STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation of Humble	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)
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, interview, and record review the facility failed to implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at S483.10(c)(2) and S483.10(c)(3), 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 for 1 (Resident #1) of 5 residents reviewed for comprehensive care plans.The facility failed to ensure Resident #1's fall mat was in place on 1/28/26 according to the care plan. The facility failed to ensure Resident #1 was changed with 2 people instead of 1 on 1/28/26 as indicated in the care plan. The facility failed to check Resident #1's brief every 2 hours on 1/28/26 as indicated in the care plan. These failures could place residents at risk of not being cared for according to their wishes and specialized care plan.Findings include: Record review of Resident #1's admission record dated 1/28/26 revealed a [AGE] year-old male who admitted on [DATE]. His diagnoses included cerebral infarction (stroke), contracture, left knee (onset: 7/2/25; contracture is a permanent shortening producing deformity or distortion.), hemiplegia (one-sided paralysis or weakness) affecting left nondominant side, need for assistance with personal care and cognitive communication deficit.Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 8 out of 15 which indicated moderate cognitive impairment. He required substantial/maximal assistance from staff with toileting hygiene and rolling left and right. He had no falls since admission/entry or reentry or the prior assessment.Record review of Resident #1's care plan reviewed on 12/29/25 revealed he was at risk for falls related to hypertension (high blood pressure) and actual fall (dated 5/7/25). Interventions included: actual fall 5/7/25 bilateral fall mats to both sides of bed. He had an ADL self care performance deficit related to CVA and contracture. Interventions included bed mobility requires staff x 2 for assistance, toilet use: requires staff x 2 for assistance. Resident #1 had bowel incontinence. Interventions were to check the resident every two hours and assist with toileting as needed.Record review of Resident #1's Kardex (care plan chart or template) dated 1/28/26 revealed he had an actual fall 5/7/25 bilateral fall mats to both sides of bed. Toileting: check resident every two hours and assist with toileting as needed. Toilet use: requires staff x 2 for assistance. Bed mobility requires staff x 2 for assistance. Incontinent care at least every 2 hours and apply moisture barrier after each episode.In an observation and interview on 1/28/26 at 10:09 a.m. of Resident #1 he was lying on a scoop mattress. There was no fall mat to the left or right side of the bed. Resident #1 nodded his head yes that someone changed him this morning, but he did not know who or when.In an observation and interview on 1/28/26 at 11:07 a.m. of Resident #1 with LVN W his brief was soiled and displayed a blue line. LVN W said the blue line indicated the brief was wet. Resident #1 shook his head no when asked if he was wet.In an interview on 1/28/26 at 11:15 a.m. CNA J said she was assigned to 18 residents. Her shift started at 6 a.m. but said she arrived at 9 a.m. and had not (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455725	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation of Humble	8450 Will Clayton Pkwy Humble, TX 77338

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changed Resident #1 yet. She said she had not been in the room with Resident #1 since she arrived. In an interview on 1/28/26 at 11:19 a.m. CNA K said he was in orientation and was following the assigned CNAs. He said he had not changed Resident #1 since the start of his shift at 6:00 a.m.In an observation on 1/28/26 at 11:25 a.m. CNA J entered Resident #1's room and changed his brief alone. Observation of the soiled brief revealed Resident #1 had a bowel movement.In an interview on 1/28/26 at 11:43 a.m. CNA L said she was in orientation and was following the assigned CNAs and had not checked on Resident #1 since the start of her shift at 6:00 a.m. In an interview on 1/28/26 at 11:45 a.m. LVN A said he arrived at the facility around 6:20 a.m. this morning and when he arrived the night CNA (assigned to Resident #1) had already left. He said CNA J arrived late but CNA A and two orientees (CNA K and CNA L) were present. He said he began to obtain blood sugars and did not change any residents.In an interview on 1/28/26 at 11:59 a.m. CNA A said she arrived at work around 6:03 a.m. and did not provide care for CNA J's section (including Resident #1) before CNA J arrived at an unknown time.In an interview on 1/28/26 at 12:40 p.m. LVN A said Resident #1 