STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455703	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKMONT HEALTHCARE AND REHABILITATION CENTER OF KA	**1525 TULL DR KATY, TX 77449**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and/or implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet residents' mental and psychosocial needs for 1 of 5 residents (Resident#1) reviewed for comprehensive care plan. The facility failed to implement Resident #1' s orders for his pressure ulcer treatment . This failure could affect all residents in the facility who require care plans . Findings include: Resident #1 Record review of Resident #1 admission face sheet revealed he was a [AGE] years male who was admitted to the facility on [DATE] and readmitted on [DATE]. His [DIAGNOSES REDACTED]. Record review Resident #1's quarterly MDS assessment, dated 2/13/20 revealed Resident #1 was admitted with no pressure ulcer. The MDS also revealed Resident #1 required total assistance from two or more staff for bed mobility and toilet use. Section H identified Resident # 1 as incontinent of bladder and bowel and had a BI[CONDITION] score was 13 indicating intact cognition. Record review of Resident #1's care plan last revised on 2/13/20 indicated Resident #1 required extensive assistance with ADLs. He was at risk for further skin breakdown. Interventions included weekly skin assessment and documentation , a low air loss mattress while in bed, and a wheelchair cushion while in wheelchair. Record review of Resident #1's pressure wound log dated 2/3/2020 at 6:13p.m., revealed During dressing to lower ext. after resident shower, a skin assessment was completed, and resident noted with 6cm x4cm area of left inner buttocks, and SDTI of right heel measuring approx. 3 x 2cm. area of buttocks cleanse with NS and covered with dry dressing. Right heel cleanse with NS and skin prep applied and left open to air. Also noted scab formation of right outer ankle measuring 0.5x 0.5cm. RP and NP notified of new areas and orders received for treatment. Refer to wound MD. Record review of Resident #1's order dated 2/3/20 revealed an order from the NP to cleanse right ischial (hip bone) with vashe (Wound cleanser) pat dry apply medi-honey, silver alginate, gauze, and dry dressing daily. Observation and interview on 3/4/20 at 10:54 a.m. revealed Resident #1 was lying in bed on a pressure relief mattress . Resident #1 had head to toe assessment done by LVN #2 which revealed no dressing to right ischium. LVN #2 said she was not aware when the dressing came off. LVN #2 said the dressing could have come off during incontinent care and normally the floor nurses would replace the dressing if it comes off. LVN #2 said the dressing was done on 3/3/20 at 9:00 a.m. In an interview on 3/4/20 at 11:00 a.m., Resident #1 said he did not know that the wound dressing was off and he did not know when the dressing came off . In an interview with CNA #1 on 3/4/20 at 11:15 a.m. she said she had been working in the facility since 2016 . She said she provided incontinent care for Resident #1 . She stated that resident did not have any wound dressing to his right ischial area when she provided incontinent care to him. She also said the resident was wet with urine at that time. CNA #1 said she would notified the nurse if dressing came off. In an interview with LVN # 1/Treatment nurse on 3/4/20 at 11:30 a.m. , she said she started work January 2020 and she was the only treatment nurse. In an interview with the DON on 3/4/20 at 4:30 p.m., regarding following physician's orders [REDACTED].
