STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675394	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Manor Nursing Home	225 S Main St Vidor, TX 77662

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on interview and record review, the facility failed to ensure the right to formulate an advance directive was provided for 1 of 4 residents reviewed for resident rights. (Resident #67) The facility did not have a valid Out of Hospital-Do Not Resuscitate (OOH-DNR) for Resident #67. This failure could place residents at risk of lifesaving procedures being performed against their wishes resulting in bruising, broken ribs, electrical shocking of the heart, having a tube placed in the throat and provided artificial breathing methods, and possibly being brought back to life in an unaware and unresponsive state. Findings included: Record review of a face sheet dated [DATE] indicated Resident #67 was an [AGE] year-old male admitted on [DATE]. His diagnoses included chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), dementia (loss of cognitive functioning), and atrial fibrillation (a type of irregular heartbeat). Record review of an undated OOH-DNR indicated it was signed by Resident #67 but there was no and was signed by his physician but had no date. Record review of an undated care plan indicted Resident #67 requested code status of no CPR with an intervention of Make sure that code status is signed by [Resident #67] or responsible party and in the active medical record. During a record review and interview on [DATE] at 11:42 a.m., LVN A acknowledged Resident #67's OOH-DNR had no date for when Resident #67 signed his section and no date for when the physician signed his section. LVN A said without the dates the OOH-DNR was incomplete so it would not be valid and Resident #67 was a full code which meant they would have to perform CPR on him. LVN A said the SW handled the OOH-DNRs. (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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review and interview on [DATE] at 11:48 a.m., the SW acknowledged Resident #67's OOH-DNR had no date for when Resident #67 signed his section and no date for when the physician signed his section. The SW said he was the one who notarized Resident #67's signature and he was the one who would help the families and residents with their OOH-DNRs. The SW said with the dates missing the form was not valid and Resident #67 was a full code. During a record review and interview on [DATE] at 11:50 a.m., the DON acknowledged Resident #67's OOH-DNR had no date for when Resident #67 signed his section and no date for when the physician signed his section. The DON said without the dates the OOH-DNR was incomplete so it would not be valid and Resident #67 was a full code which meant they would have to perform CPR. Record review of an Advanced Directives policy revised [DATE] provided by the Corporate Nurse had no indication of the OOH-DNR requiring the information to be completed. Record review of the Frequently Asked Questions about OOH-DNR accessed on [DATE] at https://www.dshs.texas.gov/dshs-ems-trauma-systems/out-hospital-do-not-resuscitate-program: Frequently Asked Questions for DNR: What happens if the form is not filled out correctly or EMS has doubts about any of the information? Health professionals can refuse to honor a DNR if they think: The patient is pregnant There are unnatural or suspicious circumstances surrounding the death. The form is not signed twice by all who need to sign it or is filled out incorrectly . Filling out the Out-of-Hospital Do-Not-Resuscitate Form indicated: Declarations: A. This box is for patients who are competent. The patient should sign his/her name, date the document, and prints or types his/her name D. This box is used when a physician has evidenced that a patient has issued a previous directive to physician or observes a person issuing an OOH-DNR by non-written communication. The physician must check the appropriate box in this section, sign and date the form, print or type his/her name and provide his/her license number

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on observation, interview, and record review, the facility failed to complete a significant change MDS assessment within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition a significant change of condition for 1 of 19 residents reviewed for assessments. (Resident # 53) The facility failed to complete a Significant Change MDS for Resident #53 within 14 days after the resident was admitted to hospice services. This failure could place residents who experienced a significant change in their condition requiring an MDS assessment at risk of not receiving needed services. Findings Included: Record review of a face sheet dated 09/24/24 indicated Resident #53 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included respiratory failure (a serious condition that makes it difficult to breathe on your own), chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), dementia (loss of cognitive functioning), anxiety disorder (persistent and excessive worry that interferes with daily activities), and hypertension (a condition in which the force of the blood against the artery walls is too high). They also indicated Resident #53's referral to hospice on 08/19/24. Record review of a physician telephone order dated 08/19/24 indicated Resident #53 was admitted on hospice services. Record review of the EMR from 08/19/24 through 09/24/24 indicated Resident #53 did not have a significant change MDS for admission to hospice within the required 14-day time frame. Record review of the current care plan reviewed on 09/24/24 indicated Resident #53 required hospice as evidenced by terminal illness of chronic obstructive pulmonary disease. During an observation and interview on 09/23/24 at 09:52 a.m. Resident #53 was in bed finishing her breakfast. She was clean, neat, and had no odors. Resident #53's RP said they asked for Resident #53 to be placed on hospice services on 08/19/24. The RP said hospice was at the facility the same day to admit Resident #53. During an interview on 09/24/24 at 11:40 a.m., LVN A said Resident #53 had a referral to hospice dated 08/19/24 and had orders from hospice to admit on 08/19/24. During a record review and interview on 09/24/24 at 11:55 a.m., the MDS Nurse acknowledged a quarterly MDS dated [DATE]. She said she had not done a significant change MDS for the admission to hospice. She said she was supposed to do a significant change MDS within 14 days after the admission to hospice. