

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455703	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2024
NAME OF PROVIDER OR SUPPLIER Oakmont Healthcare and Rehabilitation Center of Ka		STREET ADDRESS, CITY, STATE, ZIP CODE 1525 Tull Dr Katy, TX 77449	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822</p> <p>Based on observations, interviews, and record review the facility failed to provide pharmaceutical services to meet the needs of each resident for 1 of 7 residents (Resident #1) reviewed for medication administration.</p> <p>-The NF DON failed to transcribe physician orders received from hospice on 10/08/2024 until 10/10/2024.</p> <p>-LVN A failed to follow-up to see if there was an order for the medication, morphine 15mg, delivered to the NF on 10/08/24 for Resident #1. Resident #1 did not receive the morphine that was available to him at the facility on 10/8/24 until 10/10/24.</p> <p>This failure placed Resident #1 at risk for unwanted pain, discomfort, and decrease in quality of life.</p> <p>Findings:</p> <p>Record review of Resident #1's face sheet revealed a [AGE] year old male admitted to the NF originally on 07/25/2023 with diagnoses that included the following: dementia (loss of memory), history of falling, muscle weakness, heart disease, type 2 diabetes mellitus (body has trouble controlling blood sugar and using it for energy), hyperlipidemia (high cholesterol), and chronic kidney disease stage 3 (kidneys are moderately damaged and unable to remove waste and fluids from the blood as normal).</p> <p>Record review of Resident #1's MDS dated [DATE] reflected a BIMS score of 15 indicating that resident cognition was intact.</p> <p>Record review of Resident #1's Nursing Progress Notes dated 09/24/2024 indicated that the resident had incurred a fall and was transferred to the hospital for further evaluations. Further review revealed that the resident was transferred back to the NF on 10/01/2024 on hospice services.</p> <p>Record review of Resident #1's Physician Hospice orders reflected the following orders dated 10/08/2024:</p> <p>-Discontinue 1 mg lorazepam every 6 hours</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455703	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2024
NAME OF PROVIDER OR SUPPLIER Oakmont Healthcare and Rehabilitation Center of Ka		STREET ADDRESS, CITY, STATE, ZIP CODE 1525 Tull Dr Katy, TX 77449	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-New med order: 15mg morphine ER every 12 hours po</p> <p>-Continue 1mg lorazepam every 4 hours PRN agitation/anxiety</p> <p>-discontinue morphine concentrate 0.5ml/10mg every 6 hours</p> <p>-Continue 5mg/0.25ml morphine concentrate every 2 hours PRN for breakthrough pain</p> <p>Record review of Resident #1's Comprehensive Care plan revised 04/03/2024 reflected that the resident was being care planned for uncontrolled pain with an intervention that included to administer medications as ordered.</p> <p>Record review of the NF narcotic count sheet for Morphine 15mg ER revealed that Resident #1 began to receive this medication on 10/10/24.</p> <p>Record review of Resident #1's MAR/TAR for the month of October 2024 reflected that the facility had not transcribed orders for 10/08/2024 until 10/10/2024.</p> <p>Record review on 10/11/2024 at 10:06AM of an email sent to the state surveyor from the hospice nurse, of an email sent to the NF DON 10/08/2024 at 12:06PM regarding new hospice orders, dated 10/08/2024 regarding Resident #1's as reflected above (15mg morphine ER every 12 hours po, Continue 1mg lorazepam every 4 hours PRN agitation/anxiety, discontinue morphine concentrate 0.5ml/10mg every 6 hours, and continue 5mg/0.25ml morphine concentrate every 2 hours PRN for breakthrough pain) with the hospice nurse asking the NF DON to let the hospice nurse know if she had any further questions with a contact number provided.</p> <p>Interview on 10/10/24 at 1:12PM with the hospice nurse via phone said she came to the NF on 10/10/2024 around 10:00AM to see Resident #1. The Hospice nurse said there had been some concerns regarding the resident not receiving his comfort medications (lorazepam and Morphine extended release) as ordered, particularly morphine 15 mg ER by mouth every 12 hours. The Hospice nurse said the doctor had ordered for Resident #1 to receive lorazepam 1mg every 6 hours as well as PRN. The hospice nurse said the doctor ordered morphine 15mg extended release every 12 hours on the 8th of October 2024. The hospice nurse said she emailed the orders to the DON on the 8th of October. The hospice nurse said she had learned on 10/09/24 around 10:00PM that the resident was not receiving, particularly his comfort medication (morphine), as ordered by the doctor. The Hospice nurse said she contacted the DON the next day on 10/10/24 around 8:00AM via text to question why the resident was not receiving his morphine as ordered. The hospice nurse said the DON responded that she never received the doctor order via email on 10/08/2024 from hospice regarding Resident #1. The hospice nurse said she confirmed the email with the DON that she had and resent Resident #1's the physician orders to the DON.</p> <p>Observation on 10/10/24 at 3:45PM of Resident #1 being awake resting quietly in bed. Resident denied of being in pain or discomfort.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455703	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2024
