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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents have a right to a dignified existence and treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 3 (Resident #41) of 18 residents reviewed for dignity.-RN Z was providing Resident #41's bolus feeding with the door open and blinds opened on 02/25/2026.- RN Z did not provide Resident #67 privacy during insulin administration on 02/25/26.-LVN AF did not provide privacy during medication administration via G Tube to Resident #30 on 2/24/26These deficient practices could lead to psychosocial harm due to feelings of low self-esteem and/or embarrassment regardless of resident cognition. Resident #41Record review of Resident #41's face sheet last captured 02/26/2026, she was an [AGE] year-old female originally admitted on [DATE] and last re-admitted on [DATE]. Her medical diagnosis was gastronomy status (has a gastrointestinal tube to provide nutrition and medication from opening straight into stomach).Record review of Resident #41's Order Summary Report dated 02/26/2026, she had active orders with a start date of 02/04/2026 for: enteral (through gastrointestinal tube) feed order four times a day Isosource 1.5 @ 50 ml/hr for 5 hours then 1 hr bowel rest and four times a day water flush 250 mls.Observation and interview on 02/25/2026 at 4:08pm, RN Z was observed providing water flush for Resident #41 with the door open and curtain not pulled during the procedure. RN Z was observed letting water flush by gravity. Resident #41's head was turned toward the window, and she did not appear to be in any discomfort. RN Z stated that she should have pulled the curtains which she usually did but she was unsure why she did not pull the curtains that day. RN Z said it would not make residents feel good to know that others were watching their procedures. Attempted interview with Resident #41 on 02/26/2026 at 4:19pm, she appeared to be sleeping and comfortable in bed with no respiratory distress. Resident #67 Record review of Resident #67's face sheet, dated 2/24/2026, reflected the resident male, and admitted to the facility on [DATE] readmitted on [DATE] with a diagnosis of type 2 diabetes mellitus with diabetic neuropathy.Record review of Resident #67 's quarterly MDS, dated [DATE], reflected the BIMS score was 3 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was totally dependent on bed repositioning and personal hygiene. Further record review of the MDS indicated Resident #67 was incontinent to bladder and bowel. Record review of Resident's #67's care plan, dated 12/24/2025, reflected the following: I have ADL self-care performance deficit and totally dependent on staff for all ADLs and requires assistance with activities of daily living due to decreased physical and functional mobility secondary to weakness and multiple medical comorbidities.During observation of East wing nurse's medication cart parked on the hallway by the main dining room on 2/25/26 at 4:39PM, RN Z was by the medication cart. Resident #67 was propelling himself by wheelchair on the hallway, RN Z stopped Resident #67 by the medication by the cart, picked the accu check machine (machine used to measure blood sugar levels), checked Resident #67's blood glucose and picked up Humalog Kwik pen (Insulin) and opened the resident's shirt and administered to his abdomen. There were residents going by toward the dining (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455703	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room for dinner.Interview with RN Z on 2/25/26 at 4:44 PM RN Z said she always checked blood glucose before residents go to the dining room and she did not think it was wrong.Resident #30Record review of Resident #30's face sheet dated 02/24/26 revealed a [AGE] year-old male was admitted on [DATE] and re-admitted on [DATE]. Resident #30 had a diagnosis of gastrostomy (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach)Record review of Resident #30's admission MDS, dated [DATE], reflected the BIMS score was 5 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was totally dependent in bed repositioning and personal hygiene. Further record review of the MDS indicated Resident #30 was incontinent to bladder and bowel. Record review of Resident #30's care plan dated 12/24/25 reflected Resident #30 has an ADL self-care performance deficit; the goal was resident will improve current level of function through the review date:Record review of Resident #30's Physician's Orders, dated 02/1/26, reflected the following orders: Had NPO (Nothing per oral) only GT: Bolus give 1 can Isosource 1.5 five times a day. Check for residual every shift if > 150cc 's, stop feeding and notify MD every shift. Flush GT with 30 ml water before and after administration of meds, flush with 10 cc between each medication every shift.Observation of medication administration on 2/24/26 at 9:40AM LVN AF did not pull the privacy curtain. Resident #30 was lying on the bed and was visible from the hallway. LVN AF aspirated 58ml of milky fluid and pour it in a cup, then aspirated additional 30 mls milky fluid via G Tube, LVN AF the plunge it via G Tube to Resident #30's stomach and then aspirated 58 mls in the cup and plunge it via G Tube LVN AF aspirated Lacosamide 100 mg 1 tablet after crushing it and Polyethylene Glycol 3350 (17gm) dissolved in water in 60 mls syringe and plunged via Resident #30's G-Tube.Interview on 2/26/26 at 10:15AM LVN AF said she forgot about providing privacy and will be careful.Interview with the Administrator and DON on 02/25/206 at 5:35pm, the Administrator said that privacy curtains should be utilized during procedures. Residents having procedures done without them could have made them feel uncomfortable and not have privacy. Record review of the facility's policy on resident rights, undated, read in part, A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.Privacy and confidentiality .1. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits.