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/24/24 at 12:18 p.m., the DON and the Corporate Nurse said they did not know when a significant change MDS was to be done after admission to hospice. They said they thought the Corporate MDS Nurse was responsible for reviewing if a MDS was due. During an interview on 09/25/24 at 09:18 a.m., the DON said for MDS accuracy and submissions they followed the RAI guidelines. Record review of the MDS RAI manual dated October 2023 indicated 03. Significant Change in Status Assessment (SCSA) (A0310A = 04): .Assessment Management Requirements and Tips for Significant Change in Status Assessments: An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving their highest practicable well-being at whatever stage of the disease process the resident is experiencing

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41057 Based on interview and record review, the facility failed to accurately submit a PL1 (PASRR Level 1 Screening) screening when a resident admitted with a diagnosis of Mental Illness, Intellectual Disability or Developmental Disability for 1 of 6 residents reviewed for PASRR screenings. (Resident #333) The facility failed to submit a new PL1 screening when Resident #333 was diagnosed on [DATE] with Major Depressive Disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily living) during his stay. This failure could place residents at risk of not receiving specialized services. Findings included: Record review of Resident #333's face sheet dated 09/24/24 was an [AGE] year-old-male admitted [DATE] with diagnoses of seizures (uncontrolled jerking, loss of consciousness and other symptoms caused by abnormal electrical activity in the brain), anxiety disorder (mental health disorder with feelings of worry, anxiety, or fear that are strong enough to interfere with daily activities), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities causing significant impairment in daily life). Record review of Resident #333's PL1 form dated 02/24/24, indicated he was negative for mental illness, intellectual disability, and developmental disability and negative for dementia as the primary diagnosis. There was no PASRR Level II Screening or Form 1012 (Mental Illness/Dementia Resident Review) found in the clinical record from the resident's admission on 2/27/24 to 09/24/24. Record review of Resident #333's care plan created on 02/28/24 indicated Resident #333 had a history of seizures and psychotropic medication for depression and anxiety with a goal to monitor for effectiveness of psychotropic medication. Record review of Resident #333's annual MDS dated [DATE] indicated not PASRR positive and had a BIMS score of 14 indicating intact cognition. The assessment indicated a mood interview of feeling down depressed or hopeless present for 2-6 days. Record review of Resident #333's Follow up physician visit, dated 03/12/24 indicated diagnoses of seizure and major depressive disorder. Record review of Resident #333's Psychiatric Initial Assessment, dated 03/15/24 indicated a diagnosis of major depressive disorder, recurrent, moderate. Record review of Resident #333's quarterly MDS dated [DATE] with a BIMS score of 15 indicated intact cognition. The assessment indicated a mood interview of feeling down depressed or hopeless present for 2-6 days with diagnoses of convulsions (medical condition that causes the body's muscles to contract and relax rapidly and repeatedly) and depression other than bipolar (many types of depression including major depressive disorder). (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 09/24/24 at 10:20 a.m., Resident #333 as lying in bed and said he was treated well and would report any concerns to the nurse. During an interview on 09/24/24 at 3:00 p.m., the MDS nurse said she was responsible for all PASRR forms in the facility. She said Resident #333's PL1 was negative but should have had a positive PL1. The MDS nurse said Resident #333's PL1 was overlooked. She said at the time Resident #333's PL1 was completed she was new and was unaware the diagnosis of major depressive disorder was a PASRR positive diagnosis. The MDS nurse said she was educated on PASRR forms, she had watched a couple of webinars on PASRR forms completion. She said the MR was her back up and made sure all residents had a PL1 form. The MDS nurse said the risk of a PL1 form being incorrect was a resident could miss out on deserved services. During an interview on 09/24/24 at 3:05 p.m., the MR said the MDS nurse was responsible for PL1 forms. She said she was responsible for receiving the PL1 form from the referring entities and making sure it was filled out and uploaded into the facilities computer system. The MR said she was not responsible for checking PL1 forms for accuracy. During an interview on 09/24/24 at 3:30 p.m., the DON said the MDS nurse was responsible for all PASRR forms in the facility and was educated on completing PASRR forms correctly and timely. She said Resident #333 's PL1 form was overlooked. The DON said the risk of PASRR forms completed incorrectly was a resident could miss out on services if deemed PASRR positive. She said the Regional