STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675619	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks Nursing Center	507 W Jackson St Burnet, TX 78611

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39269 Based on interview and record review, the facility failed to inform the resident's family and responsible party when there was a change in resident condition for 1 (Resident #1) of 3 Residents reviewed for resident rights. The facility failed to inform Resident #1's family when Resident #1 developed pressure ulcer at her coccyx (commonly referred to as the tailbone, is the final segment of the vertebral column) area on 08/05/2024 and had to be seen by the Wound Care Doctor. This noncompliance was identified as PNC. The deficient practice began on 08/05/24 and ended on 08/26/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of their responsible party not being involved in their medical care and treatment. Findings included: Review of Resident #1's face sheet dated 09/12/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included unspecified fracture of right femur (the longest bone in the human body, it extends from the hip to the knee) , subsequent encounter for closed fracture with routine healing, essential tremor and presence of unspecified artificial knee. Face sheet also reflected Resident #1 had emergency contacts. Review of Resident #1's Nursing Home Comprehensive MDS assessment dated [DATE] reflected a BIMS score of 00, staff assessment indicated both long- and short-term memory problems. The MDS also reflected Resident #1 was at risk for developing pressure ulcer. Review of Resident #1's care plan initiated 08/01/2024 reflected Resident #1 had a communication problem related to cognition, ability to voice wants and needs; resident had potential/actual impairment to skin integrity r/t fragile skin, surgical incision to hip. Review of Resident #1's skin reported dated 08/05/2024 reflected pressure area at her coccyx area. Review of Resident #1's progress notes from 08/05/2024 through 08/24/2024 reflected no area where Resident #'s family was notified of pressure ulcer development or consent from family for Resident #1 to be seen by the Wound Care Doctor. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's wound doctor's notes reflected Resident #1 was seen by the wound care doctor on 08/15/2024 and 08/21/2024 for pressure ulcer to her coccyx area. Review of Resident #1's progress notes dated 08/24/2024 reflected Resident #1 was transferred to the local hospital. During an interview on 09/12/2024 at 2:16 pm LVN A stated she worked with Resident #1 on 08/05/2024 and that was the day the wound on Resident #1's buttocks was discovered. LVN A stated she was alerted by Resident #1's CNAs and she alerted the DON. LVN A stated she did not notify Resident #1's family because the DON took over the situation and she assumed the DON would have notified the family. LVN A stated after Resident #1 was transferred to the local hospital, the facility's administrator in-serviced staff on Resident's rights and notifying families and RPs of change of conditions. During an interview on 09/12/2024 at 3:16 pm, CNA B stated Resident #1 was admitted to the facility with a bruise at her coccyx area. CNA B stated when the area opened, she notified LVN A and LVN A went to assess Resident #1. CNA B stated she was not sure which date Resident #1's wound at her coccyx opened. During an interview on 09/12/2024 at 3:33 pm CNA C stated Resident #1 had a dark, bruise-like spot at her coccyx area and LVN A was notified when the area opened. CNA C stated she was not sure of the exact date Resident #1's wound at her coccyx opened . During an interview on 09/12/2024 at 3:53 pm the DON stated the first time he saw Resident #1's coccyx area was 08/05/2024 when the wound had opened. The DON stated he was called by LVN A, he went and assessed the wound. The DON stated he swore he called the family to notify them of the wound because he had to get consent for the Wound Doctor to treat the wound. The DON stated he did not document that he called the family or got consent for the Wound Care Doctor to treat. The DON stated if it is not documented, it is not done . The DON stated it was brought to their attention on 08/24/2024 that the family was not aware of Resident #1's pressure ulcer on the coccyx. The DON stated the Administrator conducted an in-serviced on Resident's Rights and family notification for all nurses. During an interview on 09/13/2024 at 10:31 am Resident #1's family stated they were not informed Resident #1 had developed a pressure ulcer. Resident #1's family stated they did not find out Resident # 1 had pressure ulcer until 08/24/2024 when she was being transferred to the local hospital . Resident #1's family stated they were told the wound started to develop on 08/05/2024. Resident #1's family also stated they did not know Resident #1 was being seen by the wound care doctor, they did not sign a consent. During an interview on 09/13/2024 at 1:24 pm the Administrator stated Resident #1's family had called to complain that they were not made aware by the facility that Resident #1 had a pressure ulcer at the coccyx area. The Administrator also stated during the same conversation that someone had called on 08/05/2024 to inform them. The Administrator stated he completed a grievance form, interview staff and conducted training in-serviced on Notification to Physician, family and others; a post test was completed along with the training. Review of facility's in-service dated 08/26/2024 reflected an in-serviced titled Notification to Physician, family and others and was signed by nurses. It was also reflected staff completed a post test. It was also reflected Post test addressed who, when and why notification are made. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/13/2024 at 4:00 pm LVN D stated she was in-serviced on family notification and residents' rights about 2 weeks ago. LVN D stated the family, and the physician should notify of any change in resident's condition like infection, skincare and/or anything that is not normal for the resident. During an interview on 09/13/2024 at 04:09 pm LVN E stated she was in-serviced recently on family notification. LVN E stated families and physician should be notify of falls, medication changes, skin discoloration, and any procedure that may come up for a resident. During an interview on 09/13/2024 at 04:06 pm LVN A stated she was in-serviced on family notification on change of condition. Review of facility's policy titled Resident's Rights undated reflected the following: Purpose .To ensure that resident rights are respected and protected. .To inform residents of their rights and provide an environment in which they can be exercised. To be informed of, and participate in, his or her treatment, including the right to: o Be fully informed in a language they can understand of their total health status o Be informed, in advance, of changes to the plan of care o Be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish the care o Be informed, in advance, by the physician of the risks and benefits of proposed care, of the treatment and alternatives and the right to choose the alternative option they prefer. Review of facility's policy titled Notification to Physician, Family and others undated reflected the following: The facility will remain compliant with reporting guidelines as outlined by state and federal regulations. Notifications of changes --- The facility will inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative and document in the resident's medical record where applicable, when there is: o A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment);

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39269 Based on interview, and record review the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections to the extent possible for one (Resident #1) of three residents reviewed for indwelling urinary catheters, in that: The facility failed to ensure Resident #1 had physician orders for her indwelling foley catheter (is a sterile tube that is inserted into your bladder to drain urine) or for care and monitoring. This failure could place residents with indwelling urinary catheters at risk of sepsis, renal failure, urinary tract infections, and pain. Findings included: Review of Resident #1's face sheet dated 09/12/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included unspecified fracture of right femur (the longest bone in the human body, it extends from the hip to the knee) , subsequent encounter for closed fracture with routine healing, essential tremor and presence of unspecified artificial knee. Review of Resident #1's Nursing Home Comprehensive MDS assessment dated [DATE] reflected a BIMS score of 00, staff assessment indicated both long- and short-term memory problems. Section H (Bladder and Bowel) reflected Resident # 1 had an indwelling catheter. Review of Resident #1's care plan initiated 08/01/2024 and revised 08/08/2024 reflected Resident #1 had an indwelling catheter and at risk for UTI/complications. Care plan interventions included -- assess reports of abnormal urine - sediment, odor, color, amount, etc. report to MD as needed. Empty and record output every shift and PRN, Observe for and document S/S of complications/UTI to include but not limited to: color, consistency, amount of urine, condition of skin at insertion site, pain, burning, discomfort, change in mental status and notify MD of findings, change foley tubing and bag as ordered, check tubing after providing care for kinks, tubing and bag below the level of the bladder reposition as needed, Catheter care per facility policy and PRN, change Foley Catheter every month and as needed. Review of Resident #1's Physician orders from 07/26/2024 through 08/24/2024 reflected no orders for Foley catheter, Foley catheter care, Foley catheter monitoring, Foley catheter output etc. Review of Resident #1's MARs and TARs from 07/26/2024 though 08/24/2024 reflected no evidence of Foley catheter care, Foley catheter monitoring, Foley catheter output etc. Review of Resident #1's progress notes reflected Resident #1 was transferred to the local hospital on 08/24/2024 due to Resident #1 running fever and BP low and family requested Resident #1 be sent to the hospital. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/2024 at 2:16 pm LVN A stated Resident #1 had foley catheter throughout her stay in the facility. LVN A stated the CNAs were responsible to provide catheter care, empty the foley catheter and notify the charge nurses of output. LVN A stated the charge nurses were responsible to document foley catheter output. LVN A stated the CNAs always give her Resident #1's Foley catheter output and she did not know where she documented it. During an interview on 09/12/2024 at 3:16 pm, CNA B stated Resident #1 had foley catheter throughout her stay in the facility. During an interview on 09/12/2024 at 3:33 pm CNA C stated Resident #1 had foley catheter throughout her stay in the facility. During an interview on 09/12/2024 at 3:53 pm the DON stated, she had a foley catheter, she came in with a foley catheter. I think it was discontinued at some point and reinserted. There should have been an order for catheter care, output, monitoring. We have to have some way of monitoring; it is high risk for infection. During an interview on 09/13/2024 at 10:31 am Resident #1's family stated Resident #1 had Foley catheter throughout her stay at the facility. Review of the facility's policy titled Catheter Care, indwelling Catheter undated reflected no policy or procedure related to the implementation of physician's orders with regard to the presence of a catheter. It reflected: Basic responsibility -Licensed Nurse, Certified nurse's aide. Purpose-to prevent infection, to reduce irritation. Assessment guidelines: may include, but not limited to: color, consistency, amount of urine, condition of skin at the site of insertion, pain, burning, discomfort Review of facility's Policy titled Physician orders undated reflected: Physician Orders for medications and treatments will be consistent with principles of safe and effective order writing.