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 _____	**03/11/2020**

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.

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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** Based on observation, interview and record review, the facility failed to ensure individuals with mental disorders were evaluated and received care and services in the most integrated setting appropriate to their needs for 1 of 20 residents, (Resident #17) reviewed for PASRR Level 1 screenings. The facility failed to ensure Resident #17 who had a [DIAGNOSES REDACTED]. This failure could affect resident who have indication of a mental illness, intellectual disability, and/or developmental disability. Findings Include: Resident #17 Record review of Resident #17's facesheet revealed a [AGE] year-old female admitted on [DATE]. Her [DIAGNOSES REDACTED]. with behavioral disturbances, and [MEDICAL CONDITION] disorder. Record review of Resident #17's PASRR level I dated 6/2016 revealed resident was negative for suspecting mental illness. Record review of Resident #17's behavioral medicine/progress notes from 2/5/19 current revealed she was referred and was receiving services since 12/26/2017. Notes revealed resident had a history of [REDACTED]. Further review revealed resident was evaluated and treated by psychiatrist on a consistent basis. Record review of Resident #17's nurses notes dated 3/19/19 at 12:33AM revealed in part, .Resident verbalized that she wants to die. Writer called 911 and RP was in the facility and refused. Resident denies pain or any discomfort as per RP refused taking her to ER. NP was notified. DON notified. MD gives a new order to take resident to ER for further evaluation RP refused and was thinking about involving palliative care . Record review of Resident #17's nurses notes dated 3/19/19 at 11:28AM revealed in part, .Resident noted to have call light wrapped around neck; removed; resident has one on one care at this time; resident stating wanting to die; resident sent to hospital . Record review of Resident #17's hospital history and physical dated 3/19/19 revealed in part, .female was just discharged yesterday with treatment plan for long -term IV [MEDICATION NAME] through her PICC line IV for infected sacral decubiti ulcer . was sent again from nursing home because the patient was witnessed to be strangling her neck with a cord. Patient reported to the ER nurse that she wanted to kill herself. In the ER patient pulled out her left extremity PICC line . According to the ER record, patient attempted asphyxiation with an electric cord in the nursing home. As per EMS, patient has had prior left suicide attempts. Psych response team was called from the emergency room . Record review of Resident #17's nurses notes dated 3/25/19 at 3:19PM revealed resident was readmitted from hospital. Record review of Resident #17's physician note dated 3/29/19 revealed in part, patient is being admitted to hospice today . recently multiple hospitalization s for UTI's, psychiatry issues, suicidal attempts. Patient was placed on hospice today after family decided . Patient with multiple medical problems including [MEDICAL CONDITION], stage 4 decubitus . Record review of Resident #17's significant change MDS dated [DATE] revealed she was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Further review of the MDS revealed a BIMS score of 5 indicating severe cognitive impairment. Resident mood assessment noted she felt down, depressed, and hopeless several days. Resident was noted to have behavioral symptoms not directed towards others that put her at significant risk for physical illness or injury. MDS included [DIAGNOSES REDACTED]. Further review of the MDS revealed resident was taking antipsychotics, antianxiety, antidepressants, hypnotic, and opioid medications. Record review of Resident #17's care plan last revised on 9/17/19 revealed she displayed socially inappropriate and disruptive behaviors as exhibited my multiple claims I am pregnant, being sexually assaulted, shot, stabbed, in labor and