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	11/15/2024

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 44669 Based on observation, interview, and record review, the facility failed to post in a place readily accessible to residents, family members, and legal representative of residents, the results of the most recent survey of the facility. 1. The facility failed to ensure the posting location of the previous year's surveys, certifications, and complaint investigations with plan of correction were posted in a public location for residents, family members, and visitors to review. The failure placed residents and their family members and representatives at risk for violation of the right to review the findings from State surveys and investigations conducted in the facility without asking to review the reports. Findings included: During an observation on 11/13/2024 at 10:34 a.m. the last survey results dated 09/28/2023 were in a binder at the front desk outside of ADMN's (administrator) office. During an interview on 11/13/2024 at 10:04 a.m., during the confidential group meeting, residents stated they were unaware of the location of the previous state inspection survey reports. During an interview on 11/13/2024 at 10:54 a.m., the ADMN stated that the inspection report signage was in a frame on the table behind the front desk. Upon observation, the ADMN was unable to locate the signage, but stated she had just seen the sign that morning on the table. The ADMN stated she would have the sign reprinted, place in a frame, and hung on the wall with the report binder in a wire basket underneath. During an interview on 11/13/2024 at 03:12 p.m., the ADMN stated she was responsible for placing the results from the most recent surveys, certification, and investigations in a binder outside of her office. She stated during the morning, a resident had taken the frame from the front desk. She stated the frame was located and had been placed on the wall near the front desk outside of her office along with the past inspection binder. She stated that no negative effect occurred during the time frame the signage was not posted. (continued on next page)

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Record review of undated policy titled - Mandatory Posting: Availability of TDHS Inspection Reports, Summary of Most Recent Inspection Report, Notice of Protection from Discrimination \ Retaliation as Provided by Chapter 242 of Health and Safety Code and Availability of Chapter 242 in Facility for Public Inspection.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 4 of 8 residents (Resident #45, Resident #175, Resident #9 and Resident #5,) reviewed for privacy, in that: 1. CNA (certified nursing aid) C failed to place Resident #45 Foley catheter bag inside of a privacy bag. 2. CNA L failed to place Resident #175 Foley catheter bag inside of privacy bag. 3. The facility failed to provide privacy curtain between Resident #9 and Resident #5's bed to identify a separation of space and privacy between the two residents. These failures placed residents at risk for embarrassment, at risk of loss of dignity and decrease in quality of life. The findings include: Resident #45: Record review of Resident #45's factsheet dated 10/15/2024 revealed a [AGE] year-old male admitted to the NF on 09/09/2024. Resident #45's diagnoses included the following: chronic kidney disease, functional quadriplegia (to be completely unable to move due to severe disability from another medical condition), heart disease, pressure ulcers (injury to the skin resulting from prolong pressure on the skin) stage 4 to the sacral (base of the spine) and buttock (back of the hip which a person sits). Record review of Resident #45's MDS dated [DATE] reflected that resident had a BIMS score of 10 indicating the resident's cognition was moderately impaired. Further review revealed section H (bladder and bowel) was coded 9, not rated (resident had a catheter for urinary incontinence). Record review of Resident #45's Physician's Orders for the month of September 2024 reflected the following order: - Dated 09/10/2024 Ensure Foley bag is in privacy bag while in bed or w/c. Record review of Resident #45's Comprehensive care Plan dated 09/23/2024 included the following intervention: - Position catheter bag and tubing below level of the bladder and in a privacy bag. Observation on 11/12/2024 at 9:06 a.m. revealed Resident #45 was resting quietly in bed to his left side with eyes closed. Further observation revealed the resident had an indwelling Foley catheter hanging on the right side of bed to gravity. The Resident Foley bag was not inside of a privacy bag. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/13/2024 at 9:22 a.m. revealedof Resident #45 resting in bed with his eyes closed. Further observation revealed his Foley catheter bag was not inside of a privacy bag. Interview on 11/13/2024 at 4:15 p.m. CNA C said she was Resident #45's CNA on 11/12/2024 for 6 a.m. - 6 p.m. shift. CNA C said it was her responsibility regarding Foley care to empty the Foley catheter bag and place the bag inside of a privacy bag. CNA C said that was done to provide the resident with privacy as well as dignity. CNA C said she was not aware on 11/12/2024 that Resident #45's Foley catheter bag was not inside of a privacy bag. The CNA C said it was ADON A that told her to place resident Foley bag inside of a privacy bag until 11/12/2024. Resident #175: Record review of Resident #175's face sheet dated 11/15/2024 revealed a [AGE] year-old female admitted to the NF on o3/29/2024. The resident's diagnoses included malignant neoplasm (cancer) of the uterus (female organ located between the bladder and rectum), obstructive and reflux uropathy (when the flow of urine is blocked) and pressure ulcer of the sacral region (near the base of the spine). Record review of Resident #175 quarterly MDS dated [DATE] reflected the BIMS score was 15 indicating that resident cognition was intact. Further review of section H (bladder and bowel) reflected that resident was always incontinent of bladder and bowel. Record review of Resident #175 Comprehensive Care Plan dated 10/05/2024 reflected the resident was being care planned for an indwelling catheter with an intervention that included: place Foley catheter bag inside