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	11/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644 Based on interview and record review, the facility failed to refer a resident with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review for 3 of 4 residents (Resident #14, #26, and #36) reviewed for resident assessment. The facility failed to ensure Resident #14, #26, and #36's PASRR Level I screening reflected their mental illness diagnosis. These failures could place residents at risk of not receiving specialized services for their mental illness. Findings included: 1.Record review of Resident #14's undated face sheet revealed he was a [AGE] year-old male originally admitted on [DATE], with the most recent admission being 5/7/24. He had diagnoses of bipolar disorder (mood swings, affecting a person's energy, activity levels, and concentration), and major depressive disorder, recurrent (serious mood disorder that affects how a person feels, thinks, and acts). Record review of Resident #14's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 9 out of 15, which indicated moderately impaired cognition. The MDS revealed he had diagnoses of depression and bipolar disorder. According to the MDS, the resident was taking antidepressants. Record review of Resident #14's care plan, dated 7/26/21 revealed a Focus: Resident is at risk for potential mood problem related to dx: bipolar disorder (Initiated: 11/1/21, Revised: 11/1/21). Goal: The resident will have improved mood state through the review date (Initiated: 11/1/21, Revised: 11/2/21, Target: 1/13/25). Interventions: Monitor/record/report to MD PRN acute episode feelings or sadness. Monitor mood. Focus: The resident requires antidepressant medication for Major Depressive Disorder (Initiated: 6/19/23, Revised: 6/19/23). Goal: The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date (Initiated: 6/19/23, Revised: 6/21/23, Target: 1/13/25). Interventions: Give antidepressant medications as ordered. Record review of Resident #14's Level 1 PASRR dated 12/12/19, revealed a no for mental illness, no for an intellectual disability, and no for a developmental disability, which made the screening negative. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #14's Psychiatric Subsequent Assessment performed by NP D on 8/23/22, revealed a diagnosis of bipolar disorder. Record review of Resident #14's medical record revealed there was not a new Level 1 PASRR completed after the new diagnosis on 08/23/22. Record review of Resident #14's Psychiatric Subsequent Assessment performed by NP E on 10/14/24, revealed he was still being treated for bipolar disorder. 2.Record review of Resident #26's undated face sheet revealed he was a [AGE] year-old male originally admitted on [DATE], with the most recent admission being 6/22/21. He had diagnoses of major depressive disorder with psychotic symptoms (serious mental illness that combines depression with psychosis, or a loss of touch with reality), and anxiety disorder (persistent and uncontrollable feelings of fear or anxiety that can interfere with daily life). Record review of Resident #26's Annual MDS assessment dated [DATE] revealed a BIMS score of 7 out of 15, which indicated severely impaired cognition. The MDS revealed diagnoses of depression and a psychotic disorder, and indicated he was taking antipsychotics and antidepressants. Record review of Resident #26's care plan dated 10/28/19, revealed a Focus: Resident #26 uses antipsychotic medications related to dx: depressive disorder recurrent, severe with psychotic symptoms, at risk for side effects (Initiated: 4/13/22, Revised: 3/10/23). Goal: The resident will be/remain free of psychotropic drug related complications through review date (Initiated: 4/13/22, Target: 1/5/25). Interventions: Administer antipsychotic medications as ordered. Resident #26 uses antidepressant medication related to depressive disorder, at risk for drug side effects (Initiated: 4/13/22, Revised: 4/13/22). Goal: The resident will be free from discomfort or adverse reactions through the review date (Initiated: 4/13/22, Target: 1/5/25). Interventions: Administer antidepressant medications as ordered. The resident uses anti-anxiety medications for anxiety disorder (Initiated: 8/14/24). Goal: The resident will be free from discomfort/adverse reactions through the review date (Initiated: 8/14/24, Revised: 10/21/24, Target: 1/5/25). Interventions: Give anti-anxiety medications as ordered. Record review of Resident #26's Level 1 PASRR Screening dated 10/25/19, revealed no for mental illness, no for intellectual disability, and no for developmental disability, which made the screening negative. Record review of Resident #26's Psychiatric Initial Assessment from PA F dated 2/18/20, revealed a diagnosis of major depressive disorder, recurrent, with severe psychotic symptoms. Record review of Resident #26's medical record revealed there was not a new Level 1 PASRR completed after the new diagnosis on 2/18/20. Record review of Resident #26's Physician Orders revealed the following orders from MD A: - Cymbalta Oral Capsule Delayed Release Particles 20mg, 1 PO QD for depressive disorder, recurrent with psychotic symptoms. Discontinued on 10/7/24. - Quetiapine Fumarate Tablet 25mg, 1 PO QHS for major depressive disorder, recurrent with psychotic symptoms. Give 25mg with Quetiapine 50mg for a total of 75mg QHS. Discontinued on 10/7/24. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Quetiapine Fumarate Tablet 50mg, 1 PO QHS for major depressive disorder, recurrent with psychotic symptoms. Ordered on 10/7/24. Record review of Resident #26's Psychiatric Subsequent Assessment from NP E dated 10/29/24, revealed he was still being treated for major depressive disorder, recurrent with severe psychotic symptoms, and for anxiety disorder. In an interview on 11/1/24 at 2:05 p.m. the MDS Coordinator said she started a 100% audit of residents with mental health diagnoses and was going through them to see if any had exclusionary diagnoses like Dementia. If not, she would perform a new PASRR level 1 screening for them. She said she just started last year and most of the ones she found occurred before she started. 