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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure the assessment accurately reflected the residents' status for 2 of 18 residents (CR #75 and Resident #60) whose assessments were reviewed, in that:-CR#75's behavior was not reflected on her initial MDS dated [DATE]. -Resident #60's fall on 10/15/2026 was not documented in her most recent quarterly MDS assessment on 11/29/2026.These failures could place residents at-risk of not receiving the care and services to prevent aggressive behavior or injury due to inaccurate assessments. #75 Record review of CR#75's clinical records dated 2/24/2026 revealed she was a 76-year female who was admitted to the facility on [DATE]. Her diagnoses included Non-Alzheimer's dementia (memory loss), dysphagia (swallowing difficulties), depression (feeling of unhappiness and hopelessness), respiratory failure (condition where the blood does not have enough oxygen or too much carbon dioxide), pain (unpleasant sensory and emotional experience with tissue damage), and altered mental status (a change in mental function), chronic obstructive pulmonary disease (disorder of the lungs and airway disease that restrict breathing), muscle weakness (loss of muscle function). Record review of CR #75 admission MDS dated [DATE] Section C, 500 revealed the resident had a BIMS score of 10 of 15 indicating she was cognitively aware. For Section E200: she was coded as having no behavior. Record review of the nurse's progress notes from January 2026 indicated the following dated:1/06/2026: CR #75 refused to eat, stating she was not hungry and did not like the food.1/10/2026 at 1:38 am CR #75 resident out of bed screaming and yelling.1/10/2026 at 1:34 pm CR#75 acting very agitated cursing staff, kicking walls and throwing things on floor.1/11/2026 CR#75 refused care and breathing treatment. Record review of CR #75 care plan initiated on 1/6/2026 was not review and revised to address the resident behavior of refusing to eat, refusing care and treatment, screaming and yelling, cursing at staff, kicking walls and throwing things on the floor.Resident #60Record review of Resident #60's face sheet dated 02/26/2026 reflected a [AGE] year-old female originally admitted on [DATE] and last re-admitted on [DATE]. Her medical diagnoses included unspecified dementia (declining brain function related to thinking and judgement that is severe enough to impact daily life without behavioral disturbance, psychotic disturbance, mood disturbance), muscle weakness, Schizoaffective Disorder (a mental health condition that is marked by hallucinations and delusions and mood dysfunction), extrapyramidal and movement disorder (drug-induced muscle disorder with symptoms including involuntary muscle contractions or repetitive movements) and history of falling. Record review of Resident #60's Quarterly MDS dated [DATE], she had a BIMS score of 04, indicating severe cognitive impairment related to thinking and memory. She required total assistance with toileting, footwear and substantial assistance with dressing, personal hygiene and substantial assistance with most mobility in bed. Resident #60 was coded as having no falls since the last quarterly assessment. Record review of Resident #60's falls in the Incident report last updated 02/24/2026, indicated Resident #60 had a fall on 10/15/2025.Record review of Resident #60's progress notes dated 10/15/2025 at 1:20pm Resident #60 was documented by LVN BN as sitting on her bottom on the floor.The patient states she put her feet on the floor and slipped down to her bottom. She was assessed for injuries with none noted. No complaints of pain at this time. Interview on 2/26/2026 at 3:38pm with the MDS Coordinator AK said, she was new to the facility and was working on MDS and care plan issues. She said when she completes the MDS she reviewed the nurse's notes; interviewed staff and observed residents. She stated CR#75 MDS was coded incorrectly. She was not the one who does the behavior section of the MDS. She said social service usually does that section. She said if the residents had behavior issues it should be documented on their MDS. MDS Coordinator AK said Resident #60's fall on 10/15/2025 should have been documented in her most recent Quarterly MDS on 11/29/2025 as it was within the 3-month lookback period. MDS audits were done by the MDS Coordinator and Regional MDS staff. Falls should be documented and (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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	modified MDS forms could be sent in if needed. In an interview with SW on 2/26/2026 at 4:00pm she said she was new to the facility and has not done any MDS. She said the social worker usually do the behavior section. She said to complete her MDS she checks the nurse's notes, observes residents, interviews the CNAs, and interviews the nurses. She said at that point she would complete her section of the MDS. She said the care plan should be updated to address the resident's current condition. In an interview with the Regional Nurse on 2/26/2026 at 4:33pm he said the person doing the MDS should talk to the nurses and CNA's and observe residents and complete assessments before documenting the MDS. He said the MDS nurses were responsible for the accuracy of MDS's. The Regional Nurse said that if behaviors or falls were not documented accurately in residents' MDS then they would not have the right interventions in place to prevent injuries or further falls. Record review of the facility's policy on MDS Assessment Data Accuracy dated 08/2025, it read in part, Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: 1. The assessment accurately reflects the resident's status. 2. A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals. 3. The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.

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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 20%, based on 7 errors out of 35 opportunities, which involved 2 of 7 residents (Resident #30, and Resident #6) and --2--- of ---3-- staff observed during medication administration reviewed for medication errors. 1. LVN AF failed to administer Polyvinyl Alcohol-Povidone PF Ophthalmic Solution 1.4-0.6 % (used to temporarily relieve dry, burning, itchy, or irritated eyes by wind, sun or environment) lower high fluid pressure inside the eye) Ophthalmic Solution 0.5 % eyedrops ophthalmic drops, on 2/24/26, initialed as given to Resident #30, when it was not given.2. LVN AF failed to administer Protonix Tablet Delayed Release 40 MG (Pantoprazole Sodium) Give 1 tab (used to treat gastric reflux) on 2/24/26, initialed as given to Resident #30, when it was not given. 3. LVN AF failed to administer QUEtiapine Fumarate Oral Tablet 50 MG (Used to treat mental health conditions by balancing neurotransmitters in the brain) Give 1 tablet via G-Tube two times a day for Schizophrenia on 2/24/26, initialed as given to Resident #30, when it was not given. 4. LVN AF failed to administer Ascorbic Acid Oral Tablet 500 MG (used water-soluble nutrient and essential antioxidant that the body needs) Give 1 tablet via G-Tube one time a day for Supplement on 2/24/26, initialed as given to Resident #30, when it was not given. 5. LVN AF failed to administer Thiamine HCl Oral Tablet 100 MG (an essential nutrient that helps your body convert food) (especially carbohydrates) into usable energy) Give 1 tablet via G-Tube one time a day for Supplement on 2/24/26, initialed as given to Resident #30, when it was not given. 6. LVN AF failed to administer Olanzapine oral (used to treat schizophrenia and bipolar disorder) tablet 5 mg every day on 2/24/26, initialed as given to Resident #30, when it was not given. 7. RN W failed to administer on 2/24/26, Carb/Levo10-100 mg (used to treat the symptoms of Parkinson's disease) was not given in totality and was initialed as given to Resident #30. These failures could place residents at risk for increased negative side effects, and a decline in health. 