

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455725	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER Oakmont Healthcare and Rehabilitation Center of Hu		STREET ADDRESS, CITY, STATE, ZIP CODE 8450 Will Clayton Pkwy Humble, TX 77338	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644</p> <p>Based on observation, interview, and record review the facility failed to ensure that the residents' environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #2) of five residents reviewed for accidents hazards and supervision, in that:</p> <p>-Resident #2 fell from lift, sustained a head abrasion and L foot fracture during a Hoyer lift transfer (a device designed to assist caregivers in safely transferring patients or individuals with limited mobility) when CNA K operated the Hoyer lift by herself.</p> <p>The noncompliance was identified as past noncompliance (PNC). The Immediate Jeopardy (IJ) began on 1/2/24 and ended on 1/3/24. The facility corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk of injury and hospitalization s.</p> <p>The findings include:</p> <p>Record review of Resident #2's face sheet dated 6/20/24 revealed an [AGE] year-old female who admitted on [DATE]. Her diagnosis included cerebral infarction (stroke), gastrostomy status (an opening into the stomach from the abdominal wall, made surgically for the introduction of food.), vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain), hemiplegia (total or nearly complete paralysis on one side of the body) and hemiparesis (one-sided weakness), and depression.</p> <p>Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 0 out of 15 which indicated severe cognitive impairment. She was totally dependent on staff for ADL care including chair/bed to chair transfer. She had no falls since admission/entry or reentry or the prior assessment.</p> <p>Record review of Resident #2's care plan revised on 1/10/24 revealed she had an ADL self-care performance deficit related to impaired cognition, dx: vascular dementia, impaired mobility, hemiplegia, impaired balance, hx: cerebral infarction, incontinence, wheelchair dependent (revised on 10/20/22). She was at risk for injury due to falls related to impaired cognition, impaired mobility, gait/balance problems, hemiplegia, and incontinence. Interventions were: required 2 person assist with transfers and the use of a mechanical lift (initiated 1/10/24).</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's Event Nurses-Note 12 hr Fall dated 1/2/24 by LVN E read in part, .I was informed by an AID (sic) that resident was on the floor. On entering room, resident was on the floor with a visible wound to the forehead. I provided first aid and obtained vital signs . 19. Gait and Mobility at time of event c. transferring x2 or more staff assist.</p> <p>Record review of CNA K's witness statement dated 1/3/24 read in part, .I went in to (Resident #2's) room and started cleaning her up. (CNA J) came in to assist me. I asked her to get a sling and we put it under (Resident #2). I asked her to go get the Hoyer lift. I hooked (Resident #2) up and (CNA J) went to get the chair. I had her raised up and when I got ready to turn with her, she slipped out of the Hoyer pad. I tried to help but it was too late .</p> <p>Record review of CNA J's undated witness statement read in part, .On Tuesday [DATE] at around 11:55 a.m. I (CNA J) and (CNA K) were getting (Resident #2) out of bed with Hoyer lift. While (CNA K) was operating the Hoyer lift to get (Resident #2) out of bed I stepped out the room as asked to retrieve the wheelchair. As I walked back into the room, I seen the Hoyer lift strap release and (Resident #2) fell to the floor. We immediately called for help and started applying pressure to her wound .</p> <p>In a telephone interview on 6/20/24 at 3:25 p.m. CNA J said on the day of Resident #2's incident, she notified CNA K that she was stepping out of the room to get the wheelchair. She said as soon as she walked back in the room, she saw CNA K lift Resident #2 up so that her bottom was not on the bed. She said there appeared to be some tension and then she fell . She said she was not in the room when CNA K raised the resident up and in that moment the aide was operating the Hoyer alone. She said one of the loops on the Hoyer strap may not have been on correctly. She said she might have seen the sling was not on the loop correctly if she was in the room. She said staff could tell if the sling was not fastened correctly while moving a resident. She said she was trained that while using a Hoyer lift 2 people should be in the room at all times. She said staff normally did not move the resident until everything was set in place. She said staff should never transfer resident by themselves because there could be an accident.</p> <p>Record review of Resident #2's nursing note dated 1/2/24 by LVN E read in part, Resident was transported to (Hospital) on an EMS ambulance that responded to 911 call on behalf of resident. Resident alert and oriented to own ability 3 cm skin tear to right forehead .</p> <p>Record review of Resident #2's hospital records dated 1/2/24 revealed Resident #2 presented to the emergency department after an unwitnessed fall with positive head strike. An x ray of the left ankle was conducted. Findings were a minimally displaced (slight shift in position) intra-articular fracture of the medial malleolus (inner ankle) with large overlying soft tissue swelling. Mild soft tissue swelling over the lateral malleolus (outside ankle), consistent with sprain.