3.Record review of Resident #36's Admission Record dated 11/2/24 revealed a [AGE] year-old female who readmitted to the facility on [DATE]. Her diagnosis included schizoaffective disorder - bipolar (primary diagnosis), schizophrenia, bipolar disorder, mild cognitive impairment (secondary diagnosis), major depressive disorder, chronic obstructive pulmonary disorder, and cerebral infarction (stroke). Record review of Resident #36's quarterly MDS assessment, dated 8/26/24 revealed a BIMS score of 8 out of 15 which indicated moderate cognitive impairment. Record review of Resident #36's care plan dated 10/29/24 revealed the resident required anti-psychotic medications related to schizoaffective disorder. Record review of Resident #36's PASRR Level I screening dated 7/13/24 indicated the resident had a primary diagnosis of dementia. The screening also indicated the resident did not have a mental illness (Schizophrenia). In an interview on 10/30/24 at 2:46 p.m. the MDS Coordinator said Resident #36 did not have a diagnosis of dementia but did have cognitive deficits and schizophrenia (which qualifies as a mental illness). She said her PASRR screening should have been marked no for dementia and yes for mental illness. She said the resident's previous facility sent over the screening and she entered the information into the system, and it (the inaccuracies) must have slipped by her. She said she was responsible for ensuring the PASRR screening was accurate. She said the purpose of the PASRR screening was to see if the resident had a mental illness and the State could provide more resources to the resident. In an interview on 11/2/24 at 4:42 p.m. the Administrator said she expected the PASRR to be checked for accuracy and updated when there was a new mental illness diagnosis. She said the MDS Coordinator was responsible. She said the purpose of the PASRR screening was to ensure resident received services and treatments that they qualified for. She said residents could fail to receive needed services if the PASRR was not coded accurately. Record review of Detailed Item by Item Guide for Local Authorities and Nursing Facilities to Complete the PASRR Level 1 Screening Form dated June 2023 retrieved from Texas Health & Human Services read in part, .C0090. Primary Diagnosis of Dementia- Is there evidence that dementia is the primary diagnosis for this individual? (This must be listed in the medical record as the primary diagnosis by the physician) . Examples of MI diagnoses are: Schizophrenia, Mood disorder (bipolar disorder, major depressive disorder, or other mood disorder) . Schizoaffective Disorder . (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy on PASRR was requested from the facility on 11/2/24 at 8:16 a.m. but however the policy received titled, PASRR Maintenance in the Active Paper Medical Record, did not obtain information regarding the PASRR process.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on observation, interview, and record reviews the facility failed to ensure that a resident with a pressure ulcer received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 3 of 6 residents (Resident #43, Resident #45, and Resident #7) reviewed for pressure ulcers. - The facility failed to provide daily wound care for Resident #43 on 10/1/24, 10/13/24, 10/21/24, 10/23/24, and 10/27/24, resulting in worsening of his L Heel, R Heel, R Distal (closest to foot) Leg, R Proximal (furthest away from foot) Leg, L Ischium (buttock), and R Ischium (buttock) pressure ulcers. - The facility failed to receive Resident #43's biopsy/culture results for his R heel that was performed 9/30/24, until 10/24/24. - The facility failed to start Resident 43's antibiotic for MRSA and osteomyelitis (bone infection) to his R heel until 10/31/24, when results were received on 10/24/24. - The facility failed to have the Wound Care MD see Resident #43 after 10/7/24 due to not having staff to assist him. - The facility failed to measure Resident #43's wounds throughout October 2024. - The facility failed to prevent a Stage 3 (deep wound with visible subcutaneous fat, but no exposed bone, tendon, or muscle) pressure ulcer to Resident #45's toe while at the facility between 9/9/24 and 10/1/24. - The facility failed to provide daily wound care to Resident #45's R middle toe on 10/1/24, 10/13/24, 10/21/24, 10/23/24, and 10/27/24. - The facility failed to provide daily wound care to Resident #7's Left Lateral Forefoot and Left Sacrum on 10/1/24, 10/6/24, 10/11/24, 10/12/24, 10/13/24, 10/17/24, 10/24/24, 10/27/24, 10/28/24, and 10/29/24, which resulted in worsening of the Sacrum pressure ulcer. An Immediate Jeopardy (IJ) was identified on 10/31/2024. The IJ Template was provided to the facility on [DATE] at 4:15pm. While the IJ was removed on 11/2/2024, the facility remained out of compliance at a level of more than minimal harm and a severity of no actual harm with potential for more than minimal harm that not Immediate Jeopardy and a scope of pattern due to the need for implementation of corrective measures and the effectiveness of its corrective plan. Findings included: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1.Record review of Resident #43's undated face sheet revealed he was a [AGE] year-old male admitted originally on 3/3/22, with the most recent admission being 8/30/23. His diagnoses included pressure ulcer of the sacrum (buttocks), type 2 diabetes (body does not produce insulin or is resistant to it), quadriplegia (complete or severe loss of motor function in all four limbs), muscle spasms (involuntary muscle contractions), muscle wasting and atrophy (muscle shrinkage/contraction due to not using), and neuromuscular dysfunction of the bladder (bladder does not work due to nerve issues). Record review of Resident #43's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, which indicated normal cognition. He had impairment on both sides of his upper and lower extremities and used an electric wheelchair. The resident was dependent with all ADLs and had a suprapubic catheter (a hole from the bladder through the abdomen to the outside to drain urine) and a colostomy (a hole through the abdomen from the colon to the outside to drain stool). The MDS revealed Resident #43 had 5 Stage 4 (ulcer extends into the muscle, tendon, or bone, and may expose it) pressure ulcers, and only 1 was present on admission. Record review of Resident #43's care plan dated 3/10/22 revealed a Focus: The resident has pressure ulcers: L heel Stage 3 (deep wound with visible subcutaneous fat, but no exposed bone, tendon, or muscle) Reopened, R heel Stage 4 (ulcer extends into the muscle, tendon, or bone, and may expose it), R lower leg Stage 4 (ulcer extends into the muscle, tendon, or bone, and may expose it), R ischium (R side of buttock) Stage 4 (ulcer extends into the muscle, tendon, or bone, and may expose it), L ischium (L side of buttock) Stage 4 (ulcer extends into the muscle, tendon, or bone, and may expose it), R lateral leg Stage 3 (deep