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review , the facility failed to ensure a resident who entered the facility with pressure ulcers received care and treatment consistent with professional standards of practice to promote healing and prevent further development or worsen of pressure ulcers for 2 of 2 resident (CR #3 and Resident #1) reviewed for pressure ulcers. The facility did not provide treatment to CR#3's bilateral heels facility acquired Stage 3 pressure ulcer for three days. The facility did not provide wound care/ treatment to CR#3's buttocks wound for 5 days resulting in the worsening of her wounds and delayed treatment. The facility failed to implement Resident #1' s orders for his pressure ulcer treatment. These failures could place other resident with pressure ulcers at risk of developing new pressure ulcers and decline in existing pressure ulcers. Findings included: CR #3 Record review of the face sheet for CR#3 revealed she was [AGE] years old. She was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Record review of CR #3' s admission MDS assessment dated [DATE] revealed a BI[CONDITION] score of 9 indicating moderately impaired cognition. She needed extensive assistance of two staff with bed mobility, toilet use, and personal hygiene. She was incontinent of bladder and bowel. CR #3 was totally dependent on staff for transfers. The MDS indicated CR#3 was at risk of pressure ulcers. Record review of CR #3's care plan identified the resident had physical functional deficit related [MEDICAL CONDITION](Cerebro Vascular Accident) with residual effects , left [MEDICAL CONDITION] and need moderate to extensive assistance with ADLs (Activities of Daily Living) . Care plan was initiated 12/3/2019. Record review of CR #3' s records revealed no care plan following her admission addressing CR#3's pressure ulcer risk . CR#3 had a care plan initiated 12/29/19 and revised 1/14/2020 . Record review of CR #3's admission skin assessment dated [DATE] titled Nursing-Weekly pressure Ulcer Evaluation revealed CR #3's skin was intact and on pressure sores. No further weekly skin assessment was documented as completed presented till 12/23/19. Record review of Weekly Nurses Note dated 12/23/19 at 11:52 p.m., revealed summary had wound nurse to look at BLE heels and her buttock This was written by LVN #1 to treatment nurse who no longer works with the facility. Record review of CR#3's general notes per treatment nurse revealed on 12/25/2019 at 11:09 a.m. CR #3 has SDTI (Suspected Deep Tissue Injury) to bilateral heels. Verbal order received from NP for skin prep twice a day. Will continue to monitor till resolved. Responsible Party (RP) was notified. Further review of CR#3's orders revealed there was no order for the buttock wound. Record review of CR#3's general notes per treatment nurse dated 1[DATE]19 at 2:36 p.m. revealed CR #3 had SDTI on right and left heel. Right heel measures 5.2 cm x 4.2 cm x 0.0 cm and left heel measures 4.2 cm x 4.5 cm x 0.0 cm. Continue treatment twice a day till resolved. Record review of CR#3's general notes per NP (Nurse Practitioner) dated 1[DATE]19 at 10:43 a.m. revealed order offload boots to be worn at all times. Record review of CR#3's general note dated 1[DATE]19 at 1:30 p.m. revealed CR #3 had an open wound on her buttocks. Per former DON, open wound was unstageable. NP notified and gave orders to cleanse wound and apply santyl (chemical debridement agent) and calcium alginate daily. NP also states CR#3 was to be up for all meals and then back in bed between meals and to get an air mattress for CR #3. RP notified. No measurement for the open wound to the buttock. Record review of CR#3's general note dated 12/30/2019 08:39 a.m. revealed per treatment nurse NP ordered, Air mattress received. Provolone boots are on bilateral feet. NP in the facility and evaluated wound on patient's buttocks. CR #3 was repositioned to her left side with a wedge in place and had referral to the wound care doctor. Record review of CR#3's general note dated 12/31/2019 5:12 p.m. revealed late entry: per treatment nurse revealed CR #3 was seen by wound care Dr. CR #3 had bilateral unstageable areas to heels. Right heel measured 5.7 cm x 6.6 cm cx 0.0 cm with 50% necrotic tissue and 50 % granulated tissue and left heel measured 5.2 cm x 4.9 cm x 0.0 cm with 60% necrotic tissue and 40% granulation tissue. Continue current order. CR #3also had area to right buttocks measuring 6.6 cm x 6.4 cm x 0.1 cm with moderate drainage with 40% necrotic tissue, 40% slough and 20% granulation. Continue with current

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

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.