Care Coordinator double checked PASRR forms for accuracy. She said at the time of Resident #333's PL1 form the MDS nurse was just inputting the PL1 forms as received from the referring entity and did not double check the resident's diagnoses. The DON said Resident #333 needed a positive PL1 sent in. She said the risk was a resident could miss out on services if deemed PASRR positive. The DON said her expectation was all PASRR forms completed correctly and timely. She said the facility followed the RAI for their PASRR policy. During an interview on 09/25/24 at 10:38 a.m., the Administrator said the MDS nurse was responsible for all PASRR forms in the facility and was educated on correctly and timely completing PASRR forms. She said the DON and Regional Care Coordinator were the MDS nurse's back up. She said Resident #333 's PL1 was overlooked. The Administrator said the risk of PASRR forms completed incorrectly was a resident could miss out on deserved services. The Administrator said her expectation was a PL1 form completed on admission and with a new diagnosis be correct and timely. During an interview on 09/25/24 at 10:51 a.m., the Regional Care Coordinator said the MDS nurse was responsible for completing the PL1 and PASRR forms in the facility. She said the IDT (inter-disciplinary team) reviewed the admission paperwork and on receiving a new diagnosis the IDT team would review the new PL1 and resident information and decide if a new positive PL1 needed to be completed and uploaded. She said the MDS nurse was educated on completion PL1s accurately and timely. She said the risk of a PL1 form completed incorrectly was if the resident should be positive the resident could get more assistance depending on needs. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the October 2023 Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual titled, A1500: Preadmission Screening and Resident Review (PASRR) Item Rationale Health-related Quality of Life indicated . o All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), developmental disability (DD), or related conditions o Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36214 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 1 of 19 residents reviewed for care plans. (Resident #6) The facility did not have a care plan to address Resident #6's Post Traumatic Stress Disorder (PTSD). This failure could place residents at risk of not having their individual needs met and not receiving needed services. Findings included: Record review of a face sheet dated 09/25/24 indicated Resident #6 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included PTSD (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). Record review of an annual MDS assessment dated [DATE] indicated Resident #6 had a BIMS score of 14 indicating her cognition was intact and she had a diagnosis of PTSD. Record review of a care plan dated 07/25/19 to present indicated Resident #6 had no care plan addressing her PTSD. During an observation and interview on 09/24/24 at 09:10 a.m., Resident #6 was sitting up in bed in her room. She said she felt safe at the facility and was doing alright. She said she got anxiety and irritation at times but had learned to work through those episodes. During an interview on 09/25/24 at 09:35 a.m. the ADON said she was responsible for writing care plans for Resident #6, but she did not realize she had a diagnosis of PTSD. She said she should have a care plan to address her PTSD. She said a possible negative outcome of not addressing her PTSD could be staff being unaware of the diagnosis and without precautions could trigger anxiety and distress for the resident. During an interview on 09/25/24 at 10:22 a.m., the DON said the nursing department was responsible for writing and updating care plans. She said all care plans were reviewed quarterly, but Resident #6's PTSD diagnosis was missed. She said not having a care plan to address her PTSD could result in staff not giving needed emotional support. During an interview on 09/25/24 at 1:40 p.m., the Administrator said her expectation was for care plans to address all diagnosis of residents and all care needed by the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Care Plans-Comprehensive policy revised September 2010 indicated An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained free of accident hazards for 1 of 2 residents reviewed for smoking safety evaluations. The facility did not ensure the quarterly smoking evaluations were completed for Residents #59. This failure could place residents at risk of injury and contribute to avoidable accidents. Findings included: Record review of the face sheet dated 09/25/24 indicated Resident #59 was admitted on [DATE], was [AGE] years old with diagnoses of nicotine dependence, chronic obstructive pulmonary disease, diabetes and peripheral vascular disease (blood flow reduce to limbs). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #59 used tobacco. Record review of the care plan dated 09/25/24 indicated Resident #59 was a smoker and interventions included assist resident to smoking area and keep matches/lighters at the Nurses Station. Record review of the smoking evaluation form dated 01/30/24 indicated Resident #59 was a safe smoker with direct supervision and no other evaluations were in the clinical record after that date. During an observation on 09/24/24 at 10:30 a.m., Resident #59 was smoking with supervision. During an interview on 09/25/24 at 9:50 a.m., the DON said she was responsible for ensuring smoking evaluations were completed and Resident #59's smoking evaluation was missed in April and July. She said she just missed his quarterly evaluations. She said the negative outcome could be more interventions might have been needed, smoking status could have changed, and the smoking evaluation for Resident #59 was not completed quarterly. She said the resident had to be supervised, that was the facility's policy and resident could drop his cigarette and need help. During an interview on 09/25/24 at 1:30 p.m., the Administrator said her expectation was for the smoking evaluations to be completed on all residents who smoke annually and quarterly. Record review of Resident Smoking Policy dated 01/04/24 signed by Resident #59 indicated To maintain safety for residents who smoke. 