wound with visible subcutaneous fat, but no exposed bone, tendon, or muscle) Resident refuses visits from wound care doctor and refuses treatments frequently. (Initiated: 8/10/24, Revised: 10/29/24) Goal: The resident's pressure ulcer will show signs of healing and remain free from infection by/through review date (Initiated: 3/30/22, Revised: 9/29/22, Target: 11/26/24). Interventions: Assess/record/monitor wound healing at lease weekly. Measure length, width and depth. Obtain and monitor lab/diagnostic work as ordered, report results to MD and follow up as indicated. Refer to wound care MD. Turn/reposition every 2 hours. Focus: Resident is on antibiotic therapy r/t diagnosis of osteomyelitis (Initiated: 11/12/23, Revised: 10/31/24). Goal: The resident will be free of any discomfort or adverse side effects of antibiotic therapy through the review date (Initiated: 11/12/23, Revised: 2/5/24, Target: 11/26/24). Interventions: Administer medication as ordered. Report pertinent lab results to MD. Focus: The resident has IV access (Initiated: 10/31/24). The resident will not have any complications related to IV therapy through the review date (Initiated: 10/31/24, Target: 11/26/24). Interventions: Administer IV medications as ordered. The resident has PICC line IV access to right upper arm. Record review of Resident #43's Physician Orders revealed the following orders from MD A: - Calcium Alginate-Silver External Pad 2, Cleanse wound to R Heel with wound cleanser/ns, pat dry, apply calcium alginate w/ silver and santyl (wound care medications), cover with dry dressing. Every day for wound care. Ordered on 6/3/24. - Calcium Alginate, Cleanse wound to R Posterior leg with wound cleanser/ns, pat dry, apply calcium alginate and santyl, cover with dry dressing. Every day for wound care. Ordered on 6/17/24. - Calcium Alginate-Silver External Pad 2'x2', Cleanse wound to R Heel with wound cleanser/ns, pat dry, apply calcium alginate w/ silver (wound care medications), and cover with dry dressing. Every day for wound care. Ordered on 8/19/24. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Cleanse wound to L Ischium with wound cleanser/ns, pat dry, apply Dakins 125% (wound care medication) and cover with dry dressing. Every day for wound care. Ordered on 10/9/24. - Cleanse wound to R Ischium with wound cleanser/ns, pat dry, apply Dakins 125% (wound care medication) and cover with dry dressing. Every day for wound care. Ordered on 10/9/24. - Santyl External Ointment 250U/gm (Collagenase) (wound care medication), Apply to R Heel/Lateral Leg, Every day for wound care. Ordered on 10/9/24. - No orders for any antibiotics were found for his MRSA/osteomyelitis. Record review of Resident #43's Wound Care Note dated 9/30/24, revealed a L Ischium (L side buttock) Stage 4 (ulcer extends into the muscle, tendon, or bone, and may expose it) pressure ulcer that was 5.6cm x 1.9cm x 0.1cm, a R Ischium (R side buttock) Stage 4 (ulcer extends into the muscle, tendon, or bone, and may expose it) pressure ulcer that was 3.5cm x 3.9cm x 0.1cm, L Heel Stage 3 (deep wound with visible subcutaneous fat, but no exposed bone, tendon, or muscle) pressure ulcer 2.2cm x 1.2cm x 0.1cm, R Heel Stage 4 (ulcer extends into the muscle, tendon, or bone, and may expose it) pressure ulcer 6.1cm x 5.2cm x 0.4cm, and a R Lateral Lower Leg Stage 4 (ulcer extends into the muscle, tendon, or bone, and may expose it) pressure ulcer 2.8cm x 1.9cm x 0.1cm. Debridement (removal of dead tissue) was performed on the L Ischium (L buttock), R Ischium (R buttock), R Heel, and a biopsy (tissue sent to the lab) was taken from the R Heel d/t suspicion of osteomyelitis (bone infection). Wound orders were entered for daily wound care. Record review of Resident #43's October 2024 MAR-TAR revealed blank spots where wound care was not provided to his L Heel, R Heel, R Distal (closest to foot) Leg, R Proximal (furthest away from foot) Leg, L Ischium (buttock), and R Ischium (buttock) pressure ulcers, for the following dates: 10/1/24, 10/6/24, 10/12/24, 10/13/24, and 10/26/24. Record review of Resident #43's Wound Care Note dated 10/7/24, revealed a L Ischium (L buttock) Stage 4 (ulcer extends into the muscle, tendon, or bone, and may expose it) pressure ulcer 5.6cm x 2cm x 0.1cm, a R Ischium (R buttock) Stage 4 (ulcer extends into the muscle, tendon, or bone, and may expose it) pressure ulcer 3.7cm x 3cm x 0.1cm, a L Heel Stage 3 (deep wound with visible subcutaneous fat, but no exposed bone, tendon, or muscle) pressure ulcer 2.2cm x 2.2cm x 0.1cm, a R Heel Stage 4 (ulcer extends into the muscle, tendon, or bone, and may expose it) pressure ulcer 5.3cm x 3.9cm x 0.2cm, a R Lateral Lower Leg Stage 4 (ulcer extends into the muscle, tendon, or bone, and may expose it) pressure ulcer 2.6cm x 1.5cm x 0.1cm, and a new R Proximal Lateral Lower Leg Stage 3 (deep wound with visible subcutaneous fat, but no exposed bone, tendon, or muscle) pressure ulcer 4.5cm x 1.6cm x 0.1cm. Debridement (removal of dead tissue) was performed on the R Heel and the R Proximal Lateral Lower leg. Record review of Resident #43's medical record, revealed a final report from [lab] dated 10/9/24 was faxed from the Wound Care MD's office to the nursing facility on 10/10/24, with results of acute osteomyelitis (bone infection) that was found during the biopsy (tissue removal sent to lab) on 9/30/24. Record review of Resident #43's Weekly Ulcer Assessments for 10/14/24 and 10/28/24, were the same as the last measurements from the Wound Care MD on 10/7/24. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #43's medical record, revealed culture results from [lab] dated 10/24/24 was faxed from the Wound Care MD's office to the nursing facility on 10/24/24, with results of high amounts of MRSA (a drug resistant bacteria) and multiple other bacteria that was found during the culture on 9/30/24. In an interview and observation with Resident #43 on 10/29/24 at 11:15am, the resident was observed laying on his back receiving wound care by the floor nurse, directed by the ADON. The resident said the facility no longer had a Wound Care Nurse, so the floor nurses had to perform wound care and they did not come every day. He said they were only doing it because State was there and the last time he had received wound care was on 10/27/24. In an interview with Resident #43 on 10/30/24 at 12:15pm, he said the Wound Care MD would not see him because the facility did not have a Wound Care Nurse to help him. He said the Wound Care MD wanted someone to help him position and take orders and the floor nurses were too busy to come