at risk of receiving inadequate oxygen support, which could result in serious harm or death. Findings included: Record review of Resident #1's face sheet, dated 10/31/25, reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Chronic Obstructive Pulmonary Disease (lung disease) and acute and chronic respiratory failure. Record review of Resident 1's Nursing Home PPS MDS assessment, dated 09/12/25, reflected his BIMS score was 11, which indicated moderate cognitive impairment. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #1 required supervision to moderate assistance with most ADLs. The MDS Assessment under Section I-Active Diagnoses reflected Resident #1 had a primary medical condition of cardiorespiratory with other comorbidities that included chronic lung disease, asthma, and respiratory failure. Further review of this document, under Section O-Special Treatments, Procedures, and Programs, reflected Resident #1 received continuous oxygen therapy. Record review of Resident 1's care plan, revised 09/08/25, reflected the resident had altered respiratory status/difficulty and was on continuous oxygen therapy r/t acute and chronic respiratory failure with hypoxia. Interventions included: administering medication as orders, monitoring for effectiveness and s/sx of respiratory distress and reporting to the MD. Record review of Resident #1's consolidated physician orders, dated 10/31/25, reflected in part the following: -Oxygen at 2-4 lpm via nasal cannula continuous for COPD -start date: 10/31/25-Continuous BIPAP at night at bedtime-start date: 09/09/25 Record review of Resident #1's progress notes, dated 10/29/25 at 1:45 PM by ADON A, reflected the following: [Resident #1] on the way from dental appointment. [CNA D] report [Resident #1] is having SOB in transport although resident is on oxygen tank via nasal canula. [MD] informed HGB was 6.4 and [Resident #1] is now having SOB. Order given to send to [local hospital]. Transport pulled over van and 911 called. Record review of Resident #1's hospital records, dated 10/29/25, reflected in part the following: Chief Complaint: hypoxic- pt on O2 at baseline, was being transported to doctor's appointment by [transportation service] and ran out of O2, leading to hypoxia w/ Spo2 50% on EMS arrival. EMS implemented CPAP PTA and sats came up 100%. History of present illness:[Resident #1] is a 74 y.o. male with past medical history of chronic respiratory failure secondary to COPD and chronic diastolic CHF was transported from his long-term facility to a dental appointment where apparently he had longer than usual stay and his tank ran out of oxygen. EMS called and patient was noted to be hypoxic. The patient was then brought to the hospital for further evaluation. Upon arrival, the patient noted to be in acute on chronic respiratory failure with hypoxia and hypercapnia (high levels of carbon dioxide). In the ED, chest x-ray showed peripheral infiltrate (fluid/substance in lungs) over the right lower lobe. The patient was having difficulty breathing but was on BiPAP when interviewed. The patient denied any chest pain. Does complain of some shortness of breath. Denies any nausea vomiting or abdominal pain. No headache or blurry vision. In an interview on 10/31/25 at 10:43 AM, ADON A stated she worked at the facility for about 1 and 1/2 years. She stated Resident #1 had a dental appointment at the VA and he left the facility around 8:00 AM with a full portable oxygen tank. ADON A stated Resident #1 was escorted to his appointment by CNA D, and the appointment was expected to last about 30 mins because Resident #1 was only picking up new dentures. However, ADON A stated the appointment lasted longer than expected. She stated a full portable oxygen tank could last 3-4 hours, but Resident #1 was away from the facility for approximately 5 hours. ADON A stated around 1:00 AM, CNA D notified her that Resident #1 was complaining of shortness of breath. ADON A stated she advised them to pull the van over and call 911, and Resident #1 was transported to the local hospital. ADON A stated she had never experienced a resident running out of oxygen while away from the facility because the nurses always ensured they had full portable</p>		