1. Record review of Resident #30's face sheet, dated 02/24/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #30 had diagnoses which included: iron deficiency anemias (not having enough healthy red blood cells to carry oxygen to the body's tissues), anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry or fear that interferes with daily life, unlike normal, temporary stress), hypertension (blood vessels is too high), heart failure (heart does not pump enough blood for the body's needs), hyperlipidemia (abnormally high fat and lipids), Parkinson's disease (progressive neuro degenerative disorder, not a condition with a functional use. It involves the death of brain cells that produce dopamine), gastro-esophageal reflux disease without esophagitis (gastric reflux), hemiplegia and hemiparesis (the severe or total paralysis one side of the body) following cerebral infarction (blood flow blocked to part of the tissue of the brain resulting to tissue dying due to a lack of oxygen and nutrients) affecting right dominant side, chronic kidney disease (cannot properly filter waste and extra fluid from your blood, causing toxins to build up), dialysis (treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to), essential (primary) hypertension (high blood pressure), heart failure (when the heart cannot pump enough oxygen - rich blood to meet the body's needs), hypokalemia (lower than normal potassium level in the bloodstream), dementia (decline in thinking, remembering, and reasoning), and gastrostomy (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach). Record review of Resident #30's admission MDS, dated [DATE], reflected the BIMS score was 5 out of 15, which indicated the resident had severe cognitive impairment. The resident was totally dependent on bed repositioning and personal hygiene. Resident #30 was incontinent to bladder and bowel. Record review of Resident #30's care plan, dated 12/24/25, reflected Resident #30 had an ADL self-care performance deficit, the goal was resident will (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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	improve current level of function through the review date: Resident #30 required total assist with one to two person for bathing/showering, dressing, bed mobility, personal hygiene, toilet use and follow principles of infection control and universal precaution to incontinent care. Record review of Resident #30's Physician order, dated 2026, reflected in part:-2/6/26 had Polyvinyl Alcohol-Povidone PF Ophthalmic Solution 1.4-0.6 % (Polyvinyl Alcohol-Povidone (Ophth) Instill 1 drop in both eyes two times a day for Lubricant-2/9/26 had Protonix Tablet Delayed Release 40 MG (Pantoprazole Sodium) Give 1 tablet by mouth two times a day for esophagitis-1/26/26 had Quetiapine Fumarate Oral Tablet 50 MG (Quetiapine Fumarate) Give 1 tablet via G-Tube two times a day for Schizophrenia-1/26/26 had Ascorbic Acid Oral Tablet 500 MG (Ascorbic Acid) Give 1 tablet via G-Tube one time a day for Supplement-1/26/26 had Thiamine HCl Oral Tablet 100 MG (Thiamine HCl) Give 1 tablet via G-Tube one time a day for Supplement.-2/6/26 had Olanzapine oral tab 5 mg QD. Give 1 tablet via G-Tube one time a day for Schizophrenia (a chronic, severe brain disorder that causes people to interpret reality abnormally) Record review of Resident #30's MAR, dated 2/24/2026, reflected in part . Olanzapine oral tab 5 mg, Ascorbic Acid Oral Tablet 500 MG, Thiamine HCl Oral Tablet 100 MG, Quetiapine Fumarate Oral Tablet 50 MG, Protonix Tablet Delayed Release 40 MG and Polyvinyl Alcohol-Povidone PF Ophthalmic Solution 1.4-0.6 % was initialed as given via G-Tube in AM. Observation of medication administration on 2/24/26 at 9:40 AM by LVN AF revealed LVN AF gave Lacosamide 100 mg 1 tablet after crushing it and Polyethylene Glycol 3350 (17gm) dissolved in water and administered via Resident #30's G-Tube did not flush with GTube before and after medication with water. LVN AF plunged medication via tub, did not allow it to flow by gravity. Interview with LVN AF on 2/24/26 at 9:35AM, before administering medication Resident #30, LVN AF said she administered Resident #30's blood pressure medication only and his bolus feeding via GT because the blood pressure was too high BP 197/102 and pulse at 77. LVN AF said she was going to medicate with the rest of Resident #30's medication, and she went to resident room, did not close the door, did not wear PPE while administering the medication. Interview on 2/26/26 at 10:15AM with LVN AF revealed she only gave Resident #30 two medications via G Tube for his blood pressure. LVN AF said she gave the BP medication earlier because the BP was high, she already gave the resident the BP medications through bolus feeding. The LVN only gave 2 medications because he had a lot of blood pressure medications. LVN AF did not give any response to all medications initialed as given when it was not given during medication administration and not closing the door. 2. Record review of Resident #6's face sheet, dated 2/24/26, revealed an [AGE] year-old female who was admitted to the facility on [DATE] and was readmitted [DATE]. Resident #6 had diagnoses which included: hyperlipidemia (high lipid/fat in the blood), anemia, diabetes mellitus (high glucose in the blood), essential (primary) hypertension (high blood pressure), heart failure (when the heart cannot pump enough oxygen - rich blood to meet the body's needs), Parkinson's disease without dyskinesia, without mention of fluctuations, contracture, left hand(m), dementia (decline in thinking, remembering, and reasoning), gastrostomy (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach), glaucoma (high fluid pressure inside the eye) and protein-calorie malnutrition. Record review of Resident #6's quarterly MDS assessment, dated 1/30/26, reflected a BIMS score of 3 out of 15, which indicated severe cognition impairment. She required total assistance from staff with ADL's care. Record review of Resident #6's physician order for 2/1/2024 revealed in part . Carbidopa-Levodopa Oral Tablet 10-100 MG (Carbidopa-Levodopa) Give 1 tablet via PEG-Tube three times a day related to Parkinson's Disease without Dyskinesia, without mention of fluctuations. Record review of Resident #6's physician order for February 2026 revealed in part . Carbidopa-Levodopa Oral Tablet 10-100 MG (Carbidopa-Levodopa) Give 1 tablet via PEG-Tube three times a day. During an observation on 2/24/26 at 12:50 p.m., revealed RN W punched 1 tablet of Carbidopa-Levodopa Oral Tablet 10-100 MG into a medication cup, crushed it and diluted with 15mls of water and dissolved and administered it via GT. RN W was about to discard the medication cups with a substantial amount of Carbidopa-Levodopa Oral Tablet 10-100 (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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MG residual left. The state surveyor intervened after showing RN W the Carbidopa-Levodopa Oral Tablet 10-100 MG left in the medication cup. RN W said, I will give it. She then poured 10mls of water and Carbidopa-Levodopa Oral Tablet 10-100 MG to administer in via GT. Interview with RN W on 2/24/26 at 1:10 PM, regarding not administering all Carbidopa-Levodopa Oral Tablet 10-100 MG, she said she would be careful. She knew Carbidopa-Levodopa Oral Tablet 10-100 MG not given in totality would cause forgetfulness or confusion and constipation. In an interview with the Regional Nurse on 2/26/26 at 2:38 PM, revealed her expectation for medication administration was for nurses to administer medication as ordered by the physician. The Regional Nurse said the facility had AM medication pass times to 6:00 AM to 10:30 AM and if the state surveyor did not observe medications given 2/24/2026 in the AM, he could not defend it. He said the DON always monitored the staff periodically and the pharmacist also monitored the staff. The last time the pharmacist monitored staff was in November 2025 In an interview on 2/26/26 at 2:40 PM, the Administrator said she expected nursing staff to give medications timely, correctly, and according to the physician orders. Record review of the facility's Administering Medications policy, updated 3/2024 revealed in part Policy Statement Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation. The Director of Nursing Services will supervise and direct all nursing personnel who administer medications and/or have related functions. Medications must be administered in accordance with the orders, including any required time frame. Record review of the facility's medication administration updated 3/2024 MED - PASS, Inc reflected in part . Medications are administered in a safe and timely manner, and as prescribed . Record review of the facility's policy on administering medications through an enteral tube, updated 3/2024, reflected in part .Purpose . the purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube .

