

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER Rambling Oaks Courtyard Extensive Care Community		STREET ADDRESS, CITY, STATE, ZIP CODE 112 Barnett Blvd Highland Village, TX 75077	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #1) of six residents reviewed for respiratory care. Based on interview and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #1) of six residents reviewed for respiratory care. The facility failed to ensure Resident #1 had an order for oxygen administration when she was a resident at the facility from 07/10/2025 to 07/12/2025. This failure could place residents at risk for respiratory infection and not having their respiratory needs met. Findings include: Record review of Resident #1's Face Sheet, dated 07/30/2025, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #1 had diagnoses which included acute respiratory failure (the body doesn't get enough oxygen), thrombocytopenia (low platelet count which can increase the risk of bleeding) and chronic atrial fibrillation (irregular heart rhythm). Resident #1 discharged from the facility on 07/12/2025. Record review of Resident #1's MDS (tool used to measure health status) admission Assessment, dated 07/12/2025, reflected moderate impaired cognition with a BIMS (tool used to assess cognitive function) score of 10. Section I (active diagnoses) reflected Resident #1 was treated for pneumonia (infection of the lungs) and respiratory failure. Record review of Resident #1's Baseline Care Plan, dated 07/14/2025, reflected Resident #1 received oxygen therapy while a resident. The Baseline Care Plan indicated Resident #1 was confused, removed the nasal cannula, and required frequent redirection related to the administration of oxygen therapy. Record review of Resident #1's Physician's Order, dated 07/10/2023, reflected to administer oxygen via nasal cannula 2-4 liters LPM (flow rate of oxygen) PRN to keep oxygen saturation above 92%. The end date for this order was 09/07/2023. Resident #1 did not have a current order for oxygen administration. Record review of Resident #1's hospital transfer orders, dated 07/10/2025, reflected an order to titrate oxygen delivered to keep oxygen saturation percentage above: 88-94%. The hospital transfer order reflected the resident was on supplemental oxygen at 4 LPM. Record review of Resident #1's vital signs, dated 7/10/2025, 07/11/2025, and 07/12/2025, reflected oxygen was administered via nasal cannula at 4 LPM. During a telephone interview on 07/30/2025 at 2:54 PM, LVN A stated Resident #1 had an order to receive continuous oxygen at 2-4 LPM and it was in her chart. She stated Resident #1 was administered oxygen at 4 LPM. When LVN A was asked about the date of the order, LVN A stated she had not noticed the order was for a previous admission. LVN A stated it was important to ensure, and clarify when needed, the resident had a current physician's orders for oxygen prior to administering oxygen. She stated administering less than or more than the prescribed order could have effects on the resident. She stated if not given the correct dose, a resident could have dizziness, headaches, or a nosebleed if the nasal passage became dry. She stated if orders were not followed, a resident might not receive sufficient oxygen. During an interview on 07/30/2025 at 3:08 PM, the DON stated her expectation was for nurses to check and verify that orders in the resident's chart corresponded with the resident's admission orders. She stated the DON and ADON checked to ensure orders were transcribed properly. She stated the pharmacy representative also looked at admission orders. The DON stated it was important to follow the physician's orders. She stated there was no question about that. She stated Resident #1 had an order but it was from 07/10/2023. She stated she missed it because it was the same date the resident admitted for her most recent admission. She stated it could potentially cause respiratory distress if orders were not followed. During an interview on 07/30/2025 at 3:15 PM, the [NAME] President of Clinical Services stated he when he looked at Resident #1's orders from 07/10/2023, he saw the date but did not notice the year was different. He stated other staff members probably did the same thing. He stated his expectation was for staff to follow discharge orders from whatever entity sent the resident to the facility. He stated orders were given for a reason and it was important to follow them. He stated it was important to ensure physician's orders were followed to avoid a potential negative outcome. Record review of the facility's policy Administering Medications, revised April 2019, reflected Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame</p>		