STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675394	A. BUILDING _____ B. WING _____	07/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKWOOD MANOR NURSING HOME	225 S MAIN ST VIDOR, TX 77662

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to immediately consult the physician regarding a change of condition for 1 of 5 residents reviewed for physician notification. (Resident #1) The facility did not immediately notify Resident #1's physician when Resident #1 had a decline in health condition and the ambulance transport service refused to transport Resident #1 to her home on her scheduled discharge date because she was lethargic and unable to respond to questions. This failure could place residents at risk for delayed treatment, decline of medical condition and death. Findings included: A face sheet dated 07/24/2020 indicated Resident #1 was admitted [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. The MDS dated [DATE], indicated Resident #1 was cognitively intact, required extensive assistance with 2-person physical assist with bed-mobility, transfers, and dressing, extensive assistance with 1-person physical assistance with personal hygiene and total assistance with 2-person assist with bathing. The MDS indicated was continent of bowel and had a Foley catheter. The clinical record from 06/24/20 through 07/15/20 for Resident #1 indicated there was no comprehensive care plan. A baseline plan of care dated 06/24/20 for Resident #1 indicated: *assistive device/mobility-wheelchair assist rail x 2 (2 sides) *indwelling catheter *touchdown weight bearing right leg *physical therapy screen/evaluation *incontinent of urine *continent of bowel *voiding method-toilet/bathroom *transfer status- gait belt-assist x 2 (2 person assist) *dressing/grooming-assist x 1 (1 person assist) A physical therapy discharge summary dated 7/14/2020 indicated Resident #1 received physical therapy services from 06/25/20 through 07/10/20. The summary indicated Resident #1 was assessed on the last day of services (7/10/20) and was to be discharged to live with family/friends, with assistance/support to be provided by a care attendant morning and evening. The summary indicated the prognosis for Resident #1 to maintain her current level of function was good with strong family support. During an interview on 07/24/20 at 11:02 a.m., PT E said Resident #1 was assessed on 7/10/20 (date of discharge from services) and was able to get out of bed and walk to the shower with her walker. He said OT assessed Resident #1 as able to walk to the counter and brush her teeth. PT E said Resident 1 had family support available. A Patient Discharge Plan of Care dated 07/14/20 for Resident #1 indicated she was being discharged home alone with home health services. A nursing note dated 07/14/20 at 12:17 p.m. completed by LVN G indicated she educated Resident #1 to continue to monitor for signs and symptoms of COVID-19 and Resident #1 was positive and stated, It's not that big of a deal I will be fine. The note indicated LVN G educated Resident #1 to report to home health daily any signs and symptoms. The note indicated Resident #1 understood and was able to verbalize her own needs and requested discharge around 2:00 p.m. that day. A nursing addendum note dated 07/15/20 at 7:47 p.m. completed by LVN G indicated Resident #1 was set up to be discharged on [DATE] at 2:00 p.m. The note indicated the EMS service arrived at the facility at 4:30 p.m. and refused to transport the resident to her home because the resident had increased lethargy (reduced alertness and awareness) and would be going home alone with no one at the home waiting for her. The note indicated LVN G notified her supervisor and called physician I and left a voice message asking for a return call. During an interview on 07/27/20 at 12:31 p.m., LVN G said she called the NP on 07/14/20 and left a voicemail message of Resident #1's lethargy and the EMS refusal of transport. She said she did not receive a response back from the NP before she left her shift that evening. During an interview on 07/24/20 at 11:46 a.m., LVN G said Resident #1 was supposed to go home on 07/14/20, but when the transport ambulance got to the facility to pick her up, she was very lethargic. She said the ambulance personnel said they were acting as an advocate and would not transport Resident #1 to her home because there was no one there to take care of her. She said Resident #1 had gotten weaker and more tired since she was diagnosed with [REDACTED].#1's physician the resident was lethargic and transport service did not feel it was safe to transfer the resident home. During an interview on 07/29/20 at 8:10 a.m., EMS Q said she was dispatched to the facility's COVID-19 unit to transport Resident #1 to her home on 07/14/20. She said the nurse indicated Resident #1 lived alone and the nurse did not know if Resident #1 had anyone to meet her at home. EMS Q said she called Resident #1's name loudly and the resident moaned. She said she called Resident #1's name a second time and asked her name. She said Resident #1 could not say her name, pointed at the wall, and moaned. She said she asked Resident #1 if she was ready to go home and if there was anyone to meet her at home. She said Resident #1 did not respond to any questions. She said she asked the nurse of Resident #1 was continent and she was told she had a Foley. She said the nurse did not say anything about bowel continence. She said she told the nurse she was not comfortable transporting Resident #1 home and did not feel it was safe. She said she would not transport Resident #1 to her home. During an interview on 07/29/20 at 8:02 a.m., EMS P said the dispatch records dated 07/14/20 indicated the transport was delayed and cancelled. He said the dispatch records for 07/15/20 indicated the EMS staff did not feel comfortable leaving Resident #1 in her home due to poor living conditions and she was not able to stand unassisted. The record indicated the resident was taken into her home via stretcher, and left on the couch in the living room. An emergency room hospital record dated 07/17/20 at 3:52 p.m. indicated a wellness check