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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
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. Based on observation, interview 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.1. The facility failed to ensure leftover food past the use date was discarded. 2. The facility failed to ensure leftover food to be used later was stored at a safe temperature.3. The facility failed to ensure frozen food thawed properly. 4. The facility failed to put sufficient sanitizing solution in the 3-sink compartment in the kitchen.5. The facility failed to fix broken tiles in the kitchen.6. The facility failed to store in a separate container a scoop used for food bins in the kitchen storeroom.7. The facility failed to ensure food was stored 6 inches off the floor These failures could place residents t risk of foodborne illness, disease from food handling and pest or vermin. Observation of the facility kitchen on 02/24/2026 at 8:45 AM revealed the following. 1. Thawing frozen chicken in an 8-inch-deep bucket, immersed in water that was 78 degrees Fahrenheit in the sink, measured by the Dietary Food Service Manager.2. A pan of mechanical soft sausage was 131.1 degrees Fahrenheit on the steam table.3. A pan of breakfast sausage with a used by date of 2/13/2026 was in the fridge. 4. A pan of Salisbury steak with a use by date of 1/7/2026 was in the walk-in fridge. 5. An open package of shredded cheddar cheese with no used by date was in the walk fridge. 6. An open package of sliced Swiss cheeses with no use by date was in the walk-in fridge. 7. 1 case of frozen ground beef was in the walk-in freezer on the floor. 8. 2 cases of fruit cocktail were on the storeroom floor.9. One trayful of milk was at 46.5 degrees Fahrenheit and one trayful of cranberry juice was at 53.4 degrees Fahrenheit on the serving lunch table. 10. 2 lunch dialysis bags with respective used by dates of 2/11/2026 and 2/13/2026.11. A pan of corn niblets were in the walk-in fridge did not have date opened and date discarded labelled on the item.12. The 3- Sinks compartment did not have enough sanitizing solution in the kitchen. The sink was currently in use. When the Dietary Food Service Manager used a strip of paper to measure amount in the solution, it was an insufficient amount to clean the pots and pans currently in the sink.13. The kitchen floors and walls had several broken tiles with openings in the kitchen. In an interview with the Dietary Food Service Manager on 02/07/2026 at 8:45 AM, she stated the following foods were stored in the refrigerator to be used for a later date and should have been discarded prior to use by date. She stated the leftover food with danger food temperature between 40 degrees Fahrenheit to 140 degrees Fahrenheit should have been discarded. She further stated she was responsible to ensure the department met requirements for safe food storage and handling and the dietary staff would receive in-services on proper handling, storing, and dating leftover food for compliance.Record review of the facility's policies and procedures for Food Safety, dated 03/30/23, it read in part .potentially hazardous leftover foods are properly covered, labeled, dated, and refrigerated immediately. They are discarded on the used by date unless otherwise indicated. For food storage, keep off floor.

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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and 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 7 of 12 residents (Residents #6, #30, #28, #15 #7, #35 and #5) and 5 of 5 staff (CNA J, MA T, LVN AF ,RN W, RN CC) and 1 of 2 linen closets (Linen Closet B) reviewed for infection control. 1. RN CC failed to wipe the blood pressure cuff between Resident #7, Resident #35 and Resident #5 on 2/24/26.2. MA T failed to wipe the blood pressure cuff between Resident #28 and Resident #15 on 2/24/26.3. LVN AF failed to wear PPE when administering Resident #30's G-Tube medications, who was on EBP, on 2/24/26.4. RN W failed to wear PPE when administering Resident #6's G-Tube medications, who was on EBP, on 2/24/26.5. The facility failed to ensure CNA J cleaned in between and around Resident #4's buttocks and failed to open the labia to clean during incontinent care on 2/26/26.6. The facility failed to ensure Linen Closet B did not contain an unknown staff members black purse and grey zip-up hoodie, on 02/26/2026.These failures could place residents at risk for spread of infection and cross contamination and decrease in quality of life. Findings include:1. During an observation on 02/24/2026 at 7:15 a.m. revealed RN CC performed a blood sugar test and blood pressure checks. RN CC did not wipe the blood pressure cuff in-between uses after checking Resident #7, Resident #35 and Resident #5's blood pressure.During an interview on 02/24/2026 at 11:51 a.m. with RN CC she said she forgot to wipe the blood pressure cuff between residents, she knew better because it was for infection control and the DON had given them a lot of in-services on wiping out BP cuff in-between residents.2. During an observation of medication administration on 02/24/2026 at 8:15 a.m., MA T did not wipe the blood pressure cuff in-between and after checking Resident #28 and Resident #15's blood pressure. During an interview on 02/24/2026 at 9:21 a.m., MA T said she forgot and the DON gave them a lot of in-services on wiping the BP cuff in-between residents .MA T said it could cause cross-contamination if she did not wipe the cuff between residents.3. Record review of Resident #30's face sheet, dated 02/24/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #30 had diagnoses which included: iron deficiency anemias (not having enough healthy red blood cells to carry oxygen to the body's tissues), anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry or fear that interferes with daily life, unlike normal, temporary stress), hypertension (blood vessels is too high), and heart failure (heart does not pump enough blood for the body's needs), hyperlipidemia (abnormally high fat and lipids), Parkinson's disease is (progressive neuro degenerative disorder, not a condition with a functional use. It involves the death of brain cells that produce dopamine), gastro-esophageal reflux disease without esophagitis (gastric reflux), hemiplegia and hemiparesis (the severe or total paralysis one side of the body) following cerebral infarction (blood flow blocked to part of the tissue of the brain resulting to tissue dying due to a lack of oxygen and nutrients) affecting right dominant side, chronic kidney disease (cannot properly filter waste and extra fluid from your blood, causing toxins to build up) and dialysis (treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to). essential (primary) hypertension (high blood pressure) heart failure (when the heart cannot pump enough oxygen - rich blood to meet the body's needs), hypokalemia (lower than normal potassium level in the bloodstream), dementia (decline in thinking, remembering, and reasoning), and gastrostomy (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach)Record review of Resident #30's admission MDS, dated [DATE], reflected the BIMS score was 5 out of 15, which indicated the resident had severe cognitive impairment. The resident was totally dependent to bed repositioning and personal hygiene. Resident #30 was incontinent to bladder and bowel . Record review of Resident #30's care plan, dated 12/24/25, reflected Resident #30 had an (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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADL self-care performance deficit, the goal was resident would improve current level of function through the review date: Resident #30 required total assist with one to two person for bathing/showering, dressing, bed mobility, personal hygiene, toilet use and follow principles of infection control and universal precaution to incontinent care.Observation of medication administration on 2/24/26 at 9:40AM by LVN AF revealed LVN AF gave Lacosamide 100 mg 1 tablet after crushing it and Polyethylene Glycol 3350 (17 gm) dissolved in water and administered via Resident #30's G-Tube. Resident #30's door had EPB posted. LVN AF did not wear a gown or gloves.Interview on 2/26/26 at 10:15AM with LVN AF said for not using EBP while administering medication to Resident #30, she did not know she had to put on gown because she has been doing traveling nurse and had not been doing that before and orientation when the surveyor brought it to her attention that she did not follow EBP protocols.4. Record review of Resident #6's face sheet, dated 2/24/26, revealed an [AGE] year-old female who was admitted to the facility on [DATE] and was readmitted on [DATE]. Resident #6 had diagnoses which included: hyperlipidemia (high lipid/fat in the blood), anemia (low blood count), diabetes mellitus (high glucose in the blood), essential (primary) hypertension (high blood pressure), heart failure (when the heart cannot pump enough oxygen - rich blood to meet the body's needs) and Parkinson's disease without dyskinesia, without mention of fluctuations, contracture, left