calling 911. She has emotional outburst of repeatedly of crying and has a [DIAGNOSES REDACTED]. She prefers to sleep in the nude and picks at her [MEDICAL CONDITION] bag and sometimes would remove it. She has a baby doll that she keeps in the room with her and enjoys watching cartoons. She has a [DIAGNOSES REDACTED]. The interventions included: activities, administer medications as ordered, elicit family input, encourage family to visit, escort from public area when behaviors are disruptive, labs as ordered, psych consult as directed, social services visits and evaluations, and talk with her in a calm voice when her behaviors are disruptive. Further review of the care plan last revised on 9/17/19 revealed she can sometimes be easily distracted, agitated, angered which may be associated with her [DIAGNOSES REDACTED]. Interventions included to allow her time to voice her feelings, assess for signs/symptoms of infection, medications as ordered, psych consult as directed, report changes to MD. Further review of the care plan last revised on 2/6/2020 revealed she had a long history of [MEDICAL CONDITION] and [MEDICAL CONDITION] with delusions and hallucinations. She takes antipsychotic medications for her [MEDICAL CONDITION] and [MEDICAL CONDITION] diagnoses. Her interventions included: administer medication as directed. Assess for adverse reaction to medication such as lethargy, sedation, change of level of consciousness, change in cognitive status. Evaluate the effectiveness and side effectiveness and side effects of medication for possible decrease/elimination of medication. Psych consult as directed. Record review of Resident #17's quarterly MDS dated [DATE] revealed a BIMS score of 9 indicating moderate impaired cognition. Further review of the MDS revealed she had some rejection of care. Her [DIAGNOSES REDACTED]., anxiety disorder, depression, [MEDICAL CONDITION] ([MEDICAL CONDITION] disease), [MEDICAL CONDITION], and [MEDICAL CONDITION]. Further review of the MDS revealed resident was taking antipsychotics, antianxiety, and antidepressants. Observation and interview on 3/8/20 at 3:04PM, Resident #17 was laying in bed leaning on her right side holding onto bed rail. Resident said she was okay. Resident was able to communicate but spoke very slowly. Resident said she had no complaints. Interview on 3/10/2020 at 2:00PM, the MDS Nurse said Resident #17's PASRR from 2016 was the only one completed. She confirmed the resident was negative for mental illness for her Level I PASRR. She went through the residents [DIAGNOSES REDACTED]. The MDS nurse said the resident was not evaluated for PASRR evaluation for mental illness because she had a [DIAGNOSES REDACTED]. She said she thought if the resident was on hospice they did not have to have a PASRR evaluation completed. The MDS nurse said she would check with someone and follow up with surveyor. Observation and record review on 3/11/2020 at 3:30PM, the DON delivered a form 2360 for Resident #17 that was dated 3/11/2020, the form revealed a PASRR evaluation (PE) was completed for Resident #17 and she was determined to not be eligible for PASRR specialized services. Area to date when the PE was completed was blank. Interview on 3/11/2020 at 3:45PM, evaluator listed to have completed the evaluation was called to clarify when evaluation was completed, and he reported PASRR evaluation was completed on 3/11/2020. Interview on 3/11/20 at 4:05PM, the DON said the facility did not have a policy for PASRR and said the facility followed the state PASRR guidelines.
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** Based on observation, interview and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infects for 1 of 1 resident (Resident #98) reviewed for incontinence care, in that: Resident #98 did not receive proper incontinent care. This failure could affect any resident who require incontinent and catheter care. Findings included: Resident #98 Record review of Resident #98's Face Sheet revealed he was a [AGE] year-old male who was admitted on [DATE] and was readmitted [DATE] with [DIAGNOSES REDACTED].