help, so the doctor did not have time to wait around and would not see him. The resident also said the staff would get him into his chair and then want him to get back to bed for wound care and then get back into his chair and that was too much work, so a couple times he refused. He said he felt like they would wait for him to get in his chair on purpose so they could offer it then and they know he would refuse. Resident #43 stated he felt like his pressure ulcers had worsened since the Wound Care MD had not seen him since 10/7/24. In an interview with a family member of Resident #43 on 10/30/24 at 1:45pm, who said the facility had a big problem with performing wound care daily since they did not have a wound care nurse. She said Resident #43 may have refused a few times, but he did not refuse often because he has become septic in the past and knew how important wound care was. She said the problem was staff would get him into his chair and then wanted him to get back into bed for wound care, and then get back into his chair. She said that was a lot of work for him and he would not want to do it. She said she did not understand why they would not do his wound care first and then put him in his chair. In an interview with the Wound Care MD on 10/30/24 at 1:48pm, he said he came every Monday to see residents. He said Resident #43 was complex, had a lot of wounds, and needed help getting ready before he arrived. He said he would call the facility and give them an hour notice before he arrived, but the resident still would not be ready when he arrived, and he would not have time to sit around and wait when he had other residents to get to. He said it was hard for nursing staff to keep up with wound care when there was not a dedicated wound care nurse, so it frequently did not get done or fell through the cracks. He said they had not had a wound care nurse in about a month. The Wound Care MD said he received the labs, he thought on 10/24/24 but was not sure when, and the resident had osteomyelitis before. He said he talked to NP B on Monday (10/28/24) and told her to order the antibiotics for the resident. He said he wanted to make sure she ordered the antibiotics, and they did not get missed. In an interview with NP B on 10/30/24 at 2:40pm, she said the Wound Care MD called her to inform her Resident #43 would be on Cipro/Vancomycin (antibiotics for wound infection) but did not tell her to order them. She said the Wound Care MD would inform the nurse at the facility and they would enter the orders. She said she did not enter orders for the Wound Care MD. She said she saw labs come in for the resident but if the Wound Care MD ordered them, he would be responsible for following up on them. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the DON on 10/30/24 at 3:05pm, she said she was kind of familiar with Resident #43's wounds. She was not sure if the wounds were getting better or worse. She said the floor nurse was the one responsible for measuring the wounds. She said [username] was her and that was who logged all the measurements of Resident #43's wounds for October 2024, so she must have performed the measurements. She said she thought the wounds had not changed. She did not know if the resident had had any labs/biopsies (tissue removal and sent to lab) on any of his wounds. The DON said the Wound Care MD did not give any orders to NP B because she did not work for him. She said the Wound Care MD would tell a nurse at the facility and they would enter the orders, or he would slide the orders under her door, and she would enter them. She said she did not know anything about the antibiotic orders for Resident #43 and she was going to go call the Wound Care MD. In an interview and observation of Resident #43 on 10/30/24 at 4:00pm, he said the DON never measured his wounds and that he had never even seen her face before. Measurements were performed with the DON and the Clinical Resource Nurse and were as follows: L Heel: 3.5 x 2.5 = 8.89cm x 6.35cm R Heel: 6.5 x 5 = 16.51cm x 12.7cm R Distal Leg: 2.5 x 1 = 6.35cm x 2.54 R Proximal Leg: 6 x 1 = 15.24cm x 2.54cm In an observation of Resident #43 on 10/31/24 at 10:00am with the ADON, DON, and the Clinical Resource Nurse the resident's L Ischium (L buttock) and R Ischium (R buttock) were measured as follows: L Ischium (L buttock): 6.5 x 2.5 x .1 = 16.51cm x 6.35cm R Ischium (R buttock): 6 x 3 x .2. = 15.24cm x 7.62cm There was also new maceration (skin breakdown due to moisture) to both sides. The resident was observed with a right upper arm PICC line. In an interview with the DON on 10/31/24 at 10:40am, she said she copied the last measurements the Wound Care MD entered on 10/7/24 and entered those measurements throughout October, because she did not want to enter the wrong information or the wrong staging. She said the wound care nurse left about 3 weeks ago and then before that they had another wound care nurse that was there that left. She said she expected her floor nurses to provide wound care but not touch anything having to do with measurements. She said she would know if the wounds got worse without measuring by noting the smell, drainage, and pain. In an interview with RN C on 10/31/24 at 12:51pm, she said she did not know of any labs/biopsies (tissue removed and sent to lab) that Resident #43 had to his wounds. She looked in his chart and said she did not see anything. She said when cultures/biopsies (tissue removed and sent to lab) are done, they put it on the 24hr report so they can keep track of it. She said the other nurses did not have enough time to perform wound care and that they really need a wound care nurse, but she makes time. She said Resident #43's wound care was mainly done at night, and she did not know of him refusing, maybe once or twice. (continued on next page)

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	11/02/2024