hand, dementia (decline in thinking, remembering, and reasoning), and gastrostomy (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach), glaucoma (high fluid pressure inside the eye) and protein-calorie malnutrition.Record review of Resident #6's quarterly MDS assessment, dated 1/30/26, reflected a BIMS score of 3 out of 15, which indicated severe cognition impairment. She required total assistance from staff with ADL's care.Record review of Resident #6's physician order dated 2/1/2024 revealed in part . Carbidopa-Levodopa Oral Tablet 10-100 MG (Carbidopa-Levodopa) Give 1 tablet via PEG -Tube three times a day related to Parkinson's Disease without Dyskinesia, without Mention of Fluctuations.Record review of Resident #6's physician order for February 2026 revealed in part . Carbidopa-Levodopa Oral Tablet 10-100 MG (Carbidopa-Levodopa) Give 1 tablet via PEG-Tube three times a day.During an observation on 2/24/26 at 12:50 p.m. revealed RN W punched 1 tablet of Carbidopa-Levodopa Oral Tablet 10-100 MG into a medication cup, crushed it and diluted with 15mls of water, dissolved and administered via GT. Resident #6's door had an EBP sign posted. RN W did wear PPE, including gown and gloves, before administering G Tube medication.Interview with RN W on 2/24/26 at 1:15 p.m. revealed RN W said she forgot to wear PPE during G-Tube medication administration, and she knew not wearing PPE could cause infection to the resident and herself.5. Record review of Resident #4's face sheet, dated 2/24/2026, reflected the resident was a [AGE] year old female who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included neuralgia and neuritis (intense, often unbearable, stabbing or burning pain that follows the pathway of a damage or irritated nerve), nausea with vomiting, legal blindness, (as defined in USA), hydrocephalus (water in area of brain), other recurrent depressive disorders, polyneuropathy (a condition where multiple nerves outside the brain and spinal cord are damaged simultaneously, causing numbness, tingling or burning pain typically starting in the feet and hands), urinary tract infection and stage 3 sacral pressure ulcer .Record review of Resident #4's quarterly MDS, dated [DATE], reflected the BIMS score was 3 out of 15, which indicated the resident had severe cognitive impairment. The resident was totally dependent on bed repositioning and personal hygiene. Resident #4 was incontinent to bladder and bowel.Record review of Resident #4's care plan, dated 12/24/25, reflected [Resident #4] has an ADL self-care performance deficit, the goal was resident will improve current level of function in through the review date: [Resident #4] required total assist with one to two persons for bathing/showering, dressing, bed mobility, eating, personal hygiene/oral. Toilet use and follow principles of infection control and universal precautions to incontinent care.Record review of Resident #4's MAR reflected she was on antibiotics Ciprofloxacin HCl Oral Tablet 500 MG (Ciprofloxacin HCl on 2/19/26 for 5 days urinary tract (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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection.)Observation of incontinent care performed by CNA J on 2/26/26 at 10:35 AM and assisted by LVN TN XX revealed Resident #4 was lying in bed on her back with a foam wedge. CNA J donned (put on) clean gloves, unfasten the resident's brief which was soaked with urine and feces, used the wet wipes cleaned in-between the buttocks, but did not clean around the buttocks. CNA J placed a brief under Resident #4's buttocks and she then proceeded to clean the perineal area, cleaned the right groin, and she did not open the resident's labia to clean, change gloves she fastened the clean brief then doffed (take off) her dirty gloves.Interview with CNA J on 2/26/26 at 10:36 AM, she said she had been working 2 years, then on PRN she worked 6:00 AM -2:00 PM. She said it was the first time performing incontinent care since came to work on 2/26/26, because she was waiting to change Resident #4's brief when LVN TN XX did her treatment. She stated she did not open the resident's labia to clean and not cleaning around resident buttocks. CNA J said she had in-services bi-weekly about incontinent care.Interview with LVN TN XX on 2/26/26 at 10:58 AM, revealed what she thought CNA J did not do when performing incontinent care. LVN TN XX said CNA J did not open the labia to clean and she did not clean around the buttocks. LVN TN XX stated residents were supposed to be changed every 2 hours and CNA J would need in-services.Interview with CNA J on 2/26/26 at 11:12 AM, she said she thought she messed up. She stated she did not open the resident's labia and didn't clean around the resident buttocks. CNA J said not cleaning Resident #4 well could cause urinary tract infection.Interview with the regional DON on 2/26/26 at 5:10 PM, he said CNA's were to perform incontinent care every 2 hours and as needed. The Regional DON said, he monitored CNAs randomly for incontinent care/infection control .6. Observation and interview with the HKS on 2/26/2026 at 10:59 AM, in Linen Closet B, there were personal staff items which included a small black purse and grey zip-up hoodie hanging on faucet handles along the back wall. There were clean towels, bed sheets and blankets in the closet stacked on the shelves next to the personal items. HKS said those belonged to facility staff, but he did not know whose they were. HKS said staff knew not to put their personal items in the clean closet and they had their own place to store them and this could have caused cross-contamination. HKS took the bag and hoodie and went down the hall .Interview with the Administrator on 2/26/2026 at 4:35 PM, she said staff personal items should be in staff break rooms and not in the clean linen closet due to cross-contamination . Record review of the facility's, undated, Skilled check list, titled Catheter Care-Skill, read in part, 10. With non-dominant hand: Female: Gently retract labia to fully expose urethral meatus and catheter insertion site. Maintain position of hand throughout.14. Using a clean washcloth, clean catheter tubing using one cloth per stroke, in a circular motion. Clean from the most proximal (Closest to the body) to the most distal (Farthest for the body). Continue cleaning in this manner until tubing is closed.Record review of the facility's policy on Infection Control, undated, read in part, Gloving: Gloves are worn for three important reasons: 1. To provide protective barrier and prevent gross contamination of the hands whentouching blood, body fluids, secretions, excretions, mucous membranes, and nonintact skin. The wearing of gloves in specified circumstances will reduce the risk of exposures to blood-borne pathogens and is mandatory for all employees. 2. To reduce the likelihood that microorganisms present on the hands of personnel will be transmitted to residents during invasive or other resident-care procedures that involve touching a resident's mucous membranes and nonintact skin. 3. To reduce the likelihood that hands of personnel contaminated with microorganisms from a resident or a fomite can transmit these microorganisms to another resident; in this situation, gloves must be changed between resident contacts, and hands washed after gloves are removed. 4. Masks, respiratory protection, eye protection, face shields 1. A mask that covers both the nose and mouth and goggles or a face shield are worn by personnel during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions to provide protection of the mucous membranes of the eyes, nose, and mouth from contact transmission of pathogens. The wearing of masks, eye protection, and face shields in specified circumstances is mandatory. 2. A surgical mask is generally worn by personnel to provide protection against spread of infectious large-particle (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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	droplets that are transmitted by close contact and generally travel only short distances (up to 3 feet) from infected residents who are coughing and sneezing. 5. Gowns and protective apparel 1. Gowns and protective apparel are worn to provide barrier protection and reduce the opportunity for transmission of microorganisms in the LTCF. Gowns are worn to prevent contamination of clothing and to protect the skin of personnel from blood and body fluid exposures.2. Gowns are also worn by personnel during the care of patients infected with epidemiologically important microorganisms to reduce the opportunity for transmission of pathogens from residents or items in their environment to other residents or environment. 6. Resident care equipment and articles.3. Non-invasive resident care equipment is cleaned daily or as need between use by the nursing assistant. 7. Although soiled linen may be contaminated with pathogenic microorganisms, the risk of disease transmission is negligible if it is handled, transported, and laundered in a manner that avoids transfer of microorganisms. Hygienic and common-sense storage and processing of clean and soiled linen is recommended.