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) treatment. Will continue to monitor till resolved. Record review of CR#3's general note dated 1/7/2020 5:23 p.m. revealed CR #3 was seen by wound care Dr. CR#3 had area to right heel measuring 6.1 cm x 7.2 cm x 0.0 cm. Right heel is unstageable with 40% [MEDICATION NAME] and 60% necrotic. Left heel measured 6.1 cm x 5.4 cm x 0.0 cm and is unstageable. 30% [MEDICATION NAME] and 70% necrotic. Left buttocks have area measuring 6.8 cm x 4.7 cm x 0.2 cm and unstageable. 40% slough, 20% [MEDICATION NAME] and 40% granulation. New area to left malleolus (the bony prominence on each side of the ankle) measuring 2.0 cm x 1. 1 cm x 0.0 cm. Unstageable. 20% [MEDICATION NAME] and 80% necrotic. Order skin prep. Record review of CR #3's TAR wound care revealed no documentation or initials indicating wound care and dressing changes were done on 1/5/20, 1/7/20, 1/18/20 and 1/19/20 and there were no documentation indicating CR#3 had refused wound care and wound dressing changes. Record review of CR#3's hospital record dated [DATE] revealed chief complaint was gradually worsening chronic decubitus pressure ulcer. Further review revealed a [AGE] year-old female with bilateral stroke living in a nursing home in the [LOC] area. She had developed wound in the ischial (hip bone) which has been getting worse and had started to smell. Assessment and plan revealed right hip bone pressure ulcer , has possible complication to the rectum and massive necrosis with associated [MEDICAL CONDITION], acute [MEDICAL CONDITION] and dehydration. Poor mobility also led to wounds on both heels. Plans are for aggressive debridement of the necrotic wound and antibiotic therapy for aerobic and anaerobic infection, rehydrate and correct the prerenal stage . she will need a diverting [MEDICAL CONDITION] and aggressive debridement of the wound . Flap closure but she overall was poor . Interview on 3/4/20 at 2:38 p.m., the DON said the facility did not have a treatment nurse, she said each floor nurse was responsible for wound care and performed wound treatments. The DON said she was not sure if floor nurses had been in-serviced because the treatment nurse was terminated, and former DON quit. She said she was new in the position of DON. The facility just hired a new treatment nurse a couple of weeks ago. In an interview with the NP who returned a call placed on [DATE] at 11:30 a.m., she said she gave orders for CR #3's wounds when the nurse notified her of the unstageable pressure sores. NP returned all on [DATE]20. Resident #1 Record review of Resident #1 admission face sheet revealed she was a [AGE] years male who was admitted to the facility on [DATE] and readmitted on [DATE]. His [DIAGNOSES REDACTED]. Record review Resident #1's quarterly MDS assessment, dated 2/13/20, reflected Resident #1 was admitted with no pressure ulcer. The MDS also revealed Resident #1 required total assistance from two or more staff for bed mobility and toilet use. Section H identified Resident # 1 as incontinent of bladder and bowel and had a BI[CONDITION] score was 13 indicating moderately impaired with decision making skills. Record review of Resident #1's care plan last revised on 2/13/20 indicated Resident #1 required extensive assistance with ADLs. He was at risk for further skin breakdown. Interventions included weekly skin assessment and documentation , a low air loss mattress while in bed, and a wheelchair cushion while in wheelchair. 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In an interview with LVN # 1/Treatment nurse on 3/4/20 at 11:30 a.m. , she said she started work January 2020 and she was the only treatment nurse. She said she performed weekly skin assessments and only had Resident #1 with an in house acquired pressure ulcer to right ischium and right heel. She further said Resident #1 goes to wound care center once a week and the doctor at the wound care center was the wound doctor the facility used. She further said the wound doctor visited every Tuesday and does wound debridement . In an interview with the DON on 3/4/20 at 4:30 p.m., the DON said she was new to the facility and heard about CR#3. She said the facility had a QAPI following CR#3's wound concerns. The DON said the facility did not have a policy regarding following physician's orders [REDACTED].#3 and Resident #1's pressure sores treatment, she said no matter what the facility does or tries to do, the facility would be cited. Even when the facility had QAPI and audit conducted regarding in house acquired pressure areas. Record review of the QAPI presented by the administrator revealed it was dated [DATE]20. Further review of the QAPI following authorization the DON indicted the facility conducted an audit on all residents , identifying those at-risk pressure ulcers as well as those with pressure ulcers to ensure treatment were in place. The DON/ADON will make round to compare resident 's positioning and care plan for four weeks. The facility hired a more experienced wound care nurse to ensure weekly skin assessment were done and reported weekly to the DON during daily stand up meetings. Overall number of facility acquired wounds had decreased and healed. Record review of the facility's Skin Care Guideline (July 2018) read in part, .The purpose of this procedure is to provide a system for evaluation of skin to identify risk and identify individual interventions to address risk and a process for care of changes/disruption in skin integrity. Process. Weekly review of the patient's /resident's skin will be completed by the nurse and documented in the electronic medical record. When an open area is identified: Implement resident specific interventions immediately. Specialty mattress/pressure reduction mattress on bed. Notify physician and document notification.