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 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Record review of Resident #98's MDS dated [DATE] quarterly revealed a BIMS score of 10 out 15 which indicated moderately cognitive impairment. Further review of the MDS revealed Resident #98 was frequently incontinent of bowel and had an indwelling urinary Foley catheter. He required extensive assistance from one staff for dressing, eating personal hygiene bathing and indwelling catheter. Record review of Resident #98's Care Plan revised 01/03/20 revealed he had bowel incontinence and used an indwelling urinary catheter. Observation of incontinent/indwelling urinary catheter care on 03/9/20 4:00 PM revealed CNA #1 wheeled Resident #98 from the dining room, then transferred Resident #98 in bed. Resident #98 had an indwelling urinary catheter that was not secured to his body. Urinary catheter bag had 50 cc of yellow urine. CNA #1, using wet wipes did not cleaned the resident's groin area, scrotum and did not clean the indwelling urinary catheter tube away from the insertion site and around the penis head. CNA #1 changed gloves without washing hands or using hand sanitizer then repositioned resident to left side. CNA #1 then cleaned the buttocks and surrounding area, changed gloves again without preforming any hand hygiene. CNA #1 then placed a cleaned brief on the resident. While performing incontinent/Foley catheter Resident #98 was grimacing in pain and asking CNA #1 to be gentle while moving indwelling catheter. Interview on 03/11/2020 at 4:10p.m. with CNA #1 regarding incontinent/Foley catheter care and the last time she received in Service Training, CNA#1 stated she does not remember the last time she attended an in Service. Interview and record review on 03/11/2020 at 3:22PM with RN (Clinical Educator and Infection Control Nurse) regarding CNA staff In Service training. She stated all CNAs get an Annual Competency Training that includes: Peri Care, Foley Care, and Hand Washing. Copies of Annual Competency for, CNA #1 dated 11/11/2019 were obtained and no other in services was provided. RN (Clinical Educator and Infection Control Nurse) also said CNA were trained to secured indwelling catheter. A request was made on 03/11/20 at 11:20 a.m. to the DON for the facility's policy on catheter care. The policies provided prior to exit did not address daily care of an indwelling catheter or incontinent.
F 0732 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on observation, interview and record review, the facility failed to ensure the daily nursing staffing was posted as required, in that: Daily nursing staffing information was not posted daily for 4 days. This failure placed all residents, families, and visitors at risk of not having access to current information regarding staffing data and facility census. Findings include: Observation and record review of facility's Daily Hourly Nursing Staff Posting on 3/8/20 at 1:10PM revealed posting was dated 3/4/20. Further review revealed census was 97. Interview on 3/11/20 at 4:05PM, the DON said the facility did not have a policy for posting staffing and stated they followed the state and federal guidelines for the posting of staff. Interview on 3/11/20 at 5:15PM, the Administrator said it was the responsibility of the staffing coordinator to update the staffing posting. The Administrator said she was out on leave and the Director of Education (DOE) was supposed to update the posting in the staffing coordinators absence but said she had also been out.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 9%, based on three errors out of 32 opportunities, which involved two residents (Resident #51 and #42) and two of six staff (MA#1 and LVN #1) observed for medication errors, in that: MA #1 did not administer Resident #51's [MEDICATION NAME] ([MEDICATION NAME]) medication as ordered by the physician and according to pharmaceutical recommendation. LVN #1 did not administer Memantine ([MEDICATION NAME]) and [MEDICATION NAME] ([MEDICATION NAME]) as ordered by physician via Resident #42's Gastrostomy Tube ([DEVICE]) . These failures could affect any resident who received medications from facility staff and who have [DEVICE]s. Findings include: Resident #51: Record review of Resident #51's face sheet revealed a [AGE] year old female, who was admitted on [DATE] readmitted [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #51's admission MDS assessment dated [DATE] revealed Resident #51 had BIMS score of 13, indicating moderately impaired cognitive skills. Resident #51 required minimal assistance of staff for all ADLs. Record review of Resident #51 's physician order [REDACTED]. Give 2 tablets by mouth two times a day for [MEDICAL CONDITION]. Observation on 3/9/20 at 3:47 p.m. revealed MA #1 administered medication to Resident #51. She picked up the blister package for Adlactone ([MEDICATION NAME]) 50 mg, punched 2 tablets and gave them to the resident by mouth. The Adlactone ([MEDICATION NAME]) 50 mg blister package instruction revealed Take with Food/Meal. In an interview with MA #1 at 3:49 p.m. regarding meal times (dinner) she said dinner was served around 5:00 p.m. Observation on 3/9/2020 at 5:30pm revealed dinner was served at this time. Resident #42 Record review of Resident # 42's face sheet revealed a [AGE] years female admitted on [DATE] and readmitted [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #42's physician order [REDACTED]. [MEDICATION NAME] ([MEDICATION NAME]) tablet 5 mg Give 1 tablet via [DEVICE] one time a day . Observation on 3/10/20 at 8:45 a.m., revealed LVN #1 administering [DEVICE] medication to Resident #42. She picked up other medications crushed and administered them. LVN #1 did not administered Memantine ([MEDICATION NAME]) and [MEDICATION NAME] ([MEDICATION NAME]) via Resident #42's [DEVICE]. In an interview with LVN #1 on 3/11/20 at 10:00 a.m. regarding Memantine ([MEDICATION NAME]) and [MEDICATION NAME] ([MEDICATION NAME]) that were initialed on MAR (medication administration record) indicating the were administered. LVN #1 said she was sorry, she will be more careful. In an interview with the DON on 3/11/20 at 3:15 p.m., she said staff should follow the policy regarding medication administration. Record review of the facility's policy entitled, Medication Administration competency audit - oral and Enteral tube, revealed the following: 2. Checks each label with order (if incorrect label sticker is on medication, follows proper checking protocol- meds area administered at correct time). Applies 6 rights of medication administration. 6 Rights of Administration. Administration Medication, Route, Time, Patient, Dosage, and Documentation.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review , the facility failed to ensure drugs and biologicals were stored in accordance with state and federal laws in two of two medication rooms and one of four medication carts reviewed for medication storage, in that; Expired medications were not removed from the medication cart and medication room. Medication room refrigerator had [MEDICATION NAME] Purified Protein Derivative vial that were open and not dated . These failures could place all residents whose medications were stored in facility's medication carts and medication rooms. Findings include: Observation of medication room, medication cart and treatment cart 100 hall on 03/10/20 at 4:22pm revealed 0.9% Sodium Chloride 200mls that expired January 2020. Medication Cart [MEDICATION NAME] Insulin (100U/1mL) had no open date on vial or plastic container containing vial. Treatment Cart 8 Lubricating jelly [MEDICATION NAME] that expired on 2/20. 4 Derma Septin skin protectant that expired 4/19. 200 Hall Medication room [ROOM NUMBER] opened 0.9% sterile saline bottle used for irrigation was not dated . 1 open suction tray was not dated. The refrigerator in the medication room had 1 vial [MEDICATION NAME] purified protein derivative diluted [MEDICATION NAME] 5TU/0.1 ml open but not dated. In an interview on 3/10/20 at 4:25 p.m., LVN #4 on said every vial opened should be dated while stored in the medication cart. In an interview with LVN #2/Treatment nurse on 3/10/20 at 4:30 PM , she said those items had been on the medication cart and she does not use it. In an interview on 3/10/20 at 4:40 p.m., LVN #3 said every opened vial medication stored in the medication cart should be dated. In an interview with DON on 3/11/20 at 11:20 a.m., the DON said nurses were supposed to write dates on medication vials and bottes when open. The DON did not have any system in place on monitoring opened a multi-dose container. DON was asked on 3/11/20 at 11:20 a.m., for policy regarding medication storage, none presented to the surveyor before exit.