</p> <p>Record review of Resident #2's nursing note dated 1/2/24 by the DON read in part, Resident returned from ER, transported via EMS via stretcher, assisted to bed . hospital dx: abrasion to head, left medial malleolar fracture . splint/cast brace in place to left lower extremities. Resident reports pain, medicated with PRN pain management .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's provider investigation report dated 1/10/24 revealed the sling being used on the mechanical lift was potentially not secured correctly at the time of transfer. The sling and lift were determined to be in proper working order. Staff using mechanical lift were immediately re-educated on the proper procedures for using a mechanical lift and competency check was performed for CNA K. CNA J would receive a competency check on her next scheduled shift. The findings were confirmed.</p> <p>In an observation and attempted interview on 4/16/24 at 2:00 p.m. of Resident #2 revealed she was lying in bed on her right side. Resident nodded yes when asked if she was ok. She was unable to say how she fell .</p> <p>Interview on 6/20/24 at 3:51 p.m. the ADON said CNA K and another aide transferred Resident #2 and she slid to the floor and hit her head. She said there should be two people at all times during a Hoyer transfer because you never know what could happen with the lift. She said the resident could fall if only one person was operating it. She said the facility always educated the staff on two person Hoyer lift transfers. She said she and other nurses ensured the aides were transferring residents properly via Hoyer lift. She said CNA K no longer worked at the facility.</p> <p>Interview on 6/20/24 at 3:58 p.m. the Administrator said he did not remember the details of the incident. He said additional training was certainly conducted after the incident. He said a Hoyer lift transfer required 2 people at all times for safety.</p> <p>Attempted telephone interview on 6/20/24 at 4:26 p.m. with CNA K was unsuccessful. Surveyor was unable to leave voicemail.</p> <p>Record review of the facility's Inservice binder revealed the following in services were conducted prior to Resident #2's incident on 1/2/24:</p> <ul style="list-style-type: none"> *Safe Patient Handling - 7/30/23, *Fall Prevention - 7/24/23, *Transfer Training - 7/3/23, *(Hoyer) sling care - 7/3/23, *Moving a Resident, Bed to Chair/Chair to Bed - 7/3/23, *Safe Patient Handling - 7/3/23, *Hydraulic Lift - 7/3/23. <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's undated Hydraulic Lift policy read in part, The hydraulic lift is a mechanical device used to transfer a resident from and to the bed and chair .The number of staff to provide assistance with the transfer should be determined by the manufacturer recommendations . Goals: 1. The resident will achieve safe transfer to bed or chair via a mechanical lift device . Procedure: 2. Involve as many staff members as needed to ensure feelings of security by the resident .6. Place the chair next to the head of the bed with the front facing the foot . lock the wheelchair. 7. Raise the bed to accommodate the lift under the bed .11. Check to be sure that the hooks with open ends are turned away from the resident . 12. Pump the life while holding the steering arm until a sitting position is assumed and the buttocks are lifted off the bed .</p> <p>It was determined these failures placed Resident #2 in an IJ situation from 1/2/24 to 1/3/24. The Administrator was notified by telephone and provided with the IJ template on July 9, 2024 at 4:30 p.m. via email. The facility took the following action to correct the non-compliance on 1/3/24.</p> <p>Record review of the provider investigation report dated 1/10/24 read in part, . Provider Response: upon notification of the fracture, the event was reported to TX HHSC. In-services were initiated regarding transfer training. Slings in the facility were inspected for wear and tear . and determined to be in proper working order, including the sling that was used on (Resident #2). Mechanical lifts were inspected . and determined to be in proper working order, including the mechanical lift being used for transfer of (Resident #2) . Investigation summary: . revealed the sling being used on the mechanical lift was potentially not secured correctly at the time of transfer. The sling and lift were determined to be in proper working order. Staff using mechanical lift were immediately re-educated on the proper procedures for using a mechanical lift and competency check was performed for (CNA K). (CNA J) will also receive competency check on her next scheduled shift . Provider Action Taken Post-Investigation: . no further complications or events have occurred since 1/2/24 for this resident or any resident being transferred with a mechanical lift. Transfer training and competency checks continue to be performed for CNA staff .</p> <p>Record review of the facility's in-service training attendance roster revealed a Hoyer lift training was conducted on 1/3/23 (sic). The in-service was on proper placement of sling, how to safely operate Hoyer lift and secure patient in sling, bed, proper positioning, requires 2 people for safe use of Hoyer. There were 12 CNA signatures which included CNA K and CNA J.</p> <p>Record review of Resident #2's care plan revised on 1/10/24 revealed she was at risk for injury due to falls related to impaired cognition, impaired mobility, gait/balance problems, hemiplegia, and incontinence. Interventions were: required 2 person assist with transfers and the use of a mechanical lift.</p> <p>Interview on 6/20/24 at 12:47 p.m. CNA D said Hoyer lift transfers required 2 people. She explained the Hoyer lift procedure and said she checked the Hoyer lift and slings for any wear and tear. She said any concerns would be reported to Central supply staff.