of privacy bag. Observation on 11/12/2/4 at 10:15 a.m. revealed Resident #175 was awake, resting in bed. Further observation revealed the resident having an indwelling Foley catheter hanging to gravity on the right side of. The Resident's Foley bag was not inside of a privacy bag. Observation on 11/13/24 at 8:12 a.m. revealedof Resident #175 was resting in bed to her left side. Resident Her Foley bag was inside of privacy bag. Interview on 11/13/24 at 4:28 p.m. Resident #175 said she would prefer that her Foley bag be placed inside of privacy bag because she sometimes had family visit her. Resident #175 said she would not like anyone to see her Foley bag. Interview on 11/15/2024 at 7:48 a.m. CNA L said she was Resident #175's CNA on 11/12/2024 on the 6 a.m. - 6 p.m. shift. CNA L said she was not aware that Resident #175 Foley catheter bag was not inside of a privacy bag. CNA L said the importance of concealing a resident's Foley bag inside of a privacy bag was to protect residents' privacy and that it was the resident's right. Interview on 11/13/24 at 4:33 a.m. ADON B said it was the responsibility of the CNAs's and the nurses on the units to make sure that residents who had a Foley catheter that the Foley bag be in a privacy bag to promote dignity on the resident's behalf. ADON B said it was herself as a Unit Manager and ADON to ensure that was being done. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/13/24 at 4:38 p.m. with the DON, regarding Foley bags, said every resident that had a Foley, the Foley bag should be inside of a privacy bag. The DON said that was the resident's right and it also provided dignity for the resident. The DON said it was the nurses on the unit, CNAs', including herself to ensure that this was being done. Resident #9 and Resident #5: Record review of Resident #9's face sheet, dated 11/12/2024, reflected resident was a [AGE] year-old female with an admitted [DATE] and, a readmitted [DATE], with diagnoses which included: schizophrenia (a chronic mental disorder that affects how people think, perceive reality, and interact with others), generalized (osteo) arthritis (pain and stiffness in the joints), dementia (loss of cognitive functioning - thinking, remembering, and reasoning), severity, without behavioral disturbance, psychotic disturbance (abnormal thinking), mood disturbance, and anxiety, psychotic disorder with hallucinations due to known physiological condition, multiple sclerosis (autoimmune disease that effects the brain and spinal cord), type 2 diabetes mellitus without complications (abnormal blood sugar levels), paraplegia (a chronic condition that results in the loss of motor or sensory function), major depressive disorder, recurrent, severe with psychotic symptoms, and, other abnormalities of gait and mobility. Record review of Resident # 9's Quarterly MDS assessment, dated 09/02/2024, reflected the resident had a BIMS score of 09, indicating she was mildly cognitively impaired. Resident #9 required maximum assisted at least half of the time with ADLs, and resident was incontinent for bladder and bowel. Record review of Resident #9's care plan, dated 06/30/2023, reflected Focus: had delusions with poor judgment and insight . was verbally and physically aggressive towards staff and others, yelled and cursed at CNAs during .care, made sexual comments to staff and residents. Goal: will remain safe and her concerns will be addressed. Interventions: observe and document behavior as needed. Resident #5: Record review of Resident #5's face sheet, dated 11/15/2024, reflected an [AGE] year-old female with an admitted [DATE] and, a readmitted [DATE], with diagnoses which included: dementia (loss of cognitive functioning - thinking, remembering, and reasoning), severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, atrial fibrillation (irregular heart rate causing fatigue, dizziness and trouble breathing), major depressive disorder, recurrent, severe with psychotic symptoms, anemia in other chronic diseases classified elsewhere low back pain, hypertensive heart disease without heart failure (raise in blood pressure causing strain on the heart), and adjustment disorder. Record review of Resident #5's Quarterly MDS assessment, dated 09/11/2024, reflected that the Resident had a BIMS score of 00, indicating that the resident was unable to complete the interview. Resident #5 required maximum assisted at least more than half of the time with ADLs, oral hygiene, upper body dressing, and personal care. Record review of Resident #5's care plan, dated 10/24/2024, reflected Focus: Resident had an ADL self-care performance deficit relating to Dementia. Resident is a 2-person assist. Dressing: One person. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/12/2024 at 09:14 a.m. reflected Resident #9 and Resident #5's room with 2-beds and personal property near both beds with no privacy curtain between the beds. During an interview on 11/12/2024 at 09:14 a.m., Resident #9 she stated that she had a roommate (Resident #5) who she had not gotten alone with because Resident # 5 complained all the time. She stated that there was never a curtain between their two beds and would like to not have to look at Resident #5 when they were both in the room. She stated when staff assisted her and her roommate dressing, they both were in the room. During an interview on 11/12/2024 at 04:20 p.m., the ADM stated and believed that Resident #9's room was a private room and was the reason why no curtain was hung. She stated that it was possible that Resident #9 moved into that room temporarily after a recent room change. She stated that there should have been a curtain hanged between two residents sharing a room to allow privacy. She stated she would assess the room and have a privacy curtain hung between Resident #9 and Resident #5. During an interview on 11/13/2024 08:06 a.m., the ADM stated that both Resident #9 and Resident #5 were moved out of their room because the room was assigned as a private room. She stated that both residents were relocated to different rooms and were no longer roommates. She stated she interviewed both residents the evening of 11/12/2024 and both residents stated that they were friends and had roomed together for 2-years. During an interview on 11/13/2024 at 11:32 a.m., Resident #5 was asked questions