STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455703	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	1525 Tull Dr Katy, TX 77449

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923 Based on observation, interview and record review, the facility failed to provide services that meet professional standards of quality as outlined by the comprehensive care plan for 1 (Resident #1) of 13 residents reviewed for services. -The facility failed to provide weekly skin assessments for Resident #1 for 2/12/2024 through 3/2/2024, 3/27/24 through 4/13/2024, and 04/27/2024 through 5/11/2024. This failure could put residents at risk of infection, skin breakdown, pain, and lead to further health complications due to not being regularly assessed, monitored, and treated in a timely manner. Findings included: Record review of Resident #1's face sheet last updated 11/04/2024 revealed an [AGE] year-old male originally admitted on [DATE] and last readmitted on [DATE]. Resident #1's medical diagnoses included: muscle weakness, need for assistance with personal care, Type 2 Diabetes Mellitus (excessive sugar in the blood), lower back pain, Major Depressive Disorder, Anxiety Disorder, and a history of stroke (an instance where blood flow to the brain is blocked which can cause paralysis and difficulty walking, speaking and understanding). Record review of Resident #1's most recent Quarterly MDS (resident assessment and care screening done routinely) dated 10/04/2024 revealed Resident #1 had a BIMS score (questions to gauge resident's mental status) of 15, indicating high cognitive intactness. The MDS also indicated Resident #1 required maximal or substantial assistance with the following tasks: showering and bathing self, toileting (ability to maintain perineal hygiene and adjusting clothes before and after voiding or having a bowel movement), upper and lower body dressing and personal hygiene. Resident #1 was also documented having MASD which included incontinence-associated dermatitis and that he required a pressure reducing device for bed and ointments or medications related to skin and ulcer or injury treatments. Record review of Resident #1's active and complete Physician Orders last updated on 11/06/2024 revealed the following orders related to skin: -Apply Zinc to the buttocks after every change with a start date of 02/10/2024. -Apply skin barrier ointment/petroleum jelly to the MASD (Moisture-Affected Skin Damage) of the Buttock and Scrotum Area to take out the Dry Zinc Oxide Paste, Clean with NS (normal saline). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Apply Lotrisone External Cream 1-9.96% (Clotrimazole with Betamethasone) to the groin and bilateral (both sides) inner thighs topically (on skin) two times a day for Rash for 30 Days (with a start date of 02/13/2024 and end date of 03/14/2024). -Nystatin External Powder 100000 UNIT/GM (Nystatin) Topical)) Apply to groin, perianal area topically three times a day for MAD (Moisture Affected Damage) for 2 Weeks, with a start date of 07/20/2024 and end date of 08/03/2024. Record review of Resident #1's care plan last reviewed 08/20/2024 revealed the following focus areas for skin: -(Initiated 02/12/2024) Resident #1 has a history of a rash in the groin and bilateral inner thighs and will have intact skin, free of redness, blisters or discoloration, with interventions including notifying nurse immediately of any new areas of skin breakdown like redness, blisters, discoloration noted during bath or daily care, following facility policies or protocols for the prevention and treatment of skin breakdown -(Initiated 11/01/2023) Resident #1 has Diabetes Mellitus and will have no complications related to diabetes through the review date, with interventions including checking all of body for breaks in skin and treat promptly as ordered by doctor. Record review of Resident #1's progress notes indicated he was hospitalized on two separate occasions from 06/02/2024 to 06/03/2024 and 09/01/2024 to 09/17/2024. Record review of Resident #1's pressure sore risk assessments revealed on 2/10/2024 Resident #1 scored a 14 out of 23 points which indicated he was at moderate risk of developing pressure sores. Record review of Resident #1's skin assessments revealed: -11/01/2023 (admission) had perineal area redness noted. -Beginning 2/12/2024 (weekly skin assessment) Resident #1 had rash noted on the groin and bilateral inner thighs and sacrum redness. -There were no skin assessments document for the weeks between 2/12/2024 through 3/2/2024, 3/27/24-4/13/2024, and 04/27/2024 to 5/11/2024. -10/25/2024 skin assessment revealed no changes in condition, Resident #1's rash is being treated. Observation of Resident #1's incontinent care on 11/05/2024 at 1:40pm, Resident #1's skin on the buttock area had a light pink rash with skin intact. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #1 on 11/04/2024 at 2:40pm, the resident was sitting in his wheelchair with his phone in his hands. He appeared well-groomed, his room had clothes and personal items spread around the room, with no odors. Resident #1's bed was an air-mattress with a purple pressure-relieving wedge on top. The resident said he was doing okay. When asked questions about the food and his new diet, Resident #1 became agitated and went to look for his wife. Resident #1 wheeled himself to the Laundrylaundry room outside his room and knocked loudly on the door and yelled for his wife to come out, saying that they're asking me too many questions and I don't know how to answer them. A nearby nurse was informed of the situation and Surveyor A left. Interview with ADON B on 11/06/2024 at 12:22pm, she was the unit manager for Resident #1 