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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
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** Based on observation, record review and interviews, the facility failed to ensure that comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment for 2 of 18 residents (Residents #57 and CR#75) reviewed for care plans. The facility did not review and update Resident #57's care plan when he had an 18.8 pounds weight loss.The facility did not review and update CR #75's care plan when she had behaviors of refusing care, throwing things on the floor, hitting walls and throwing stuff on the floor. These failures could place residents with weight loss and behavior issues from getting the care and services that could improve their quality of life. Resident #57Record review of Resident #57's clinical records dated 2/25/2026 revealed he was a 73-year male who was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included Alzheimer's disease (is brain disorder that affects memory, thinking and behavior), and dysphagia (swallowing difficulties),. Record review of Resident #57's admission MDS dated [DATE] revealed for Section C, 500 revealed the resident had a BIMS score of 11 indicating he had cognitive issues. For Section K200: Weight and Height he was coded 65 inches for height and weight was 142 pounds. Record review of facility weight record revealed the following weights:1/9/2026 his weight was 142 pounds2/2/2026 his weight was 123.2 pounds.This resulted in a weight loss of 18.8 pounds weight loss. Record review revealed the care plan was last reviewed on 12/13/2025. Further record review revealed the care plan was not revised to address Resident #57's weight loss of 18.2 pounds on 2/2/2026. CR#75 Record review of CR#75's clinical records dated 2/24/2026 revealed she was a 76-year female who was admitted to the facility on [DATE]. Her diagnoses included Non-Alzheimer's dementia (memory loss), and altered mental status (a change in mental function). Record review of CR#75 admission MDS dated [DATE] Section C, 500 revealed the resident had a BIMS score of 10 indicating she was cognitively aware. For Section E200: she was coded as having no behavior. Record review of the nurse's progress notes revealed the following:1/06/2026: CR#75 refused staff assistance, refused to eat stating she was not hungry and did not like the food.1/10/2026 at 1:38 am CR#75 got out of bed screaming and yelling.1/10/2026 at 1:34 pm CR#75 acting very agitated cursing staff, kicking walls and throwing things on floor.1/11/2026 CR#75 refused care and breathing treatment. Record review of CR#75 Care Plan initiated 1/06/2026 revealed the care plan was not review and revised to address the resident's behavior of refusing care, cursing at staff, screaming and yelling and pushing her walker in the wall. In an interview on 2/26/2026 at 3:36pm with MDS Coordinator AK said she was new to the facility and she was not the one who did the MDS. She said dietary was responsible to review the MDS. She said Resident #57's care plan should be revised to address his weight loss. She said, when there were changes in residents' condition the care plan should be revised to address the changes. In an interview on 2/26/2026 at 4:33pm the Regional Nurse said it was the MDS Coordinator's duty to assess the residents and if there were any issues they should be addressed on the care plan. He said care plans should be updated when there are changes in residents' condition. He said the appropriate intervention should be placed to address residents' needs. She said the behaviors for Resident #75 should be addressed in her care plan. Record review of the undated Comprehensive Care Planning read 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 that are identified in the comprehensive assessment. Comprehensive care plans may include but are not limited to resident Kardex records, baseline care plans, and task listings.The comprehensive care plan will describe the following - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.Each resident will have a person-centered comprehensive care plan developed and implemented to meet his (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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.Residents' goals set the expectations for the care and services he or she wishes to receive. Measurable objectives describe the steps toward achieving the resident's goals, and can be measured, quantified, and/or verified.The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented. When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services. Comprehensive Care PlansA comprehensive care plan will be- Developed within 7 days after completion of the comprehensive assessment. Prepared and/or contributed to by an interdisciplinary team, that includes but is not limited to--o The attending physician.o A registered nurse with responsibility for the resident.o A nurse aide with responsibility for the resident.o A member of food and nutrition services staff.o To the extent practicable, the participation of the resident and the resident's representative(s). An explanation will be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.O or Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. 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, preferences and needs of the resident and in response to current interventions. Interdisciplinary means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident. It does not mean that every goal must have an interdisciplinary approach. The mechanics of how the interdisciplinary team (IDT) meets its responsibilities in developing an interdisciplinary care plan (e.g., a face-to-face meeting, teleconference, written communication) is at the discretion of the facility. In instances where an IDT member participates in care plan development, review or revision via written communication, the written communication in the medical record will reflect involvement of the resident and resident representative, if applicable, and other members of the IDT, as appropriate.