regarding her roommate but did not respond. Resident made eye contact smiled and confirmed that she was resident #5. During an interview on 11/14/2024 at 2:21 p.m., RN O stated that she was the nurse for Resident #9 and Resident #5. She stated she had just returned to the facility and worked last in October of 2024. She had not noticed that the resident's had not had a privacy curtain hanging between their beds. She stated the importance of a privacy curtain was for residents to feel ownership to their own space. She stated also during ADL service, the privacy curtain protects a residence privacy. She stated that it was her expectations that all staff including CNAs who became aware of the missing privacy curtain, should follow the chain of command to have the curtain placed. Record review of the facility's policy titled Resident Rights revised dated 11/18/2016. Privacy and confidentiality reflected in part: .The resident has a right to be treated with respect and dignity .The resident has a right to personal privacy . Asked and not received, a facility policy specific to privacy curtains in resident rooms.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32422 Based on interview and record review the facility failed to report the results of all investigations to the State Survey Agency, within 5 working days of the incident for an allegation of abuse to report for 1 of 4 residents (Resident #61) reviewed for abuse/neglect in that: -Resident #61 had an incident with an allegation of abuse on 09/3/2024. The facility did not submit the final 3613 facility investigation report to the State Agency within 5 working days. This failure could place residents at risk of having allegations of abuse, neglect, exploitation not being investigated or reported to the State agency. Findings Include: Record review of the admission record dated October 17, 2024. revealed that Resident #61 was an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included hemiplegia and hemiparesis after cerebral infarction (related conditions that cause weakness or paralysis on one side of the body) and need for assistance with personal care (a physical, cognitive, or behavioral limitation that makes it difficult for an individual to perform activities of daily living or instrumental activities of daily living (IADLs). ADLs The ADL's included tasks like bathing, eating, dressing, and using the toilet, while IADL'ss include tasks like cleaning, preparing meals, and taking medication.). Record review of Resident #61's Admission MDS assessment dated [DATE] reflected a BIMS (brief interview for mental status) score of 8 out of 15 indicating he had moderate cognitive impairment. He had upper and lower extremity impairment on one side. Resident #61 required substantial to maximal assistance with bathing/showering, toileting, lower body dressing, putting on and removing footwear. Record review of Resident #61's care plan revealed the following: The resident has LEFT Hemiplegia/Hemiparesis r/t STROKE.LEFT HAND CONTRACTURE Date Initiated: 07/23/2024. Revision on: 08/03/2024. The goal, the resident will remain free of complications or discomfort related to Hemiplegia. Interventions read in part . Assist with ADL's/Mobility as needed. Date Initiated: 07/23/2024 CNA . Discuss with resident/resident and family any concerns, fears, issues regarding diagnosis or treatments . Record review of the Facility Incident Intake #: 534855 reflected in part . Resident alleges CNA was rough during transfer. Actions and Notifications CNA suspended, resident assessed, MD, RP notified . Record review of the facility investigation worksheet in Tulip (the online system for submitting long term care information) revealed read in part . Intake ID 534855 .Priority Facility 45-day Priority Date: 9/30/2024 , Received Date 09/30/2024 Final Report Received: False. Record review revealed that there was no final 3613 (provider investigation report) submitted into Tulip for facility incident intake #: 534855 submitted on 9/30/2024. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility incident/accident report revealed on 9/30/2024 an incident under the category other. An interview on 10/14/2024 at 12:28 p.m. with the Administrator, she said that the facility had the initial 3613 incident submitted but did not have the final 3616 submitted. During an interview on 10/15/2024 at 9:57 a.m., with the Administrator, she confirmed that there was no final 3613 investigation report submitted for incident #: 534855. She said the former DON said that she submitted the final 3613 thinking that she had but it was not submitted. When asked about a possible negative outcome if the final 3613 was not submitted, she said she always submitted her reports,, She said the investigation was completed but was not submitted. An interview on 11/15/2024 at 3:12 p.m. with the DON, she said that the Administrator planned to train her to submit facility investigation reports into Tulip soon, being that she was recently hired she had not had training. Record review of the facility policy and procedure entitled Reporting Events; Home Office and State read reflected in part . Guidelines for reporting incidents to DADS is contained in Provider Letter 19-17 dated 7/10/19. Record review of Long-Term Care Regulatory Provider Letter 19-17 date issued: July 10, 2019, read in part . This letter provides guidance for reporting incidents to HHSC (Health and Human Services Commission) . A NF (Nursing Facility) must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: Abuse . In addition to reporting an incident, a provider must investigate, or ensure that an investigation was completed, to determine why it occurred, what actions the provider will take in response to the incident and what changes will be made to help prevent a similar incident from occurring. 4. A provider must submit a PIR (Provider Investigation Report) to CII (Complaint and Incident Intake) using HHSC Form 3613-A (for use by an NF) . or HHSC Form 361 . The PIR must include all information from the initial incident report and any additional information the provider has obtained since making the initial report, including witness statements. The provider must submit the PIR within the applicable required time frame, as follows: Five working days for an NF or skilled NF .