</p> <p>In an observation on 6/20/24 at 1:40 p.m. of CNA P and CNA M revealed they transferred Resident #2 from her wheelchair to her bed using a Hoyer lift safely and without incident. The resident no longer had a brace on her leg.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 6/20/24 at 2:09 p.m. Medical Records who also works as a CNA said Hoyer lift transfers always required 2 persons. She said she checked the Hoyer slings for any rips or tears. She said she would notify the Administrator or DON about the integrity of the sling.</p> <p>Interview on 6/20/24 at 2:35 p.m. RN K said two persons were required for Hoyer transfer. She said she checked for any holes on the sling and strap defects. She said if there was a concern during transfer, she would immediately stop and correct the problem, get another pad/Hoyer lift to prevent injury.</p> <p>In a telephone interview on 6/20/24 at 3:25 p.m. CNA J said after the incident with Resident #2 the DON conducted an in-service on Hoyer transfer. She was reminded there should be 2 people to conduct a Hoyer transfer and to not move the individual without 2 people.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644</p> <p>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 #1) of 5 residents viewed for infection control.</p> <p>-LVN A did not wear appropriate PPE when providing peg-tube care (PEG tubes allow you to receive nutrition through your stomach) to Resident #1 who was on enhanced barrier precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms in nursing homes).</p> <p>This failure could place residents at risk of infections.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet dated 6/20/24 revealed a [AGE] year-old male who admitted on [DATE]. His diagnosis included metabolic encephalopathy (a problem with your brain that is due to an underlying condition), seizures, hypertension (elevated blood pressure), and open wound of unspecified part of neck.</p> <p>Record review of Resident #1's discharge-return anticipated MDS assessment dated [DATE] revealed he was dependent on staff for ADL care. He had a feeding tube. There was no cognitive status assessment completed.</p> <p>Record review of Resident #1's care plan dated 4/26/24 indicated he was on enhanced barrier precautions related to g-tube placement. Interventions were: gloves and gown should be donned if any of the following activities are to occur - linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity.</p> <p>Record review of Resident #1's Physician Orders revealed an order for Jevity 1.5 peg tube feeding at 65 mL/hr for 22 hours every day and night shift for feeding, order date 6/10/24.</p> <p>In an observation on 6/20/24 at 9:36 a.m. of Resident #1's doorway revealed a sign on the door that read in part Enhanced Barrier Precautions (EBP) Steps perform hand hygiene, wear gown, wear gloves, dispose of gown and gloves in room . Use EBP during high-contact care activities for residents with: 1. Indwelling medical devices (e.g. central line, urinary catheter, feeding tube .) . protect residents and stop the spread of germs . There was a bin with PPE in the hallway near the room.</p> <p>In an observation on 6/20/24 at 9:38 am LVN A was in Resident #1's room near his bedside with on gloves and an N95 mask, he did not have on a gown. LVN A was working with the resident's tubing and g-tube machine. After working with the machine, LVN A connected the feeding tube to Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 6/20/24 at 9:45 a.m. LVN A said he just administered Resident #1's medications via g-tube and replaced his empty feeding bottle with a new one. He said he did not wear a gown while performing those activities and did not have to wear any special PPE with Resident #1 because he was not on contact isolation. LVN A said he was not sure what enhanced barrier precautions was but said staff had to wear gloves and gowns for residents who had multidrug resistant organisms (a drug that is resistant to many antibiotics). He said the DON trained him a couple of weeks ago and said the CDC instructed them to wear PPE for residents with multi-resistant organisms. He said the purpose of the PPE was to protect himself and residents. He said if he did not wear the appropriate PPE, he could pass infection to himself and the residents.</p> <p>Interview on 6/20/24 at 11:53 a.m. the ADON said residents who had a g-tube or other internal devices were placed on enhanced barrier precautions to protect the resident from infection. She said the nurse should have put on a gown, gloves, and used proper hand hygiene when providing care to the resident who was on enhanced barrier precautions. She said staff were previously trained on enhanced barrier precautions and were provided with tools on the electronic health system. She said if proper PPE was not worn with residents on enhanced barrier precautions, staff could transfer infection to the next resident.</p> <p>Record review of the facility's undated Enhanced Barrier Precautions policy read in part, . Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . EBP are indicated for residents with any of the following . Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO . Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies Administer medications enterally [NAME] gloves and gown: Yes . Device care or use: central, urinary catheter, feeding tube, tracheostomy/ventilator [NAME] gloves and gown: Yes . Any other high-contact activity that includes close bodily contact or coming into contact with the indwelling medical device don gloves and gown: Yes .</p>		