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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain, grooming, and personal hygiene for 1 of 3 residents (Resident #4) reviewed for ADL care. The facility failed to ensure CNA J cleaned Resident #4 in a timely manner on 2/26/26. This failure could place residents at risk for pain, infection and hospitalization.Record review of Resident #4's face sheet, dated 2/24/2026, reflected the resident was [AGE] years old, female, and admitted to the facility on [DATE] with diagnoses of urinary tract infection and stage 3 sacral pressure ulcer. Record review of Resident #4's quarterly MDS, dated [DATE], reflected the BIMS score was 3 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was totally dependent on bed repositioning and personal hygiene. Further record review of the MDS indicated Resident #4 was incontinent to bladder and bowel. Record review of Resident's #4's care plan, dated 12/24/2025, reflected the following: I have ADL self-care performance deficit and totally dependent on staff for all ADLs and requires assistance with activities of daily living due to decreased physical and functional mobility secondary to weakness and multiple medical comorbidities. I will remain clean, dry, without odor and comfortable every shift on a daily basis, with all needs to be anticipated and met by staff through the next 90 days. Record review of Resident #4's weekly skin assessment on 2/26/26, reflected pressure wound was not deteriorating and wound doctor was evaluating the wound. Record review of nurse's progress reflected in-facility pressure ulcer wound care by the 2/18/26 by wound doctor was STAGE 3 PRESSURE WOUND OF THE LEFT HIP FULL THICKNESS and physician order was DRESSING TREATMENT PLAN Primary Dressing(s) Santyl apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days; Alginate calcium apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days Secondary Dressing(s) Gauze island w/ bdr apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days. Observation of incontinent care performed by CNA J and pressure ulcer treatment on 2/26/26 at 10:35 AM performed by LVN TN XX revealed Resident #4 was lying in bed on her back with foam wedge. CNA J donned (put on) cleaned gloves unfasten brief soaked with urine and feces, the was no dressing to the left hip pressure ulcer, there was small brownish drainage on the soaked brief. Interview with CNA J on 2/26/26 at 10:36 AM she said she has been working 2 years, then on PRN she works 6:00 AM -2:00 PM. CNA J said she was not aware that the dressing was not in place, CNA J said would have informed LVN TN XX. She said it was the first time performing incontinent care since came to work on 2/26/26, because she was waiting to change Resident #4's brief when the LVN TN XX does her treatment. She said Residents were supposed to be changed every 2 hours and as needed. CNA J said she was in-serviced for incontinent care and skilled check, checking on resident every 2 hours for incontinent needs. CNA J knew if dressing was in place to the pressure ulcer, it could lead to wound not healing well and infection. Interview with LVN TN XX on 2/26/26 at 10:58 AM, LVN TN XX said she was not aware that the old dressing on Resident #4 came off and would have changed the dressing earlier. LVN TNXX said the CNAs were supposed to inform the charge nurse if old dressing to pressure ulcer fall off during incontinent care to prevent infection getting on the wound. Residents were supposed to be changed every 2 hours and report any skin condition to the nurses and CNA J would need in-services. Interview with the Regional DON on 2/26/26 at 5:10 PM, he said CNAs were to perform incontinent care every 2 hours and as needed. Regional DON said, he did monitor CNAs randomly for incontinent care/infection control. Record review of the facility's policy on Nursing: Personal Care Perineal Care, revised 04/25/22, reflected: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.

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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who was incontinent of bladder and bowel received appropriate treatment and services for 1 of 3 residents (Residents #4) reviewed for incontinent care, in that: CNA J did not open Resident #4's labia to clean during incontinent care on 2/26/26. This failure could place residents at-risk for infection due to improper care practices. Record review of Resident #4's face sheet, dated 2/24/2026, reflected the resident was [AGE] years old, female, and admitted to the facility on [DATE] with diagnoses of urinary tract infection and stage 3 sacral pressure ulcer. Record review of Resident #4's quarterly MDS, dated [DATE], reflected the BIMS score was 3 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was totally dependent on bed repositioning and personal hygiene. Further record review of the MDS indicated Resident #4 was incontinent to bladder and bowel. Record review of Resident #4's care plan dated 12/24/25 reflected Resident #4 has an ADL self-care performance deficit, the goal was resident will improve current level of function in through the review date: Resident #4 required total assist with one to two persons for bathing/showering, dressing, bed mobility, eating, personal hygiene/oral. Toilet use and follow principles of infection control and universal precautions to incontinent care. Record review of Resident #4's MAR reflected she was on antibiotics: Ciprofloxacin HCl Oral Tablet 500 MG (Ciprofloxacin HCl on 2/19/26 for 5 days urinary tract infection. Observation of incontinent care performed by CNA J on 2/26/26 at 10:35 AM and was assisted by TN XX revealed Resident #4 was lying in bed on her back with foam wedge. CNA J donned (put on) clean gloves and unfastened Resident #4's brief which was soaked with urine and feces, using wet wipes cleaned in-between the buttocks and did not clean around the buttocks. Then CNA J placed a brief under Resident #4's buttocks and she then proceeded to clean the perineal area, cleaned the right groin, and she did not open the resident's labia to clean, change gloves she fastened the clean brief then doffed (take off) her dirty gloves. Interview with CAN J on 2/26/26 at 10:36 AM she said she has been working 2 years, then on PRN she works 6:00 AM -2:00 PM. She stated she did not open the resident's labia to clean and not cleaning around resident buttocks. CNA J said she had in-services bi-weekly about incontinent care. Interview with TN XX on 2/26/26 at 10:58 AM, TN XX said CNA J did not open the labia to clean and she did not clean around the buttocks She stated CNA J would need in-services. Interview with CNA J on 2/26/26 at 11:12AM She said she thought she did mess up. She stated she did not open the resident's labia and did not clean around the resident's buttocks. CNA said not cleaning Resident #4 well could cause urinary tract infection. Interview with the Regional DON on 2/26/26 at 5:10 PM, he said CNAs were to perform incontinent care every 2 hours and as needed. Regional Nurse said, he did monitor CNAs randomly for incontinent care/infection control. Record review of the Skilled check list, titled Care-Skill, undated, read in part, . 10. With non-dominant hand: Female: Gently retract labia to fully expose urethral meatus and catheter insertion site. Maintain position of hand throughout.14. Using a clean washcloth, clean catheter tubing using one cloth per stroke, in a circular motion. Clean from the most proximal (Closest to the body) to the most distal (Farthest for the body). Continue cleaning in this manner until tubing is clean.