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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** 35822 Based on observation, interview, and record review, the facility failed to have a person-centered comprehensive care plan developed and implemented to meet each resident's preferences and goals, and address the resident's medical, physical, mental and psychosocial needs for 1 of (Resident #42) 6 residents reviewed for care plans. - Resident #42's comprehensive centered care plan revealed that resident was not being care planned for foot care. This failure placed resident at risk for not having their individual medical needs met. Findings Included: Record review of Resident #42's face sheet dated 11/15/2024 revealed a [AGE] year-old male admitted to the NF on 10/04/2023. Resident diagnoses included Alzheimer's Disease (disease that destroys memory and other mental functions), cerebral infarction (when blood flow to the brain is blocked), hemiplegia and hemiparesis (condition that causes paralysis or weakness), and type 2 diabetes mellitus (long term condition where the body has trouble controlling blood sugar and using it for energy). Record review of Resident #42's admission MDS dated [DATE] reflected a BIMS score of 14 indicating the resident's cognition was intact. Further review of section GG (Functional Abilities) reflected the resident required moderate assistance with personal hygiene. Record review of Resident #42's Physician Order for June 2024 reflected the following: -Dated 06/10/2024 May have Podiatry (medical field that specializes in the treatment and diagnosis of foot care, ankle, and lower limb disorders) consult PRN. Record review of Resident #42's comprehensive centered care plan 09/18/2024 reflected that resident was not care planned for podiatry services/foot care. Record review of the NF residents on the list for podiatry services for the month of 10/02/2024, did not included Resident #42. Further review reflected the next time podiatry services to return to the NF was 12/04/2024. Observation on 11/12/24 at 9:40 a.m. revealed Resident #42 resting in bed awake, alert and oriented times 3. Further observation was conducted of the resident's feet being exposed. Resident #42's right foot great toenail appeared calcified (thick and dry) and long. The 3rd and 4th toenails to the right foot was thick, long and curved. Observation of the resident's left foot great toenail revealed it long. The 2nd and 4th toenails appeared thick, long and curved. Interview on 11/15/2024 at 1:47 p.m. the MDS Coordinator said she done the initial care plans and the quarterly care plans. The MDS Coordinator said it was the unit nurses, ADON or DON that done any revisions or acute care plans . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/13/24 at 2:18 p.m. revealed Resident #42's toenails with ADON B said some of the toenails were long and thick and beginning to curve. Interview on 11/15/24 at 1:59 p.m. ADON B said she updated the resident care plan for psych medications (medications to treat mental disorders), dietary, and the Infection Control Nurse done any revisions that involved changes in the resident care. Interview on 11/15/24 at 2:05 p.m. the DON said anyone that was on the IDT (consisted of the nursing department, physical therapy, social worker, and anyone involved in the resident care) could update a resident care plan. The DON said it was ultimately the MDS Nurse Coordinator's responsibility to make sure that each resident had a comprehensive centered care plan addressing each resident needs. The DON said if the resident needs were not being address in the care plan, it placed the resident (s) at risk for lack of care. Interview on 11/15/24 at 2:20 p.m. the Social Worker said no one had informed her that Resident #42 needed podiatry services therefore it would not trigger for her to care plan. The Social Worker said now that she had been made aware that Resident #42 needed podiatry services, she would make sure that Resident #42 was added to the list and care planned as well. Record review of the NF policy on Comprehensive Centered Care Plans not dated reflected in part: .The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs .The resident's care plan will be reviewed after each admission, quarterly, annual and/or significant change MDS assessment, and revised based on changing goals, preference and needs of the residence and in response to current interventions .Interdisciplinary means that professionals disciplines, as appropriate, will work together to provide the greatest benefits to the resident .

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review the facility failed to ensure that residents received proper treatment and care to maintain mobillity and good foot health for 1 (Resident # 42) pf 6 residents reviewed for foot care. -The facility failed to provide Resident #42 who had diabetes mellitus podiatry services. This failure placed resident at risk for injuries, infections, unwanted hospitalization , and amputation leading to a decrease in quality of life. Findings Included: Record review of Resident #42's face sheet dated 11/15/2024 revealed a [AGE] year-old male admitted to the NF on 10/04/2023. Resident diagnoses included Alzheimer's Disease (disease that destroys memory and other mental functions), cerebral infarction (when blood flow to the brain is blocked), hemiplegia and hemiparesis (condition that causes paralysis or weakness), and type 2 diabetes mellitus (long term condition where the body has trouble controlling blood sugar and using it for energy). Record review of Resident #42's admission MDS dated [DATE] reflected a BIMS score 14 indicating the resident cognition was intact. Further review section GG (Functional Abilities) reflected the resident required moderate assistance with personal hygiene. Record review of Resident #42's Physician Order for the month of June 2024 reflected the following: -Dated 06/10/2024 May have podiatry (medical field that specializes in the treatment and diagnosis of foot care, ankle, and lower limb disorders) consult PRN. Record review of the NF residents on the list for Podiatry services for the month of October 02, 2024, did not included Resident #42. Further review reflected the next time Podiatry services to return to the NF was December 04, 2024. Record review of Resident #42's shower sheet dated 11/11/2024 CNA D documented the resident was given a bed bath. Further review reflected that CNA D documented the resident's fingernails were cleaned and clipped and the resident's toenails were clean and did not need to be clipped. Observation on 11/12/24 at 9:40 a.m. of Resident #42 resting in bed awake alert and oriented times 3. Further observation was conducted of resident feet being exposed. Resident right foot great toenail appeared calcified (thick and dry) and long, 3rd and 4th toenail to right foot was thick and long and curved. Observation of resident left foot great toenail long, 2nd and 4th toenail appeared think, long and curved. Interview on 11/12/2024 at 9:40 a.m. Resident #42 said he could not remember the last time he had been seen by the podiatrist. Resident #42 said he would like for his toenails to be clipped. The resident denied any discomfort to his toenails. (continued on next page)