11. A smoking evaluation will be completed for residents who smoke on admission, quarterly and significant change of condition.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based on observation, interview, and record review, the facility failed to ensure an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections were maintained for the facility for 2 of 7 residents (Resident #24 and Resident #27) reviewed for infection control procedures. The facility failed to ensure LVN B used enhanced barrier precautions (a set of infection control guidelines used to prevent spread of infections) while she administered medication to Resident #24 through a gastrostomy tube (a tube inserted through the belly that brings nutrition directly to the stomach). The facility failed to ensure LVN B used enhanced barrier precautions while she performed tracheostomy care (surgical opening into the neck for breathing) to Resident #27. These failures could place residents at risk for exposure to infections and communicable diseases. Findings included: 1. Record review of Resident #24's admission sheet dated 09/25/24 indicated she was admitted on [DATE] and was [AGE] years old with diagnoses of dysphagia (difficulty in swallowing). Record review of Resident #24's physician's orders dated September 2024 indicated her orders included NPO (nothing by mouth), was to receive gastric feedings and medications via a gastrostomy tube. The orders included Enhanced Barrier Precautions with a start date of 04/25/24. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #24 had severely impaired cognition. She required a feeding tube (g-tube). Record review of a care plan dated 09/25/24 indicated Resident #24 had a feeding tube (g-tube) and interventions included Enhanced Barrier Precautions implemented. During an observation on 09/24/24 at 8:32 a.m., LVN B prepared medications for Resident #24 and the resident's room had a sign which indicated EBP was required for residents who have indwelling medical device such as feeding tube. LVN B entered the room, washed her hands, donned gloves and checked placement of Resident #24 gastric tube. LVN B then administered medications per gastric tube without wearing an isolation gown. 2. Record review of Resident #27's admission sheet dated 09/25/24 indicated he was admitted on [DATE] and was [AGE] years old with diagnoses of tracheostomy, aphasia (difficulty in speaking) and dysphagia (difficulty in swallowing). Record review of Resident #27's physician's orders dated September 2024 indicated his orders included NPO (nothing by mouth), was to receive tracheostomy care with dressing change and change the inner cannula of the tracheostomy daily. The orders included EBP with start date of 04/25/24. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the quarterly MDS assessment dated [DATE] indicated Resident #27 was severely impaired with his cognition. He required a trache. Record review of a care plan dated 09/24/24 indicated Resident #27 had a feeding tube (g-tube), tracheostomy, and interventions included EBP implemented. During an observation on 09/24/24 at 10:45 a.m., LVN B walked into Resident #27's room to perform tracheostomy care. Bedside the door was a sign which indicated EBP for residents who have tracheostomy. LVN B donned gloves after she washed her hands. She then removed the soiled dressing then cleaned around the tracheostomy. LVN B completed the care to the tracheostomy; however, she did not use an isolation gown while providing care to the resident. During an interview on 09/24/24 at 2:00 p.m., LVN B said she was trained on EBP and just forgot to put on a gown when she provided care to Resident #24 and #27. She said she should have worn a gown. During an interview on 09/24/24 at 2:05 p.m., the DON said her expectation was for staff to wear gowns and gloves when providing close contact care to residents who required EBP to prevent spread of infections. She said nurses should wear gowns and gloves when administering medications via a resident's g-tube and when providing tracheostomy care. During an interview on 09/24/24 at 3:30 p.m., the Administrator said her expectation was for the staff to follow policy on EBP and wear PPE as required. During an interview and record review on 09/25/24 at 9:00 a.m., with the ADON and the UM, the ADON said she was the ICP nurse. The ADON said EBP was put in place to prevent the spread of infections. The UM said she was the backup ICP nurse and assisted the ADON with training the staff and ensuring the staff implemented the EBP. The ADON said she was responsible for ensuring the staff wore PPE while providing care as needed. The UM said they made rounds- daily and re-educated staff as needed. The ADON provided the last completed training forms for EBP dated 05/31/24 and 06/03/24. The ADON said the staff were to wear gowns and gloves while providing close contact resident care. She said the PPE was located in the rooms for each resident on EBP. Record review of the Enhanced Barrier Precautions dated March 2024 indicated Policy: Enhanced Barrier Precautions (EBP is an infection control intervention to reduce transmission of multidrug resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. EBP is indicated for residents with . Chronic wounds . and or indwelling medical devices . tracheostomy tubes . feeding tubes . 13. Gowns and gloves used for each resident during high-contact resident care activities .