and has worked at the facility for 4 years. ADON B said that CNAs are responsible for reporting new skin issues to the resident's nurse, the treatment nurse or the ADON. ADON B said that the risk to not doing weekly skin assessments on residents was that staff can miss skin tears which can develop into cellulitis and infection and possibly lead to a resident having to have amputations. ADON B said that she was aware that Resident #1 did not have some weekly skin assessments documented but that she was making sure that her nurses were completing the assessments. Interview with the Compliance Nurse on 11/06/2024 at 1:45pm, she stated she started in July 2024. The Compliance Nurse said that nurses should be doing residents' skin assessments weekly at minimum and as needed and that this was the standard. If staff find new skin concerns, they should do an impromptu skin assessment, document the concern, tell the resident's RP, treatment nurse, charge nurse, the NP, MD and the DON. If skin assessments are not done weekly, the Compliance Nurse aid stated it could lead to skin breakdowns, sepsis, infection and hospitalization . She said that skin assessment documentation should be collaborative effort between treatment nurses, the ADON and DON. The Compliance Nurse said that she was not able to find the weekly skin assessments requested for the weeks between 2/12/2024 through 3/2/2024, 3/27/24-4/13/2024, and 04/27/2024 to 5/11/2024. Record review of the facility's Skin Integrity Management policy last revised 10/05/2016 revealed that care planning in response to risk prediction must be completed. It also stated to document in resident's chart the area of change, who you notified, and treatment applied. Record review of the facility's Pressure Injury: Prevention, Assessment, and Treatment last revised 08/12/2016 revealed that pressure injuries can be prevented by assessing for early signs of skin breakdown and report any abnormal findings such as redness, tenderness and swelling of the skin.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review the facility failed to ensure residents who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene, for 1 of 19 (Resident #1) reviewed for ADLs as evidenced by: -CNA A failed to provide bowel and bladder incontinent care for Resident #1 for over 7 hours. This failure placed resident at risk for skin break down, infections, hospitalization , and decrease in quality of life. Findings included: Record review of Resident #1's face sheet dated 11/05/2024 revealed an [AGE] year-old male admitted to the NF on 11/01/2023. Resident diagnosis included the following: cerebral infarction (when blood flow to the brain is blocked), need for assistance with personal care, paralytic syndrome (weakness, muscle wasting, and loss of reflexes), depression, type 2 diabetes mellitus (when the body has trouble controlling blood sugar and using it for energy), and myopathy (disease that affects the muscles that control voluntary movements in the body. Record review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 11 indicating that resident cognition was moderately intact. Further review section GG (Functional Abilities and Goals) reflected that resident was dependent with toilet hygiene, shower/bathe self, and personal hygiene. Further review section H (Bladder and Bowel) reflected that resident was frequently incontinent of urine and bowel. Record review of Resident #1's Comprehensive Care Plan dated 11/01/2023 reflected resident being care planned for bladder and bowel incontinence that included the following interventions: -Incontinence care at least q2h and apply moisture barrier after each episode -Check resident every two hours and assist with toileting as needed Further review of Resident #1's Comprehensive Care Plan reflected resident being care planned for erythema (redness to the skin) of the sacrum (a large triangular bone that forms the base of the spine) and the groin (upper thigh meets the stomach on both sides) area r/t incontinent of bowel and bladder date initiated 09/20/2024 and revised 11/01/2024 included the following interventions: -Keep skin clean and dry -Apply Zinc oxide to the sacrum and groin area on each incontinent episode daily Record review of Resident #1's Physician Order Summary report reflected the following orders: -Dated 02/10/2024 Apply Zinc to the buttocks after every change (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dated 06/03/2024 Cefdinir (medication used to treat bacterial infections) capsule 300mg give 1 capsule by mouth two times a day for UTI for 5 days Record review of Resident #1's MAR for the month of June 2024 reflected that resident was administered Cefdinir 300mg 1 capsule by mouth two times a day for UTI for 5 days. Observation on 11/05/2024 at 1:25PM Resident #1 was resting in bed on his back awake on his back. Resident said he felt a little discomfort on his buttocks. Observation on 11/05/2024 at 1:40PM of incontinent care for Resident #1 by CNA A and CNA B. Resident was wearing pants. When CNA A removed resident pants, it was observed that resident was doubled brief with feces in his pants. Further observation was made when CNA A removed resident brief, resident brief was heavily soiled with urine and feces that was present in the groins, inner thighs, and buttocks. CNA B began to clean resident using disposable wipes. Observation was made of resident penis, scrotum, inner left thigh with redness. The inner left thigh also had a red rash. When the CNA's positioned resident to his right side to further provide care, it was observed that resident buttocks was heavily soiled with dried feces. CNA B asked CNA A to go and get another container of