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	455703	A. Building B. Wing	11/15/2024

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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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/13/24 at 2:18 p.m. of Resident #42's toenails with ADON B said some of the toenails were long and thick and beginning to curve. Interview on 11/13/2024 at 2:18 p.m. ADON B said the nurses were supposed to do a head-to-toe assessment on the residents every week. ADON B said when providing the residents a shower the CNA's should be reporting to the nurse if the resident's toenails need to be clipped. ADON B said the nurse would then contact the Social Worker to add a resident to the list to be seen by the podiatrist (a doctor who specializes in the diagnoses and treatment of foot, ankle, and lower limb disorders). ADON B said if a resident's toenails were not being groomed, the toenail would continue to grow and began to curve into the resident skin placing resident at risk for injuries. Interview on 11/13/24 at 2:38 p.m. CNA C said she was Resident #42's CNA. CNA C said Resident #42 received his showers on Tuesdays, Thursdays, and Saturdays. CNA C said she had documented on the resident shower sheet about toenails needing to be clipped but could not remember when she documented this and who she reported it to. Interview on 11/13/24 at 2:47 p.m. CNA D said she worked at the facility on the 6:00 p.m. - 6:00 a.m. but came to the facility to work an extra shift. CNA D said she did not report to the nurse that Resident #42's toenails needed to be clipped and must have forgot. CNA D said it was important to communicate with the nurse if the resident's toenails needed to be clipped because the resident could get an infection. Interview on 11/13/24 at 2:55 p.m. the Social Worker, after reviewing her list of residents to be seen by pPodiatry services, said Resident #42 was not on the list to be seen by pPodiatry services. The Social Worker said records showed that the last time podiatry services was at the facility was 10/02/2024, and before that date she believed it was 09/11/2024. The Social Worker said she thought the next time podiatry services would be back at the facility was 12/04/2024. The Social Worker said podiatry services came to the NF at least every 2-3 months. Interview on 11/13/2024 at 4:03 p.m. with LVN N said the residents' skin was assessed on a weekly basis by performing a head to the toe. LVN N said she was Resident #42's nurse. LVN N said she had not done a head-to-toe assessment on Resident #42 because the system in point click care did not trigger for her to do so. LVN N said after reviewing resident weekly skin assessment with last one done on 11/07/24 reflected no skin breakdown. LVN N said a resident who had diabetes and was not being followed by pPodiatrist services put the resident at risk for infections, sepsis(life-threateng infection that could lead to death), and could escalate from there. Interview on 11/13/2024 at 4:38 p.m. the DON said regarding podiatry services, she would have to review the NF policy. The DON said the nurses should be performing weekly skin assessments and reviewing the CNAs's shower sheets for any changes toin the resident's condition. The DON said if there was a change in a resident's condition regarding nail care, the unit nurse needed to alert the wound care nurse who would then alert social services for the resident to be added to the list for podiatry services. The DON said when residents were not being assessed in a timely manner, it placed residents who had diabetes and required podiatry services at risk for infections, hospitalization , and amputation. The DON said unfortunately, she was still learning the facility process and would be in-servicing her staff as well as implementing a plan to ensure that residents were being assessed properly and care was being provided in a timely manner. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/14/2024 at 9:47 a.m. the Wound Care Nurse said she done the initial skin assessments on all new and readmitted residents and the unit nurses done the weekly skin assessments on the residents. The Wound Care Nurse said that it was important for a resident who had a diagnosis of diabetes be placed on podiatry services to care for the resident's toenails and fingernails to ensure that the resident's nails were being groomed properly and to avoid injuries to the resident. The Wound Care Nurse said nail care was extremely important for a resident who had diabetes because of the risk of injuries, infections, and poor blood circulation particularly in the lower extremities. The Wound Care Nurse said if the resident developed an injury or infection to the lower extremity, it could lead to hospitalization . The Wound Care Nurse said diabetes was the number cause of amputation. Record review of the NF policy on Foot Care, not dated, reflected the following: .Foot management is the daily assessment, bathing, lubrication, and protecting of the feet. It is done to promote cleanliness and peripheral (away from the center of the body, example the hands and toes) circulation of the feet. Foot care is especially important in those residents with diabetes mellitus or peripheral circulatory conditions because of the susceptibility to infection and skin breakdown. If required, trimming of the toenails is performed by a Podiatrist (.Become familiar with medical conditions that compromise circulation in the feet and assess for need of nail trimming. Request referral to Podiatrist if nail trimming is needed .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care and services, including oxygen administration was provided such care, consistent with professional standards of practice for 1 of 4 residents (Resident #20) reviewed for respiratory therapy in that: 1. The facility failed to ensure Resident #20's oxygen was set according to physician's orders. This failure could place residents at risk of respiratory distress. The findings were: Record review of Resident #20's sheet dated 11/15/2024 revealed a [AGE] year-old female was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #20 had diagnoses included: cerebral infarction (when blood flow to the brain is disrupted, causing brain tissue damage.), hypertension (when the blood pressure in the blood vessels is too high), and cerebrovascular disease (condition [NAME] affect the blood vessels and blood flow in the brain and spinal cord). Record review of Resident #20's quarterly MDS assessment dated [DATE] revealed Resident #20 had BIMS of 06 out of 15 which indicated severely impaired cognition. Durther review revealed Resident #20 was on oxygen therapy. Record review of Resident #20's care plan dated 06/03/2024 revealed the resident had shortness of breath hypoxia(when the body's tissues are not receiving enough oxygen) O2 at 1-2 L via NC continuous to maintain O2 sats >92%. Intervention: monitor /document changes in orientation, increased restlessness, anxiety, and air hunger(uncomfortable sensation of not being able to get enough air). Record review of Resident #20's order summary report dated November 2024 reflected in part . O2 at 1 to 2 liters via NC continuous to maintain O2 sats >than 92% start date 09/18/24 . Record review of Resident #20's MAR for November 2024 revealed the resident was on O2 @ 1-2 L via NC continuous to maintain O2 sats > 92%; every shift for hypoxia and was signed off but the oxygen saturation was not documented. During an observation and interview on 11/12/2024 at 10:28 a.m., revealed Resident #20's oxygen concentrator was set at 3.5L. Resident #20 had difficulty with speech but was able to say no when she was asked if she knew how many liters of oxygen she was supposed to be on. Resident #20 also said no when she was asked if she had changed the setting on the concentrator. Resident #20 did not appear to be in any distress at the time. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/12/2024 at 10:35 a.m., RN R said Resident #20's oxygen was set at 3.5 L. RN R said Resident #20's concentrator should be set at 2 L, but she was not sure and said she would check where the oxygen should be set at. RN R returned at 10:37 a.m., saying the oxygen setting should be between 1 and 2 L. During an interview on 11/13/2024 at 11:26 a.m., RN R said she did initial rounding when she came to work today at 7:00 a.m. during the start of her shift, and she forgot to check the oxygen setting on the concentrator. RN R said the setting on the concentrator was not what the physician ordered for Resident #20, which meant the physician's order was not followed. RN R said Resident #20 was given more oxygen than ordered. Resident #20 could become hyperventilated(breathing faster and deeper than the body needs). RN R said that could cause Resident #20 to depend on oxygen, and it would be difficult to wean Resident #20 from using oxygen. RN R said the DON monitored nurses during rounding. RN R said she had a skills check-off and in-service on oxygen administration. Record review of the facility nurse proficiency audit dated 06/03/2024 revealed RN R signed the audit, and it included oxygen administration and maintenance. During an interview on 11/13/2024 at 11:38 a.m., ADON A said the nurses monitored the oxygen setting on the concentrator during rounding. ADON A said if Resident #20's oxygen was above the physician's order, then Resident #20 was not receiving oxygen as ordered. ADON A said if Resident #20 received more oxygen than ordered, it could lead to hyperoxygenation(overbreathing), which could cause a change in the condition of Resident #20 breathing. ADON A said RN R should have done the skills- check-off, which included oxygen administration and monitoring before working with residents who were on oxygen. ADON A said the ADON monitored the nurses during random rounds. ADON A said nurses should check on the oxygen concentrator setting every two hours when they make rounds. During an interview on 11/14/2024 at 7:50 a.m., the DON said RN R should check the oxygen setting on Resident #20's concentrator every 2 hours during rounding. The DON said the oxygen concentrator for Resident #20 should be set according to the physician's order. The DON said that for a resident to be on oxygen, the resident would have a physician's order and that the nurse should follow the physician. The DON said if Resident #20 was given more oxygen than was ordered, then Resident #20 could have hyperventilated respiratory distress, and Resident #20 lungs could be affected. During an interview on 11/15/2024 at 10:26 a.m., NP Z said RN R must notify the physician's order before the nurses would increase Resident #20's oxygen. NP Z said Resident #20 could get micro changes in her eyes(vision changes) if Resident #20 were administered more oxygen than ordered. NP Z said Resident #20 could become lethargic and feel dizzy. NP Z said he was not notified about the increase in Resident #20 oxygen setting. Record review of the facility oxygen administration nursing policy and procedure manual 2003 Rev March 21, 2023, reflected in part . the mount of oxygen by percent of concentration or L/min, and the method of administration is ordered by the physician .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview and record review, the facility failed to ensure residents were free from any significant medication errors for 1 of 7 residents (Residents #43) reviewed for significant medication errors. 1. MA Y failed to administer medications as ordered to Resident #43 by attempting to administer Carvedilol 3. 125mg outside of ordered parameters. This failure could place residents at risk of decrease pulse, and potential hospitalization . The findings were: Record review of Resident #43's face sheet dated 11/14/2024 revealed an [AGE] year-old female was admitted to the facility on [DATE]. Resident #43 had diagnoses included: paroxysmal atrial fibrillation (short or sudden episodes of an irregular heart usually start and stop on their own), hypertension (when the blood pressure in the blood vessels is too high), and angina pectoris (chest pain or discomfort that occurs when a part of the heart doesn't get enough blood or oxygen). Record review of Resident #43's quarterly MDS assessment dated [DATE] revealed Resident #43 had a BIMS of 15 out of 15 which indicated intact cognition. Further review revealed Resident #43 needed limited assistance with ADLs. Record review of Resident #43's care plan dated 07/05/23 revealed the resident had congestive heart failure. Interventions: give cardiac medications as ordered. Record review of Resident #43's order summary report for November 2024 reflected in part .Coreg 3.125 md give 1 tablet by mouth two times a day for hypertension, hold for HTN for less than 110 , pulse less than 60 start date 09/18/24 . During medication observation on 11/13/2024 at 7:56 a.m., MA Y was about to administer Carvedilol 3. 125mg medication to Resident #43 when the surveyor intervened because Resident #43's heart rate was 59. During an interview on 11/13/2024 at 7:58 a.m., MA Y said Carvedilol 3.125 mg was among the morning medication for Resident #43, then she looked at the computer and the medication blister packet and said she should have held the medication because Resident #43's heart rate was 59. MA Y took the Carvedilol out and administered other medications. During an interview on 11/13/22 at 5:49 p.m., MA Y and the DON were present during the interview with MA Y. MA Y said if Resident #43 heart rate was low and she gave Resident #43 carvedilol, the resident's heart could drop more than 59. MA Y said Resident #43 could have a heart issue (heart collapsed or stopped). MA Y said she had skills - check off on medication administration before she started passing medication. MA Y said the ADON monitored the MA when she made random rounds. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an Interview on 11/14/2024 at 7:42 a.m., the DON said MA Y should have training on medication administration before passing medication. The DON said MA Y should have followed the five medication rights, and if the medication had a parameter, MA Y should have followed the parameter. The DON said medication that had permitter should be followed because it could cause harm or advice reaction to Resident #43. The DON said if the MA Y had given the medication to Resident #43, she could have gone into carid arrest(heart suddenly stops). The DON said the nurse and the DON monitored the medication aides when they made random rounds. During an interview on 11/14/2024 at 8:25 a.m., ADON B said MA Y should have had skills- check off on medication administration before she passed medication. ADON B said for Resident #43 to be on medication, she should have a doctor's order. ADON A said MA Y should have followed the physician's order and the perimeter given by the physician. ADON B said MA Y was trained on the six rights of medication. ADON B said if Resident #43's heart rate was lower than 60 and MA Y had given Resident #43 the heart medication, the medication would lower the heart rate more, and Resident #43's heart could stop, and the resident would pass away. ADON B said she would be the person to monitor the medication aides. During an interview on 11/15/2024 at 10:41 a.m., NP K said resident #43 had been under her in the facility since 2023. NP K said MA Y should have held Resident #43 heart medication if the heart was less than 60. NP K said the medication would lower Resident #43's heart rate, and it could kill Resident #43 if it was given when the heart was lower than the perimeter. Record review of the facility pharmacy policy and procedure manual 2003, Revised October 25, 2017, on medication administration procedures reflected in part . #20 . the five rights of medication administration should be adhered to 1. Right drug, 1. Right dose. 3. Right resident, 4. Right time, and 5. Right route . Record review of the facility medication aide proficiency revealed #12. Observes special parameters and MA Y signed the medication aide proficiency on 04/03/21.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35897 Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement. The facility failed to ensure foods were dated as opened/prepared discarded after used by date /time. These failures could place residents at risk of food borne illness and disease. Findings Included: Observation of the facility kitchen refrigerator on 11/12/24 at 8:15 AM revealed the following: 1. An open box of cream cheese dated 10/30/24 with no use date 2. Sliced deli meat in a plastic bag in the refrigerator dated 11/01/24 3. Sliced Swiss Cheese in a plastic bag in the refrigerator dated 11/01/24 4 Shredded Mozzarella cheese in a plastic bag in the refrigerator dated 10/15 5. Shredded Mozzarella cheese in a plastic bag in the refrigerator dated 11/06/24 6. Sliced deli ham in a plastic bag in the refrigerator and no label no date. 7. Canned beets in a plastic container in the refrigerator dated 11/05/24 and a use by date of 11/12/24 8. Beef stew in a plastic container in the refrigerator dated 11/4/24 and a use by date of 11/07/24 In an interview with the Dietary Food Service Manager on 11/12/24 at 8:20 AM, revealed that she was responsible to make sure dietary staff are labeling and dating food that have to be used later. Also, staff had to discard food prior to expiration date or used by date. She stated she or the designee, shall be responsible for checking the refrigerator daily for food items that were expiring, and shall be discarded prior to expiration date. Record review of facility's policies and procedures for Food Safety dated 2012 reflected in part . perishable opened food shall be used with in 7 days or less, to be in compliance to code 2 with the Texas Food Establishment rules.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 35897 Based on observation, interview, and record review the facility failed to dispose of garbage and refuse properly for 1 of 2 dumpster reviewed for food and nutrition services. -The facility failed to ensure the dumpster door was closed at all times when no one was dumping garbage. This failure could place residents at risk of infection from improperly disposed garbage. Findings include: Observation on 11-12-24 at 8:45 am, revealed the facility's dumpster area, which was in the lot behind the dietary department had a commercial -size dumpster 3/4 full of garbage and the dumpster door was open. In an interview on 11-12-24 at 8:45 am, with the Director of Food and Nutrition, she stated the dumpster door should not be left open when not in use to prevent bugs, flies, rodents getting in the dumpster and from entering facility. She stated housekeeping, and nursing also discarded their waste garbage in the dumpster. It was the responsibility of staff from dietary, nursing and housekeeping for ensuring the dumpster doors are kept closed when not in use. Interview with the Administrator on 11/15/24 at 2:30 PM revealed that the facility did not have a policy and procedure on disposal of garbage and refuse.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #45, Resident #9 and Resident #5) of 8 residents reviewed for infection control. 1. The facility failed to have infection control signage on Resident #45's door entrance to alert staff and visitors in preventing the development and transmission of infections. 2. The facility failed to label and store Resident #9's personal care item at sink area of a semi-private room shared with Resident #5. These failures placed residents, staff and visitors at risk for cross contamination, unwanted infections, and decease in quality of life. Findings Resident #45 Record review of Resident #45's factsheet dated [DATE] revealed a [AGE] year-old male admitted to the NF on [DATE]. Resident #45 diagnoses included the following: chronic kidney disease, functional quadriplegia (to be completely unable to move due to severe disability from another medical condition), heart disease, pressure ulcers (injury to the skin resulting from prolong pressure on the skin) stage 4 to the sacral (lower back at the base of the spine), buttock (back of the hip which a person sits), and colostomy (opening in the stomach wall to allow stool to drain into a bag or pouch). Record review of Resident #45's MDS dated [DATE] reflected that resident had a BIMS score of 10 indicating that resident's cognition was moderately impaired. Further review of section H (bladder and bowel) was coded 9 not rated (resident had a catheter for urinary incontinence). Record review of Resident #45's Physician's Orders for the month of [DATE], [DATE], and [DATE] reflected the following orders: -Dated [DATE] Change Foley catheter using a 16Fr, 10ml bulb. -Dated [DATE] Flush IV midline with 10 ml of NS. -Dated [DATE] Ceftriaxone 1 gm intravenous once daily. -Dated [DATE] Vancomycin 750mg/150ml intravenous for pressure sores with osteomyelitis (inflammation of the bone caused by infection) until [DATE] two times a day. Record review of Resident #45's Comprehensive care Plan dated [DATE] and revised on [DATE] reflected that resident was care planned for enhanced barrier precautions with the included