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the ADON on 10/31/24 at 1:00pm, she said she did not know anything about the culture/biopsy (tissue removed and sent to lab) results for Resident #43 until the results were recently brought to her attention. She said the Wound Care MD did not communicate well and only communicated with the wound care nurse when they had one. If they did not have a wound care nurse, he kept to himself. She was not sure how it was ordered because there were no orders in the system. She said the results were always sent to the Wound Care MD's office and then they would fax them to the nursing facility. In an interview with the Administrator on 10/31/24 at 1:40pm, she said the ADON, and the floor nurses were assigned to handle the wound care treatment for the residents since they no longer had a wound care nurse. She said the floor nurses were aware they would be providing treatment and if they were not able to round with the Wound Care MD, then the ADON was responsible for rounding and entering orders. She said the ADON, and the DON were responsible for following up on the orders. The Administrator said when the last wound care nurse left there were no loose ends, or anything left outstanding that she was aware of. She said only the Wound Care MD measures the wounds and then the nurse enters the measurements in the system. She said if the Wound Care MD had not seen the resident in a while, like Resident #43, then the DON/ADON should have seen the resident and taken measurements. In an interview with the Wound Care MD on 10/31/24 at 3:15pm, he said he did his own biopsies (tissue removed and sent to lab)/cultures and took them to the lab himself. He said he left a copy of his handwritten notes and a copy of the order at the facility. He said he usually gave it to the wound care nurse but if the wound care nurse was not there, he would give it to the floor nurse. If the floor nurse was not available or he could not find anyone, then he would give it to the DON or slide it under her door. He said he gave it to a floor nurse, but he did not remember who it was. He said the results were faxed to the facility. He said he got a biopsy/culture because the wound was deteriorating, and it appeared to look like it had osteomyelitis. 2.Record review of Resident #45's undated face sheet revealed he was a [AGE] year-old male originally admitted on [DATE], with the most recent admission on 4/8/24. He had diagnoses of unspecified dementia (decline in cognitive abilities, such as thinking, remembering, and reasoning), pressure induced deep tissue damage of left heel (a type of pressure ulcer that occurs when underlying soft tissue is damaged by pressure or shear forces), protein calorie malnutrition (reduced availability of nutrients leads to changes in body), contractures of right and left knees (inelastic fiber-like tissue in the knees preventing normal movement), muscle wasting and atrophy (thinning of your muscle mass), dehydration, type 2 diabetes (body does not produce insulin or resists it), and iron deficiency anemia (body is not producing enough iron). Record review of Resident #45's Annual MDS assessment dated [DATE], revealed a BIMS score was unable to be obtained due to medical issues. The MDS revealed he had severely impaired cognitive skills for daily decision making. He had impairment of both sides of his upper and lower extremities and was dependent with all ADLs. The resident had a nephrostomy (hole into kidney through abdomen to drain urine) and a colostomy (hole from colon through abdomen for stool to collect in bag outside of body). Resident #45 had a Stage 3 (deep wound with visible subcutaneous fat, but no exposed bone, tendon, or muscle) pressure ulcer that was not present on admission. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #45's care plan dated 4/20/23 revealed a Focus: The resident has a pressure ulcer: R Second toe (Initiated: 4/24/24, Revised: 10/14/24). Goal: The resident's pressure ulcer will show signs of healing and remain free from infection by/through review period (Initiated: 4/24/24, Revised: 4/24/24, Target: 11/17/24). Interventions: Administer treatments as ordered and monitor for effectiveness. Assess/record/monitor wound healing at least weekly. Measure length, width, and depth. Turn every 2 hours. Record review of Resident #45's Physician Orders from MD A revealed the following orders: - Zinc Oxide External Cream 10%, Cleanse abrasion to left buttock with wound cleanser/ns, pat dry, apply zinc oxide (wound medication). Every shift for wound care. Ordered on 10/27/23. - Cleanse right great toe with normal saline or wound cleanser, pat dry, and apply skin prep, leave open to air. Every day for wound care. Ordered on 9/24/24. - Calcium Alginate, Cleanse right second toe with NS/Wound cleanser, pat dry, apply calcium alginate/silver (wound medications), cover with dry dressing. Every day for wound care. Ordered on 9/29/24. - Skin Prep Spray, Clean posterior left heel with normal saline, pat dry, apply skin prep daily (wound medication), float heels, leave open to air. Every day for deep tissue injury (a type of pressure ulcer that occurs when underlying soft tissue is damaged by pressure or shear forces). Ordered on 11/1/24. Record review of Resident #45's October 2024 MAR-TAR revealed blank spots where wound care was not provided for the following dates: 10/1/24, 10/13/24, 10/21/24, 10/23/24, and 10/27/24. Record review of Resident #45's Wound Care Note dated 10/7/24, revealed R Medial (middle) Second Toe Stage 3 (deep wound with visible subcutaneous fat, but no exposed bone, tendon, or muscle) pressure ulcer 2.1cm x 1.5cm x 0.3cm with bone exposed (Wound Care MD should have classified it as a Stage 4 since bone was exposed). Record review of Resident #45's progress note from MD A dated 10/9/24, revealed a note that read 9-9-24: Since last evaluation, chronic medical conditions remain stable .No present wound issues. Staff reinforcement done to promote turning, pressure relief, skin care and safety. Another note read 10-9-24 Since last eval, chronic medical issues have been stable .Has developed wound on right second toe, followed by wound care service . In an observation of Resident #45 on 10/29/24 at 9:16am, he was lying on his left side in bed, without his pressure relieving boots on. In an observation of Resident #45 on 10/30/24 at 9:06am, he was asleep on his left side with his pressure relieving boots on his nightstand. In an observation of Resident #45 on 11/1/24 at 10:30am, he was lying on his left side with hand splints on and his bilateral boots on. (continued on next page)