had a fall in the past and that was why he had a fall mat. In an observation and interview on 1/28/26 at 1:30 p.m. CNA J said Resident #1 was a one person assist with incontinent care but was unsure what the Kardex said. CNA J reviewed the Kardex and said Resident #1 was a 2 person assist. She said she was unsure why he required two people for incontinent care but said it could be because his legs were contracted, and he did not help with turning in the bed. She said she was supposed to check and change him every 2 hours and last changed him at 11 a.m. She said she never saw a fall mat at the bedside and the Kardex would notify her if he needed one. Observation revealed the fall mat was in the resident's closet.In an interview on 1/28/26 at 2:11 p.m. the DON said the facility was working on personalizing the care plan to the resident but had not reviewed Resident #1's yet. She said the charge nurses should monitor to ensure the fall mat was in place and the purpose of the mat was to provide cushion in the event of a fall. She said if the care plan specified two people were required for care she expected staff to have two people for safety and not do it by themselves so the residents and staff would not be at risk. She said she expected her staff to be present at the beginning of their shift to receive a shift report and start their day. If not, it could impact resident care.In an interview on 1/28/26 at 2:11 p.m. the Regional Consultant Nurse said Resident #1 was weaker and required more assistance on admission. He said his care plan should be updated (to reflect his current needs). In an interview on 1/28/26 at 4:04 p.m. LVN W said fall mats were one of the first fall interventions for Resident #1 but since they got the scoop mattress, he did not need the mats anymore and had not fallen since. She said the facility needed to update his care plan. Record review of the facility schedule for 1/28/26 revealed CNA J was assigned to Resident #1 from 6 a.m. - 2 p.m. Record review of the facility's undated Comprehensive Care Planning policy 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. 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. 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.

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	455725	A. Building B. Wing	01/28/2026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 (Resident #1) of 5 residents reviewed for range of motion.The facility failed to ensure Resident #1's leg and hand splint was offered and applied according to MD orders.This failure could result in worsening of contractures and ADL decline.Findings include:Record review of Resident #1's admission record dated 1/28/26 revealed a [AGE] year-old male who admitted on [DATE]. His diagnoses included cerebral infarction (stroke), contracture, left knee (onset: 7/2/25; contracture is a permanent shortening producing deformity or distortion), hemiplegia (one-sided paralysis or weakness) affecting left nondominant side, and cognitive communication deficit.Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 8 out of 15 which indicated moderate cognitive impairment. He required assistance from staff with ADL care. His range of motion in his upper and lower extremities was impaired on one side. Record review of Resident #1's care plan reviewed on 12/29/25 revealed he had alteration in musculoskeletal status related to contracture left hand, left knee. Interventions were to encourage/supervise/assist the resident with the use of supportive devices splints, as recommended. Monitor left hand and left knee splint/carrot (designed to position the finger away from the palm) daily and wear as tolerated.Record review of Resident #1's Order Summary Report revealed orders for:Splint order: Don/doff (put on/remove) left knee splint and will safely wear during daily tasks without redness, skin irritation, swelling, pain or discomfort, every day shift for contracture patient to wear up to 4 hours daily or as tolerated, order date 7/2/25;Splint order: complete hand hygiene prior to donning. [NAME] left hand orthotic daily and wear as tolerated. Monitor for skin irritation, skin breakdown, swelling, and/or pain every day shift for left hand contracture wear splint 4 hours or as tolerated, order date 7/2/25.Record review of Resident #1's MAR for January 2026 revealed the left knee splint for contracture, patient to wear up to 4 hours daily or as tolerated was signed as administered every day from 1/1/26 - 1/27/26. LVN A documented as administered on 1/1/26, 1/5/26, 1/6/26, 1/9/26, 1/10/26, 1/11/26, 1/14/26, 1/15/26, 1/19/26, 1/20/26, 1/23/26, 1/24/26, and 1/25/26. The left hand orthotic wear as tolerated every day shift for 4 hours or as tolerated was documented as administered every day from 1/1/26 - 1/27/26. LVN A