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.** Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen, in that: The refrigerator had food items

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) that were not labeled and did not have use by dates. Can opener blade was not clean. Food Cart delivery was dirty. Drawers with serving utensils were dirty. These failures could place all residents who ate food prepared by the kitchen . Findings included: Observation of the facility 's kitchen on 03/08/20 at 12:30 pm with Dietary Aide #1 revealed: Cottage Cheese in a plastic container dated 3 3 20 with no use by date. Two containers of Cottage Cheese not opened with manufacturer's use by date 2 23 20. A container of Peanut Butter labeled with use by date 2 10 20. Assorted open cheese packages in Ziploc bag opened 2 1 20 with no use by date. An open package of sliced American cheese with no label and no date. A container of sour cream dated 2 15 20 with no use by date. A container of Pimento cheese was not labeled and was not dated. Manufacturer use by date was 2 27 20. A container of sliced deli ham no labeled and had no use by date. Observation and interview on 03/08/20 at 12:35pm revealed a can opener blade handle was greasy with food debris. Dietary Aide #1 said that the can opener should be washed and sanitized when it is soiled. Observation and interview on 03/08/20 at 12:40 pm revealed that work table drawer with serving utensils was dirty with food debris. Dietary Aide #1 removed serving utensils and the drawer and put through the dish machine to be washed and to be sanitized. Observation on 03/08/20 at 12:45pm revealed the delivery food cart was dirty with food debris in the bottom shelf of the cart . Interview with the Dietary Manager on 03 08 20 at 1:30 pm revealed that leftover food must be labeled with date and that after 5 days food is used or discarded. The Dietary Manager said a can opener should be washed and sanitized when soiled and dirty, food drawers and utensils must be free from food debris and must be washed and sanitized. Requested Policy and Procedure from the Dietary Food Service manager for washing and sanitizing food carts, can opener, drawers with serving utensils; but was not provided. Record review of facility's Food and Nutrition Services Policy and Procedure for Leftover Foods dated 01/01/17 revealed in part that leftover cold foods should be completely labeled and dated. All refrigerated leftover foods are used within 5 days or discarded.
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** Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of one resident (Resident #98) reviewed for infection control, in that; CNA #1 did not perform appropriate hand hygiene during incontinent and catheter care on Resident # 98 This failure could affect any resident who require incontinent and catheter care from staff. Findings include: Resident #98 Record review of Resident #98's Face Sheet revealed he was a [AGE] year-old male who was admitted on [DATE] and was readmitted [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #98's MDS dated [DATE] quarterly revealed a BIMS score of 10 out 15 which indicated moderately cognitive impairment. Further review of the MDS revealed Resident #98 was frequently incontinent of bowel and had an indwelling urinary Foley catheter. He required extensive assistance from one staff for dressing, eating personal hygiene bathing and indwelling catheter. Record review of Resident #98's Care Plan revised 01/03/20 revealed he had bowel incontinence and used an indwelling urinary catheter. Observation of incontinent/indwelling urinary catheter care on 03/9/20 4:00 PM revealed CNA #1 wheeled Resident #98 from the dining room, then transferred Resident #98 in bed. Resident #98 had an indwelling urinary catheter that was not secured to his body. Urinary catheter bag had 50 cc of yellow urine. CNA #1, using wet wipes did not cleaned the resident's groin area, scrotum and did not clean the indwelling urinary catheter tube away from the insertion site and around the penis head. CNA #1 changed gloves without washing hands or using hand sanitizer then repositioned resident to left side. CNA #1 then cleaned the buttocks and surrounding area, changed gloves again without preforming any hand hygiene. CNA #1 then placed a cleaned brief on the resident. Interview on 03/11/2020 at 4:10p.m. with CNA #1 regarding incontinent/Foley catheter care and the last time she received in Service Training, CNA#1 stated she does not remember the last time she attended an in Service. Interview and record review on 03/11/2020 at 3:22PM with RN (Clinical Educator and Infection Control Nurse) regarding CNA staff In Service training. She stated all CNAs get an Annual Competency Training that includes: Peri Care, Foley Care, and Hand Washing. Copies of Annual Competency for, CNA #1 dated 11/11/2019 were obtained and no other in services was provided. RN (Clinical Educator and Infection Control Nurse) also said CNA were trained to secured indwelling catheter , hand washing and using hand sanitizer. Record review of Perry and Potter Clinical Nursing Skills and Techniques 6th edition, Chapter 8 page 192 revealed in part: .If hands are not visibly soiled, an alcohol-based hand rub should be used for routinely decontaminating hands in the following situation: 1. Before having direct contact with clients .3. After contact with intact skin .4. After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressing .5. When moving from a contaminated body site to a clean body site during care .