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	455725	A. Building B. Wing	11/02/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #45's SBAR dated 11/1/24, revealed he had a skin change which was a deep tissue injury to his left heel (a type of pressure ulcer that occurs when underlying soft tissue is damaged by pressure or shear forces). 3. Record review of Resident #7's undated face sheet revealed she was a [AGE] year-old female originally admitted on [DATE], with the most recent admitted [DATE]. She had diagnoses of Alzheimer's disease (brain disorder that gradually destroys memory and thinking skills), muscle wasting and atrophy (thinning of your muscle mass), protein calorie malnutrition (reduced availability of nutrients leads to changes in body), dementia (decline in cognitive abilities, such as thinking, remembering, and reasoning), and cerebral infarction (stroke). Record review of Resident #7's Quarterly MDS assessment dated [DATE] revealed a BIMS score was unable to be performed due to medical concerns. She had impairment on both sides of her lower extremities and was bedbound. She was dependent with all ADLs and was always incontinent of bowel and bladder. The MDS revealed she had 2 Stage 3 (deep wound with visible subcutaneous fat, but no exposed bone, tendon, or muscle) pressure ulcers that she was not admitted with. Record review of Resident #7's care plan dated 1/31/20, revealed a Focus: The resident has a pressure ulcer to L Lateral (outside) foot, L Sacrum (buttock) (Initiated: 3/6/24, Revised: 10/14/24). Goal: The resident's pressure ulcer will show signs of healing and remain free from infection by/through review date (Initiated: 3/6/24, Revised: 4/4/24, Target: 12/30/24). Interventions: Administer medications and treatments as ordered. Assess/record/monitor wound healing at lease weekly. Measure length, width, and depth. Enforce turning/repositioning. Record review of Resident #7's Physician Orders revealed the following orders from MD A: - Zinc Oxide External Paste (wound medication), apply to sacrum (buttocks) two times a day. Ordered on 7/18/24. - Zinc Oxide External Cream 10%, cleanse sacrum (buttocks) with wound cleanser/ns, pat dry, apply zinc oxide (wound medication), every shift. Ordered on 7/22/24. - Skin Prep Wipes, apply to right lateral (outside) ankle every day for wound care. Ordered on 7/29/24. - Betadine External Solution, apply to left plantar (bottom) foot every day for wound care. Ordered on 8/26/24. - Cleanse left lateral (outside) foot with normal saline or skin cleanser, apply medi-honey and calcium alginate (wound medications), cover with dry dressing, daily and PRN. Every day for wound care. Ordered on 10/4/24. - Calcium Alginate Powder, cleanse sacrum (buttocks) with normal saline, pat dry, apply calcium alginate (wound medication), cover with dry dressing. Every day for wound care. Ordered on 10/4/24. - Cleanse sacrum (buttocks) with normal saline or skin cleanser, pat dry and apply calcium alginate (wound medication), cover with dry dressing, daily and PRN. Every day for wound care. Ordered on 10/8/24. (continued on next page)

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	455725	A. Building B. Wing	11/02/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of resident #7's Wound Care MD Note from 9/30/24, revealed a Left Lateral Forefoot (outside front part of foot) arterial ulcer (due to bad circulation) 2.5cm x 1.2cm x 0.3cm, and a Left Sacrum Stage 3 (deep wound with visible subcutaneous fat, but no exposed bone, tendon, or muscle) pressure ulcer 2.7cm x 1.5cm x 0.1cm. Record review of Resident #7's October 2024 MAR-TAR revealed blank spots where wound care was not provided for the following dates: 10/1/24, 10/6/24, 10/11/24, 10/12/24, 10/13/24, 10/17/24, 10/24/24, 10/27/24, 10/28/24, and 10/29/24. Record review of Resident #7's Weekly Ulcer Assessment performed by the Clinical Resource Nurse on 10/30/24, revealed measurements for the sacrum (buttocks) 9.5cm x 6cm. In an observation of Resident #7 on 10/29/24 at 10:02am, she was asleep on her left side in bed. In an interview with Resident #7's family member on 10/29/24 at 1:48pm, she said she would like to see the resident up in her wheelchair at least once a month. She said the facility never got Resident #7out of bed and into her wheelchair and she laid in bed every day. She said she spoke to the Administrator and DON about it, but still nothing changed. In an observation of Resident #7 on 11/1/24 at 10:35am, she was asleep on her left side in bed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's policy and procedure on Pressure Injury: Prevention, Assessment and Treatment (Revised 8/12/16) read in part: Procedure: 1. Nursing personnel will continually aim to maintain the skin integrity, tone [color], turgor [elasticity of skin] and circulation to prevent breakdown, injury and infection. 2. Early prevention and/or treatment is essential upon initial nursing assessment of the condition of the skin on admission and whenever a change in skin status occurs. The nurse will determine if prevention and/or treatment of pressure sore(s) is indicated and notify the Treatment Nurse/designee of any potential problems. 3. Upon assessment and identification of a pressure sore the staff nurse will notify the treatment nurse/designee. The treatment nurse/designee will: 1. Notify the physician of pressure sore and obtain and follow any orders as directed by the physician. 2. Notify family and dietary department. Document Notification . Nursing Action/Rationale: 1. Prevention: The nurse can assist in the prevention of pressure injuries by performing the following nursing interventions: NOTE: Add any interventions to care plan. 1. Determine resident's skin tolerance to pressure and develop a turning schedule; residents should be turned every two (2) hours or more often if necessary and notify the Treatment Nurse/designee of any potential problems. 2. Do the blanching test by pressing the finger into a reddened area, a normal blood supply to the reddened area is seen when the area blanches white and then turns pink again. If the area remains red, a pressure sore is impending due to impaired circulation, keep resident off the area for 24 hours and then repeat the test . 9. Assess for early signs of skin breakdown and report any abnormal findings. Early signs of pressure sores include redness, tenderness and swelling of the skin. Notify Treatment Nurse/designee of any potential problems by completing Skin Concern Notification Worksheet. 10. Treatment Nurse/designee or Director of Nursing will assess site and evaluate for appropriate stage as listed in this procedure. Notify physician; obtain an order and monitor site daily. Sign off on treatment sheet any treatment completed (i.e., Stage I through Stage IV). 11. Director of Nursing or designee to inservice nurses and CNA's on above prevention. 2. Pressure sore identification: Director of Nursing or treatment nurse/designee will classify the pressure injury according to the following descriptions of the different stages. Staging definitions are per the guidelines of the National Pressure injury Advisory Panel February 2016 definitions .7. Nursing Care Plan. 1. Identify the problem of pressure injuries on the Nursing Care Plan 2. Under Nursing Intervention, list physician ordered treatments .Assessment of the pressure injury should also include the site, size, and W x L x D, of the injury. Surrounding tissue, color, exudate [drainage], wound edges, sinus tracts [narrow abnormal channel that connects a cavity], odor, tunneling [passageway that extends from the wound into deeper tissue] and undermining [closed passageway originating from the wound's edges and spreading outwards] should also be documented at least weekly and upon decline. An Immediate Jeopardy (IJ) was identified on 10/31/24 at 4:15pm. The Administrator and DON were notified. The Administrator was provided with the IJ template, and a Plan of Removal was requested at that time. The facility's Plan of Removal was accepted on 11/1/24 at 2:52pm and read as follows: [Facility] Plan of Removal 10/31/24 F686 Failure to Prevent Pressure Ulcers (continued on next page)