was performed at Resident #1's residence and she was found covered in feces. A Foley was noted, to gravity drainage and the urine was overflowing. The record indicated Resident #1 was responsive to voice, lucid, able to follow commands, confused, and unable to answer questions appropriately. An emergency room hospital record dated 07/17/20 indicated: (Resident #1) is resting comfortable .symptoms do not appear to be due to acute stroke, [MEDICATION NAME] hemorrhage or meningitis . unsure the acute [MEDICAL CONDITION] but may be secondary to COVID-19 . Resident #1 is unable to meet her ADLS . Although Resident #1 is maintaining an O2 SAT she is not able to take care of herself at home .will be admitted . An emergency room nursing note dated 07/17/20 at 4:30 p.m. indicated Resident #1 was and had been lying in feces for an unknown amount of time. An emergency room record dated 7/17/20 at 6:24 p.m., indicated Resident #1 was diagnosed with [REDACTED]. During an interview on 07/27/20 at 12:19 p.m., LVN K (for Physician I and FNP C) said she was told on 07/15/20 the ambulance refused to take Resident #1 home on 07/14/20 because of her positive COVID-19 status. She said she learned of the change of condition when she called the facility on 07/15/20 to set up the telehealth visit. She said the facility never contacted her about Resident #1's lethargy, not being able to care for herself, or not being able to self-transfer and ambulate without assistance. During an interview on 07/24/20 at 12:12 p.m., Physician I said she was not notified the Resident #1 was lethargic or the ambulance refused to take her home the day before (07/14/20) the telehealth visit. She said she would not have discharged Resident #1 had she known of her decline and going home with no support. A facility policy for Physician notification dated 03/2019 indicated: It is the responsibility of the nursing staff to observe the change, make and assessment, and notify the physician as indicated based on the assessment. The Nurse will: recognize the condition change .notify the physician, patient, and patient representative of any change in condition.

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
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 interview and record review, the facility failed to develop and implement a comprehensive, person centered care plan 1 of 5 residents reviewed for care plans. (Resident #1) The facility did not develop a person-centered care plan for Resident #1. This failure could place residents at risk for not receiving proper care and services. Findings Included: A face sheet dated 07/24/2020 indicated Resident #1 was admitted [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE], indicated Resident #1 was cognitively intact, required extensive assistance in performing most activities of daily living, was continent of bowel and had a Foley catheter (a device used to drain the bladder). The clinical record dated 06/24/20 to 07/15/20 for Resident #1 did not include a comprehensive care plan. During an interview on 07/27/20 at 10:00 a.m., ADON LVN M said when a resident admitted to the facility there was a basic care plan in the computer. She said she would pull the baseline and transcribe it to the comprehensive care plan within 7 days of the compressive assessment. She said Resident #1's comprehensive care plan should have been completed by 07/08/20. She said she did not complete Resident #1's comprehensive care plans on time and as required because she was on vacation. She said the previous DON was her back up and it was not completed. She said she completed the comprehensive care plan on the evening of 07/23/20. During an interview on 07/23/20 at 4:09 p.m., MDS LVN D said she completed Resident #1's MDS on 07/01/20 and knew the comprehensive care plan was supposed to be completed within 7 days of the MDS. She looked at the computer with the investigator and acknowledged the discharge care plan was not completed and available to staff. She said the social worker was responsible for completing Resident #1's discharge plan. During an interview on 07/23/20 at 3:07 p.m., SW B said she did not complete Resident #1's discharge plan of care. During an interview on 07/27/20 at 1:30 p.m., the administrator said she was not aware the care plans were not completed. She said Resident #1's care plans were not completed due to a lack of communication and follow-up by the nursing staff. A patient discharge plan of care dated 07/14/20 for Resident #1 indicated she was being discharged home alone with home health services. The form did not include scheduled follow-up appointments, required equipment, dietary instructions, or pharmacy information. Resident #1 did not sign the form. The facility's Patient care Management System dated 11/2017 indicated: A Comprehensive, Person-centered Plan of Care, . must be completed by the 21st day after admission (or within 7 days of the CAA completion date) and must include discharge planning as appropriate. A facility policy Discharge of the Patient dated 03/2019 indicated: Purpose .To provide safe departure from the Facility .Equipment .patient's medical record, discharge order, medications .discharge instruction forms .explain discharge procedure to patient .complete discharge home instructions .the attending physician is required to write a discharge order .telephone orders are acceptable .Documentation-patient status, physical and emotional, type of transportation . A facility Social Services policy dated 11/2016 indicated: 2. A patient Discharge Plan of care must be completed for each patient discharging to home or to another Facility by the interdisciplinary team members. A copy of the patient Discharge Plan of care must be given to the Patient and/or Patient Representative at discharge .i. The post-discharge plan of care must indicate where the individual plans to resident, any arrangements that have been made for the Patient's follow care and any post-discharge medical and non-medical services to prevent readmissions .5. The facility must ensure that a transfer or discharge of the patient is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider.