interventions: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Posting at the resident's room entrance indicating the resident is on enhanced barrier precautions. -Gowns and gloves should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, or other high-contact activity. Observation on [DATE] at 9:00 a.m. revealed Resident #45's door was closed. Outside of the resident's doorway entrance was a 3-bin plastic container with PPE inside that consisted of disposable gowns and gloves. There was no signage on the resident's door. Interview on [DATE] at 9:00 a.m. Medication Aide X said Resident #45 was on precautions and that the staff needed to wear PPE before entering resident room. Observation and interview on [DATE] at 9:05 a.m. revealed CNA C coming out of Resident #45's room. CNA C said she believed the reason why Resident #45 had PPE outside of doorway was because the resident had a gastrostomy tube . CNA C was coming out of resident room caring 2 large bags of soiled material in plastic bags. Observation on [DATE] at 9:06 a.m. revealed Resident #45 resting quietly in bed to his left side with eyes closed. The resident was resting on an air mattress. The resident had an indwelling Foley catheter hanging on the right side of bed to gravity. On the right side of the resident's bed was an IV pole. Hanging on the IV pole was a 100ml bag with the medication on the label that reflected ceftriaxone 1gm intravenous. The medication was infusing to his right extremity IV via dial-a-flow. Observation on [DATE] at 8:15 a.m. revealed Resident #45's room had an infection control signage on the door. Interview on [DATE] at 10:32 a.m. CNA C said she worked at the NF 6 a.m. - 6 p.m. shift. CNA C said it was the responsibility of the nurses and ADON to ensure infection control signage were on the resident doors that had Foley catheter bags, colostomy, wounds, etc. Interview on [DATE] at 10:38 a.m. ADON B said it was the responsibility of the Infection Control Nurse as well as herself to ensure residents with indwelling Foley catheters, gastrostomy feedings. iIntravenous lines, wounds, colostomy bags, etc. had infection control signage on their doors to prevent the spread of infections. ADON B said the signage was not only for the staff but visitors as well so that all would be informed about wearing PPE to prevent spread of any infections. Interview on [DATE] at 10:30 a.m. LVN M said she was Resident #45's nurse. LVN M said all residents with wounds, a colostomy bag, Foley catheters, gastrostomy tubes, and intravenous lines, the staff was supposed to wear PPE before entering the room to provide care for the resident to prevent the spread of infections. LVN M said that was required by the state. LVN M said it was the infection control nurse that was responsible for making sure all necessary signage was on the doors of residents regarding infection control. (continued on next page)

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	11/15/2024

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 3:11 p.m. ADON A said he was also the NF Infection Control Nurse. ADON A said residents that had indwelling devices such as Foley catheters, gastrostomy tubes (surgically inserted tube in the stomach to allow liquid nutrition, fluids, and medications into the stomach), IV's, colostomy bags, dialysis ports, and wounds had to be on enhanced barrier precautions to prevent the spread of infections by wearing PPE that consisted of gloves and gowns when providing direct care for the resident. ADON A said if the infection control signage was not on the resident doors, it placed all involved in the resident's care as well as visitors encountering the resident at risk for the spread of infections. ADON A said he was responsible for ensuring that signage was on the doors of these residents. ADON A said Resident #45 had recently changed rooms. ADON A said the staff had been in-serviced on infection and how to prevent the spread of infections. Interview on [DATE] at 4:38 p.m. the DON said residents that had Foley catheters, dialysis catheters, wounds, gastrotomy tubes, tracheostomy (surgical procedure that creates an opening in the neck to provide an airway and remove secretions form the lungs), colostomy bags, etc. should have infection control signage on their doors. The DON said that was done to protect the staff and visitors from exposure to bacteria/infections and to alert the staff to wear PPE when providing direct care to the resident. Resident #9 and Resident #5: Record review of Resident #9's face sheet, dated [DATE], reflected resident was an [AGE] year-old female with an admitted [DATE] and, a readmitted [DATE], with diagnoses which included: schizophrenia and dementia. Record review of Resident #5's face sheet, dated [DATE], reflected an [AGE] year-old female with an admitted [DATE] and, a readmitted [DATE], with diagnoses which included: dementia, psychotic disturbance, mood disturbance, and anxiety. Observation on [DATE] at 09:14 a.m. reflected Resident #9 in bed-A and a second bed, bed-B with personal property. A hairbrush was observed sitting at the sink area in the room with no identifiable name or labeling. During an interview on [DATE] at 09:14 a.m., Resident #9 she stated that she had a roommate (Resident #5) who was not in the room at that time. She stated that the hairbrush at the sink was hers. She stated a staff placed the brush at the sink that morning after brushing her hair. She stated that she was not able to brush her own hair due to her physical inabilities. She stated that she was unable to provide the staff's name who brushed her hair. During an interview on [DATE] at 04:20 p.m., with the ADMN and DON, the DON stated that Resident #9's hairbrush should be in a plastic bag and labeled and not to be observed as community property. The ADMN stated that Resident #9's hairbrush should not have been sitting at the sink the semi-private room. She stated that they have been trying to remind CNAs to keep resident's personal items labeled. She stated that Resident #9's hairbrush was not a community brush and should not have been placed at the sink unlabeled. She stated that the CNAs have been educated about labeling resident's personal items. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:21 p.m., RN O stated that she was the nurse for Resident #9 and Resident #5. She stated she had just returned to the facility and worked last in October of 2024. She stated she was not aware that Resident #9's hairbrush was placed at the sink of a semi-private room. She stated that it was her expectations that all staff including CNAs who became aware of resident's personal items would place the personal item at that residents' bedside in a box with their other personal items. She stated the reason items were to be keep separate and labeled was to prevent cross contamination. Record review of the policy titled Infection Control Plan updated date of ,d+[DATE] revealed: Overview Infection Control. The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Infection Control Program. Asked and not received, a facility policy specific to resident's personal property in resident rooms.