disposable wipes along with a wash basin. CNA B commented that she would need to clean resident skin with soap and water to ensure that all the feces had been removed from resident skin. CNA B said the feces on resident buttock area had begun to dry on resident. Resident #1's skin to buttock area had a light pink rash with skin intact. When CNA A and CNA B finished providing incontinent care for Resident #1, CNA B applied Zinc oxide paste to resident skin. Observation on 11/05/2024 at 3:18PM of ADON A with Resident #1's RP , the RP placed the phone call on speaker. ADON A told Resident #1's RP that the resident requested to be double-briefed and that meant he was going to wear two briefs. The RP told ADON A that Resident #1 had never told them that he wanted to wear two briefs. ADON A told the RP to talk to Resident #1 and let Resident #1's nurse know. The RP told ADON A to meet in Resident #1's room and hung up the phone. Interview on 11/05/2024 at 2:08PM with Resident #1 said the last time his brief had been changed was at 6:00AM on 11/05/2024. Further interview with resident said he never requested to wear two briefs. Resident said he just let the staff do what they felt they needed to do in caring for him. Interview on 11/05/2024 at 2:20PM with CNA A said she was Resident #1's CNA. CNA A said the last time she had provided incontinent care for Resident #1 was at 6:00AM. CNA A said she was supposed to provide incontinent care at least every 2 hours. CNA A said the reason she had not provided incontinent care for resident was due to resident being in therapy at one time but could not answer the other times why she did not checked resident for incontinent care. Further interview with CNA A said she was not supposed to double brief resident because it was not good hygiene practice and exposed resident to infections. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/05/2024 at 2:40PM with LVN C said she was Resident #1's nurse. LVN C said the CNA's supposed to check the resident's at least every two hours for incontinent care. LVN C said this was done to prevent skin break down. LVN C said the residents should not be double brief for infection control purpose. LVN C said she made rounds on the resident's every two hours to ensure the CNAs were providing incontinent care for residents. LVN C said she had not assessed Resident #1 for incontinent care but did do a weekly skin assessment on resident the week prior due to Resident #1 complaining of some discomfort to his buttocks. LVN C said when she assessed Resident #1's skin on last week, he did not have any break in the skin but had some redness. LVN C said Zinc oxide was applied to resident skin and after each incontinent episode. Interview on 11/05/2024 at 2:45PM with the DON said 11/04/2024 was her first day working at the NF. The DON said incontinent care should be provided to the residents every two hours to prevent skin breakdown. The DON said it was okay to double brief if its care planned as the resident preference. The DON said she preferred that the resident not be double briefed because it placed the resident at risk for skin breakdown. The DON said she just care planned Resident #1 on 11/05/2024 because resident wanted to be to be double briefed. Interview on 11/05/2024 at 3:20PM with Resident #1's RP, she said she only saw Resident #1 with double briefs once during his time at the facility and that Resident #1 never told her that he wanted to be double-briefed. Interview on 11/06/2024 at 12:42PM with ADON A, he said the Interim DON told him that Resident #1 wanted to be double-briefed and to call Resident #1's RP to let them know of the resident's request. ADON A said when he went to see Resident #1 the resident said that he never requested to be double-brief and did not approve of the change. ADON A then told the Interim DON that Resident #1 refused and didn't approve of being double-briefed, but did not document any communications because ADON A was told to document that Resident #1 wanted it but since Resident #1 didn't, ADON A didn't need to document. ADON A said that the process if residents wanted to be double-briefed is that the facility would educate and re-educate on the risks of being double-briefed and call the resident's family. Then the nurse should tell the DON, NP/MD and Administrator to go from there. ADON A said risks to being double-briefed is skin breakdown, skin contact dermatitis, open wound, infection and so on. Record review of Resident #1's revised care plan dated 11/05/2024 done by the DON reflected the following: I prefer to wear double brief as tolerated .interventions as educate on peri-care provide incontinent care as needed . Interview on 11/05/2024 at 3:12PM with Resident #1's family member said she had never known for resident to asked to be double briefed. The family member said resident had gone for hours without his brief being changed. Record review of in-services dated 11/05/2024 done with staff reflected the following: -Double briefing residents -Check residents per day times 4 weeks for continent care documenting date, time, resident's name, if there was any negative response, document any negative response and corrective action (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In-service every 1-hour check for dryness -1 on 1 employee (CNA A) Disciplinary Report Action regarding job duties and responsibilities with residents -Perineal care for male and female -Abuse and Neglect -Resident Rights Record review of the NF policy on Perineal Care dated 04/25/2022 reflected in part: .Purpose aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, prevent infections and skin irritation, and observing the residents skin condition .