documented as administered on 1/1/26, 1/5/26, 1/6/26, 1/9/26, 1/10/26, 1/11/26, 1/14/26, 1/15/26, 1/19/26, 1/20/26, 1/23/26, 1/24/26, and 1/25/26.In an interview on 1/28/26 at 10:22 a.m. Resident #1's family member said his legs were restricted from his knee and it was not like that when he admitted to the facility. She said he remained in the same position and staff did not rotate him or anything. In an observation on 1/28/26 at 10:56 a.m. Resident #1 was lying on his right side and his lower extremities were contracted and folded toward the right side. There was no splint observed on his legs. In an observation on 1/28/26 at 11:26 a.m. of Resident #1 there was no splint on his left hand.In an interview on 1/28/26 at 12:40 p.m. LVN A said he sometimes put a pillow in place for Resident #1's contractures. In an interview on 1/28/26 at 12:59 p.m. the Director of Rehabilitation said when Resident #1 was on therapy services for PT they worked on left lower extremity strength, passive ROM of the left knee and issued a left knee splint. When therapy applied the splint, the resident tolerated it for a short amount of time and would become aggressive. For OT they supplied a left-hand carrot. She said Resident #1 was no longer on PT or OT and ended services at the end of October 2025.In an interview on 1/28/26 at 1:16 p.m. LVN A said the nurse was responsible for applying the splint to Resident #1 on the day shift, (continued on next page)

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	455725	A. Building B. Wing	01/28/2026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and he did not wear a splint at night. He said the last time he saw a splint on Resident #1's left hand was a few weeks ago. He could not find the splint for Resident #1's hand because the resident moved rooms. The hand splint was needed for contractures, and he did not ask the therapy department for a replacement splint. He said he could not remember the last time he applied a splint on the leg, maybe last year. His leg splint was needed for his contracture; his leg contracture was the same and had not worsened. He said sometimes he forgot about the resident's splints and if Resident #1 was up in the wheelchair that would remind him that he needed his splint on. He said the nurses document application of the splints on the computer. He said he signed off on the computer that the splint was applied but that was not correct. He said sometimes the resident would refuse and was a difficult patient but if he refuses, there should be a nursing note and a notification to the NP. He said his contractures could get worse if his splints were not applied as ordered.In an interview on 1/28/26 at 1:30 p.m. CNA J said she did not normally work with Resident #1 but was assigned to him today. She said his legs were contracted and she had never seen a splint on him and was not told one should be on.In an observation on 1/28/26 at 1:55 p.m. LVN A placed a splint on Resident #1's left leg.In an interview on 1/28/26 at 2:11 p.m. the DON said PT could monitor to ensure the splints were in place but ultimately the charge nurse was responsible. She expected physical therapy staff to train staff on splints. She said if the care was documented as done she expected it to be done. The purpose of the splint was to ensure the contracture did not worsen. She said if a resident refused care the nurse should report it to the ADON, DON, and PT for advice. In an interview on 1/28/26 at 2:11 p.m. the Regional Compliance Nurse said the application of Resident #1's splints was transferred over to the nursing department. He said if the resident refused the splints staff should contact the provider to determine if it should be continued or not. He said a waiver would also be signed.In an interview on 1/28/26 at 2:19 p.m. LVN E said she thought Resident #1 wore splints but could not remember because there were a lot of residents who wore splints. She said the nurses were responsible for putting on the splints. She could not remember the last time she applied the splints on Resident #1 but said if she charted it she did it. In an interview on 1/28/26 at 3:36 p.m. CNA B said she normally worked with Resident #1. She said he used to have splints but the last time she saw one on the resident's leg was about 1 month ago. She said she never saw a splint on his hand. Record review of the facility's undated Immobilization Devices, Splints/Slings/Collars/Straps policy read in part, .Splintsare also used to treat contractures to prevent further decline. Goals 1. The resident will achieve safe and effective application of supportive immobilization devices. Procedure. 1. Review physician's order. Perform hand washing. 15. Document all care and the residents' response to treatment in the clinical record.