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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to restore, if possible, oral eating skills and prevent complications of enteral feedings including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal-pharyngeal ulcers for 2 of 3 residents (Resident #30, #6) reviewed for feeding tubes. -The facility staff failed to ensure LVN AF allow medication and feed flow by gravity. Resident #30's medication and feeding was plunge via G tube and LVN AF did not flush GTube with water before and after medication 2/24/26. -The facility staff failed to ensure RN W allow medication and water flow by gravity. Resident #6's medication was plunged into GTube on 2/24/26. This failure could place residents at risk for complications such as aspiration pneumonia (occurs when food or liquid is breathed into the airway or lungs, instead of being swallowed), pneumothorax (a condition that occurs when air leaks into the space between the lungs and chest wall), perforations, empyema (one of the diseases that compromises chronic obstructive pulmonary disease), bronchopleural fistula (a sinus tract between the main stem, lobar, or segmental bronchus and the pleural space), and/or hospitalization. Record review of Resident #30's face sheet dated 02/24/26 revealed a [AGE] year-old male was admitted on [DATE] and re-admitted on [DATE]. Resident #30 had a diagnosis of gastrostomy (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach). Record review of Resident #30's admission MDS, dated [DATE], reflected the BIMS score was 5 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was totally dependent on bed repositioning and personal hygiene. Further record review of the MDS indicated Resident #30 was incontinent to bladder and bowel. Record review of Resident #30's care plan dated 12/24/25 reflected Resident #30 has an ADL self-care performance deficit; the goal was resident will improve current level of function through the review date: Record review of Resident #30's Physician's Orders, dated 02/1/26, reflected the following orders: Had NPO (Nothing per oral) only GT: Bolus give 1 can Isosource 1.5 five times a day. Check for residual every shift if > 150cc's, stop feeding and notify MD every shift. Flush GT with 30 ml water before and after administration of meds, flush with 10 cc between each medication every shift. Observation of medication administration on 2/24/26 at 9:40AM by LVN AF, aspirated 58ml of milky fluid and pour it in a cup, then aspirated additional 30 mls milky fluid via G Tube, LVN AF then plunged medication and milky fluid via G Tube to Resident #30's stomach and then aspirated 58 mls in the cup and plunged it via G Tube LVN AF aspirated Lacosamide 100 mg 1 tablet after crushing it and Polyethylene Glycol 3350 (17gm) dissolved in water in 60 mls syringe and plunged via Resident #30's G-Tube. LVN AF did not flush GTube with water before and after medication. Interview on 2/26/26 at 10:15AM with LVN AF about medication and milky residual not given to Resident #30 on 2/24/26, by gravity, she said she feed Resident #30 earlier and was just checking the residual to ensure Resident was not too full. LVN AF did not give any response to why medications and residual was not given by gravity and she did not flush G Tube before and after medication administration. Resident #6 Record review of Resident #6's face sheet dated 2/24/26 revealed an [AGE] year-old female resident that was admitted to the facility on [DATE] and was readmitted [DATE]. Resident #6 had a diagnosis of gastrostomy (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach). Record review of Resident #6's quarterly MDS assessment, dated 1/30/26, reflected a BIMS score of 3 out of 15, which indicated severe cognition impairment. She required total assistance from staff with ADL's care. Record review of Resident #6's physician order for 2/1/2024 revealed in part . Carbidopa-Levodopa Oral Tablet 10-100 MG (Carbidopa-Levodopa) Give 1 tablet via PEG-Tube three times a day related to (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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PARKINSON'S DISEASE WITHOUT DYSKINESIA, WITHOUT MENTION OF FLUCTUATIONS. During an observation on 2/24/26 at 12:50 p.m. revealed RN W punched 1 tablet of Carbidopa-Levodopa Oral Tablet 10-100 MG into a medication cup, crushed it and diluted with 15mls of water and dissolved, RN W then used 60cc syringe aspirated 30 cc of water, she poured in a glass cup and plunged it via GT. RN W then administered medication by plunging it via G Tube. During an interview with RN W on 2/24/26 at 1:15 PM, , RN W said she had hard times with Resident#6's G tube checking for placement and RN W knew not allowing water and medication to flow by gravity could cause aspiration pneumonia, bloating and being too full. RN W said he had medication training upon hire by DON. During an interview on 2/25/26 at 2:50 PM, the Regional Nurse said check tube for proper placement by visual inspection of aspirated stomach content prior to instilling medication and water, feeding and medication she be administered by gravity. The Regional Nurse said plunging water, feeding and medication could result in infection, bloating, or discomfort. Record review of the facility provided policy titled Gastrostomy Tube care, undated, reflected the following . Policy Explanation and compliance Guidelines .3. Attach the syringe barrel to the feeding tube and irrigate with 30 mls water to check for the tube patency.5.Allow the feeding to flow by gravity adding more formula before the barrel empties until the entire measured amount is given6. flush with 30-60 ml water to clear the formula

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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure all drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 4 medication carts (Nurses Cart East Wing) reviewed for medication storage. The facility failed to ensure the East Wing nurse medication cart did not contain opened and undated medication. This failure could place residents at risk of receiving expired medication and improperly stored medications which could result in delayed healing. During an observation on [DATE] at 4:44 PM of the nurse medication caret for the East Wing revealed the following opened medications were not dated when they were opened: The following eye drops were open with no date:1. Ciprofloxacin Ophthalmic2. Refresh Tears3. Cipri Dexa [NAME] 0.3-0.1 Interview with RN Z on [DATE] at 4:44 PM revealed she was not aware of the following eye drops that were opened and not dated. She stated the medication was good for 30 days for effectiveness. RN Z said she checked her medication cart whenever she administered her medications. During an interview on [DATE] at 2:38 p.m., the Regional Nurse said eye drops opened should have an open date. The Regional Nurse said the medicines would not be effective for the treatment after 30 days. Record review of the facility's policy, revised February 2023, Storage of drugs and Biologicals: Medication Labeling reflected: Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. 1. The medication label includes, at a minimum .expiration date, when applicable; resident's name; route of administration; and appropriate instructions and precautions.

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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Ka	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)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop policies and procedures to ensure the resident's medical record included documentation that indicated, at minimum that the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization and that the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal for 1 of 5 residents (Resident #8) reviewed for immunizations.The facility failed to ensure Resident #8 had record of receiving education or being offered the pneumococcal vaccine. This failure could cause residents to be vulnerable to preventable illnesses. Record review of Resident #8's face sheet, dated 02/26/2026, reflected an [AGE] year-old female who was originally admitted to the facility on [DATE] and last re-admitted on [DATE]. Her medical diagnoses included chronic congestive heart failure, unspecified dementia (declining brain function related to thinking and judgement that is severe enough to impact daily life without behavioral disturbance, psychotic disturbance, mood disturbance), cognitive communication deficit, hyperlipidemia (high cholesterol) and chronic obstructive pulmonary disease (blockages in lungs creating difficulty breathing).Record review of Resident #8's Quarterly MDS, dated [DATE], reflected she had a BIMS score of 15, which indicated high cognitive intactness related to thinking and memory. Section I - Active Diagnoses documented her pneumococcal vaccination was not up to date and it was not received due to not being offered. Record review of Resident #8's immunization page in her medical records, reflected she did not have any record of current or prior pneumococcal vaccines since admission. Record review of Resident #8's progress notes, reflected there was no record of education or vaccination since admission. Resident #8 did not have any infection requiring antibiotics. Interview with Resident #8 on 2/25/2026 at 10:30 AM, revealed she appeared well-groomed and in a pleasant mood and no apparent distress. Attempted interview with Resident #8's RP on 2/26/2026 at 3:30 PM was unsuccessful, a voicemail was left and no returned communication as of exit.Interview with the Regional Nurse on 2/26/2026 at 6:45 PM, he said he could not locate Resident #8's pneumococcal vaccination records. He stated Resident #8's immunizations should have been in the corresponding section in her medical record, which included the education and uploaded documentation which indicated she either received or refused the pneumococcal vaccine. This vaccine would have been offered upon admission and documented by either the charge nurse or the ADON at the time. A negative outcome of not receiving the vaccine would be Resident #8 could have gotten ill from not being vaccinated.Request from the Administrator for Resident #8's education and documentation of pneumococcal vaccine on 2/26/2026 at 5:29pm was sent by email. No documents were supplied as of exit. Record review of the facility's, undated, policy on Influenzas and Pneumococcal Vaccine, read in part, It is the policy of this company that all residents will be offered the pneumonia immunization unless the immunization is contraindicated or the resident has already been immunized.The facility will maintain documentation of pneumonia vaccinations or refusals of the pneumonia immunization in the Point Click Care clinical record and will include:o That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumonia immunization; [NAME] That the resident either received the pneumonia immunization or did not receive the pneumonia immunization due to medical contraindication or refusal.