NAME OF PROVIDER OR SUPPLIER Oakmont Healthcare and Rehabilitation Center of Ka		STREET ADDRESS, CITY, STATE, ZIP CODE 1525 Tull Dr Katy, TX 77449	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/10/24 at 3:49PM with the DON regarding Resident #1, she said the hospice service had been changing the resident's medications, morphine and Ativan a lot. After the DON reviewed the hospice orders dated 10/08/2024, the DON said the hospice nurse must have written the wrong date. The DON then called Resident #1's physician, in the presence of the state surveyor, asking if that the doctor would give her an order date of 10/10/2024 regarding resident morphine and Ativan so that the facility would be in compliance. The DON told the physician that the hospice nurse had made a mistake regarding the date of the order.</p> <p>An observation on 10/11/24 at 8:30AM of a medication cart with LVN A being present was made. On the medication cart was the medication morphine 15mg ER tablets every 12-hours orally filled on 10/08/24 and delivered to the facility on [DATE].</p> <p>In an interview on 10/11/2024 at 8:30AM with LVN A, said she was not aware of a resident being on morphine 15mg ER every 12 hours and thought he was receiving 0.25ml orally.</p> <p>Observation on 10/11/24 at 8:35AM Resident #1 resting in bed awake being fed by a staff member. Resident #1 did not appear to be in pain.</p> <p>Interview on 10/11/2024 at 8:35AM with Resident #1 said he was not in any pain at the present time.</p> <p>Interview on 10/11/14 at 9:16AM with the DON regarding Resident #1's, morphine 15mg ER every 12hours orally, said if the NF excepted the medication and did not see an order, the staff should have been following up with the hospice services. The DON said it was the ADON that checked the narcotic book to ensure the narcotic sheets were being signed. The DON said it was the nurses on the units that should be checking the orders daily. The DON said whenever medication was delivered to the NF, the nurse should be checking the order for that medication. The DON said she was not aware of the order dated 10/08/24 for morphine 15mg ER every 12 hours for regarding Resident #1 until 10/10/24 when she spoke with the hospice nurse. The DON said the hospice nurse told her that she would bring a copy of the order to the facility. The DON said the hospice nurse never emailed her an order on 10/08/24 regarding Resident #1's new hospice orders .</p> <p>In an interview on 10/11/24 at 10:20AM with the Corporate Nurse said if the facility received medication and they could not locate the order, the staff should follow up with the doctor for clarification. The Corporate nurse said after the DON received the order via email on 10/08/24 she should have printed the order out and transcribed it on the MAR/TAR. The Corporate Nurse said the nursing staff should be checking in PCC (Point Click Care) for any new physician orders each shift. The Corporate nurse said when a resident admits to the NF the charge nurse does a medication reconciliation with the doctor. The Corporate nurse said Resident #1 admitted back to the facility on [DATE] on hospice services and normally the hospice nurse admits the resident and write the orders to give to the charge nurse to carry out.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455703	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2024
NAME OF PROVIDER OR SUPPLIER Oakmont Healthcare and Rehabilitation Center of Ka		STREET ADDRESS, CITY, STATE, ZIP CODE 1525 Tull Dr Katy, TX 77449	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/11/24 at 10:24AM with LVN A said she received the medication morphine 15mg ER tablet to be given every 12 hours by mouth on 10/08/24 but did not check the orders. LVN A said she just counted the medication with the pharmacy, and made sure she placed the medication on the medication cart and placed the paper count in the narcotic control binder. LVN A said the hospice nurse had told her prior to the medication (morphine 15mg ER) was delivered to the facility on [DATE] that some changes had been made to the resident's medications. LVN A said she did not enquire with the hospice nurse what changes had been made. LVN A said she did not know she was supposed to look at the orders when medications were delivered to the facility. LVN A said for resident's admitted to the NF not on hospice services, the nurse would contact the NP or physician to verify orders. LVN A said it was the nurse responsibility to check for any new orders .</p> <p>Record review of the NF in-services revealed that an in-service had been done by the corporate nurse one on one with LVN A on what to do when a medication [NAME] delivered to the facility and no order [NAME] noted to call hospice or the physician for clarification and to enter a progress note. Further in-services dated 10/11/2024 done by the corporate nurse with the DON regarding medication orders, control medication orders, training the nurses on transcribing orders, locating new orders, etc.</p> <p>Record review of the NF Policy on Control of Medication Orders Manually 2003 undated reflected in part:</p> <p>.When drugs are delivered, the nurse on duty checks the drugs against the pharmacy drug order sheet .New Orders: It is the responsibility of the nurse who picks up the order to enter the medication into the drug administration recording system (MAR) and sign the entry .</p>