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	455725	A. Building B. Wing	11/02/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interventions 1. A head-to-toe assessment was completed on resident #43 as of 10/31/24 by the DON and Regional Compliance Nurse. No additional pressure wounds were identified. 2. All of resident #43's wounds were measured by the DON and Regional Compliance Nurse as of 10/31/24. The MD was notified of all changes in measurements by the Regional Compliance on 10/31/24. All measurements were documented in the chart by the Regional Compliance nurse as of 10/31/24. 3. Resident #43's antibiotic medication was initiated as of 10/31/24 by the charge nurse. 4. As of 10/31/24 the Administrator has designated that the ADON will round with the wound care MD. In the event the ADON is unavailable the designated nurse for the resident will round with the MD. 5. As of 10/31/24 the Administrator has designated that the ADON (LVN) will measure all resident wounds in the facility and document findings in the resident's chart. Wound assessments will be completed weekly. DON/Weekend RN will oversee the ADON (LVN) /Charge Nurse to ensure wound measurements and treatments have been completed and ar[TRUNCATED]

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644 Based on observation, interview, and record review, the facility failed to assist residents in obtaining routine and 24-hour emergency dental care for 1 of 8 residents (Resident #3) reviewed for dental services. The facility failed to ensure Resident #3 was referred to the dentist after she complained of tooth pain. This failure could place residents at risk of pain and decline in health. Findings included: Record review of Resident #3's Admission Record dated 11/2/24 revealed an [AGE] year-old female who readmitted to the facility on [DATE]. Her diagnosis included pain, type 2 diabetes, malnutrition, and cerebral infarction (stroke). Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed a BIMS score of 6 out of 15 which indicated severe cognitive impairment. She required assistance from staff with ADL care. Record review of Resident #3's nursing note dated 10/18/24 written by the ADON read in part, late entry: followed up with concern RP (name) shared regarding resident's teeth. Resident states, I don't have any pain in my mouth. I don't know what (RP) is talking about. Denies pain at this time. Resident consuming gummy bears at the time. Resident able to consume all meals without any complaints of pain. Will continue plan of care. Record review of Resident #3's Customer Concern/Grievance Communication Form dated 10/24/24 completed by the Administrator indicated the resident's family member left a message and thought the resident may need to see the dentist. The resident was assessed per ADON, and resident denied pain. The resident did not complain of pain. There were no signs or symptoms of pain or discomfort. The resident was eating gummy bears while speaking to ADON. The concern was resolved, and the resident would be monitored. In an observation and interview on 10/29/24 at 2:46 p.m. Resident #3 said she has had a bad tooth for a few weeks and needed to see the dentist. She said she told several nurses. Resident #3 opened her mouth and pointed to the bottom right side. Observation of her tooth revealed it appeared cracked. In an interview on 10/31/24 at 8:56 a.m. LVN E said Resident #3 told her more than two weeks ago that her tooth was hurting, and she asked for pain medicine. LVN E said she gave her pain medicine and the resident never complained about the pain again. She said she did not report the pain to anyone because it was a one-time event. She said if it was persistent, she would report it to the Social Worker so the resident could get on the dental list. She said Resident #3's family member came to the facility yesterday (10/30/24) and asked when the dentist was coming to the facility. LVN said she did not know if Resident #3 was being seen by the dentist. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/31/24 between 11:00 a.m. - 12:00 p.m. this Surveyor informed the Administrator that Resident #3 said she had tooth pain and had reported it to several nurses. The Administrator said the resident was previously assessed (on an earlier date) and denied having tooth pain but said the facility would send the resident to the dentist for evaluation. In a telephone interview on 10/31/24 at 11:40 a.m. Resident #3's family member said Resident #3 told him her tooth was hurting last week and he reported it to the nurses (unknown which nurse) and Administrator. He said the nurse informed him that she would give the resident pain medicine. He said he did not receive any other feedback. He said the facility contacted him yesterday and said Resident #3 said her tooth was not hurting. He said he did not know if the resident would see the dentist. Record review of Resident #3's nursing note dated 10/31/24 at 12:20 p.m. written by LVN E read in part, Resident out on pass to Dental appointment accompanied by an executive driver via wheelchair and facility staff. Denies any pain or discomfort. Record review of Resident #3's Dental Statement dated 10/31/24 revealed the resident was seen for a limited emergency exam and x-rays. Record review of an undated email from the dental office read in part, .Attached is the invoice for [Resident #3's] visit. [Dentist Name] did note that #29 could be painful for the patient, it looks like there is an infection starting and recommended having the tooth extracted . Record review of Resident #3's nursing note dated 10/31/24 at 2:22 p.m. written by the previous DON read in part, Resident returned from Dental appointment with x-rays and recommendation, call placed to NP [name] received new orders for prn Tylenol and orajel for tooth pain and antibiotic for 7 days will continue to monitor resident for tooth discomfort and infection to tooth. In an interview on 10/31/24 at 3:24 p.m. LVN E said a few weeks ago she gave Resident #3 Tramadol for tooth pain. She said the resident never complained of tooth pain before and was unsure if this was a new area of pain. She said when a resident complained of pain the nurse would do a pain assessment. She said she did not notify the MD because the resident had medication orders for pain. She said the only thing she may have done differently was tell the Social Worker to add the resident to the dental list. She said the risk of not reporting tooth pain could be infection. In an interview on 11/1/24 at 2:56 p.m. the ADON said she was informed during a staff meeting to follow up with Resident #3's tooth pain after the grievance was filed from her family member (on 10/24/24). She said she assessed Resident #3 and the resident said she did not have pain in her mouth. She said she did not look in her mouth and the resident was eating gummy bears. She said she spoke with CNAs about any eating or chewing problems with the resident and there were no issues. She said the dentist was scheduled to come to the facility on [DATE] and she was unsure if the resident was on the dental list. She said if the resident was not on the list, it was still possible for the dentist to see the resident that day or the facility would have made her an appointment. She said the Social Worker was out on leave. She said she was not aware the resident had previously complained of tooth pain to the nurse and if she had known, and if it were recurrent, she would have notified the MD. She said a SBAR should be done anytime a resident said anything about pain because it was a change in condition, and you do not don't want anyone to suffer in pain. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/2/24 at 1:16 p.m. LVN S said Resident #3 had a toothache last week, but he was waiting for the Social Worker. He said the resident told him one side of her tooth had pain on a scale of 4 out of 10. He said he did not look inside of the resident's mouth but did assess for swelling with none found. He said he gave her Tramadol, and it was effective. He said he did not report the resident's pain to anyone else. He said he would notify the MD if there were no orders for pain medication. He said he looked for the social worker and someone told him she was on leave. He said he did not ask if anyone else (besides the social worker) could put the resident on dental list. He said he could have reported the dental pain to the Administrator for follow up. He said the risks of not reporting could include her tooth pain getting worse. In an interview on 11/2/24 at 4:42 p.m. the Administrator said the facility should have proceeded to get other entities involved to see if something was going on with Resident #3. She said the nurses should have assessed the resident, notified the social worker and the MD for a dental visit consultation. She said if the social worker was unavailable, they should contact the Administrator. She said there could or could not be risk to the resident. She said the mouth could be irritated or inflamed but it would vary. Record review of the facility's Dental Services policy dated 2003 read in part, .Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care . Policy Interpretation and Implementation: 1. Oral health services are available to meet the resident's needs. 2. Routine and emergency dental services are provided to our residents through: a contract agreement with a local dentist; referral to the resident's personal dentist; referral to community dentists; or referral to other health care organizations that provide dental services. 3. The Director of Nursing Services, or his/her designee, is responsible for notifying Social Services of a resident's need for dental services. 4. Social Services personnel will be responsible for assisting the resident/family in making dental appointments and transportation arrangements as necessary.

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	11/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49710 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 for the facility's only kitchen reviewed for dietary services in that: -The facility failed to ensure that drink items in the dry storage area were not expired. -The facility failed to ensure that the refrigerator temperatures were logged daily. These findings could place residents at risk for food contamination and/ or food borne illnesses. Findings included: Observation of the facility's kitchen area on [DATE] beginning at 8:35 am revealed the refrigerator temperature log was not filled out since [DATE]. In an interview on [DATE] at 9:00am the Dietary Manager stated the logs should be checked daily but they have been short staffed so they may have been missed. She said she told her staff to check the temperatures daily. Observation of the pantry on [DATE] at 8:45 am revealed an expired box of thickener dated [DATE]. In an interview on [DATE] at 9:00 am the Dietary Manager stated she was unaware of the expired thickener being in the pantry. She said they started using a new brand of thickener and knew none of the residents received this expired box. In an interview on [DATE] at 4:42 p.m. the Administrator said she expected all expired items to be discarded. Record review of the facility's Storage Refrigerators policy dated 2012 read in part, .all storage refrigerators shall be maintained clean and have a proper temperature for food storage and to ensure a proper environment and temperature for food storage. Procedure: . 2. Storage refrigerators shall have thermometers frequently monitored throughout the day and recorded in the am and pm shifts. Temps are recorded on the Refrigerator/Freezer Temperature Log. The refrigerator should be 41 degrees F or less, and the freezer should be maintained at less than 0 degrees F . Record review of the facility's Food Safety policy dated 2012 read in part, .2. Food is to be wrapped or sealed and covered in clean containers. Opened food shall be labeled, dated and stored properly. Perishable opened foods shall be used within 7 days or less, in compliance with the Texas Food Establishment rules. Non-perishable foods will be used as long as the quality of the product is maintained . 8. Do not keep potentially hazardous food in refrigerator past the labeled expiration date .