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the comprehensive plan of care was developed within 7 days after completion of the comprehensive assessment and revised to reflect the current status for 1 of 5 residents reviewed for comprehensive plans of care. (Resident #1) The facility did not develop a comprehensive care plan within 7 days of the completion of the comprehensive assessment for Resident #1. This failure could place residents at risk of not receiving appropriate care and services. Findings included: A face sheet dated 07/24/2020 indicated Resident #1 was admitted [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. The MDS dated [DATE], indicated Resident #1 was cognitively intact, required extensive assistance in performing most activities of daily living, was continent of bowel and had a Foley catheter to bladder. The clinical record from 06/24/20 to 07/15/20 for Resident #1 included no comprehensive care plan. During an interview on 07/23/20 at 4:09 p.m., MDS LVN D said she completed Resident #1's MDS on 07/01/20 and knew the comprehensive care plan was supposed to completed within 7 days. She said the care plan was not completed and available to staff. She said the nursing staff usually completed the care plans after they were initiated in the computer. During an interview on 07/27/20 at 10:00 a.m., ADON M said when a resident admitted to the facility there was a basic care plan in the computer. She said she would pull the baseline and transcribe it to the comprehensive care plan within 7 days of the compressive assessment. She said Resident #1's comprehensive care plan should have been completed by 07/08/20. She said she did not complete Resident #1's comprehensive care plans on time and as required because she was on vacation. She said the previous DON was her back up and it was not completed. She said she completed the comprehensive care plan on the evening of 07/23/20. The facility's Patient care Management System dated 11/2017 indicated: A Comprehensive, Person-centered Plan of Care, . must be completed by the 21st day after admission (or within 7 days of the CAA completion date) and must include discharge planning as appropriate.
F 0660 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure an effective discharge planning process to effectively transition to post discharge care and reduce factors leading to preventable readmissions was provided for 1 of 3 residents reviewed for discharge. (Resident #1) The facility did not develop and implement a discharge plan to meet the needs of Resident #1 prior to sending her home. Resident #1 was found by the fire department lying in feces and unable to get out of bed 2 days after she was discharged from the facility. The resident was hospitalized with COVID-19, UTI, dehydration and altered mental status. An Immediate Jeopardy (IJ) situation was identified on 07/24/20. While the IJ was removed on 07/25/20, the facility remained out of compliance at actual harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place residents at risk for a decline in heath, hospitalization and death. Findings included: A face sheet dated 07/24/2020 indicated Resident #1 was admitted [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. The MDS dated [DATE], indicated Resident #1 was cognitively intact, required extensive assistance with 2-person physical assist with bed-mobility, transfers, and dressing, extensive assistance with 1-person physical assist with personal hygiene and total dependence with 2 person physical assist with bathing. The MDS indicated the resident was continent of bowel and had a Foley catheter. A baseline plan of care dated 06/24/20 for Resident #1 indicated: *assistive device/mobility-wheelchair assist rail x 2 (2 sides) *indwelling catheter *touchdown weight bearing right leg *physical therapy screen/evaluation *incontinent of urine *continent of bowel *voiding method-toilet/bathroom *transfer status- gait belt-assist x 2 (2 person assist) *dressing/grooming-assist x 1 (1 person assist) The clinical record from 06/24/20 through 07/15/20 for Resident #1 indicated there was no comprehensive care plan. During an interview on 07/23/20 at 4:09 p.m., MDS LVN D said she completed Resident #1's MDS on 07/01/20 and knew the comprehensive care plan was supposed to be completed within 7 days of the MDS. She said the comprehensive care plan was not completed and available to staff. She said the social worker was responsible for completing Resident #1's discharge plan. During an interview on 07/27/20 at 10:00 a.m., ADON M said when a resident admitted to the facility there was a basic care plan in the computer. She said she would pull the baseline and transcribe

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F 0660 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) it to the comprehensive care plan within 7 days of the compressive assessment. She said Resident #1's comprehensive care plan should have been completed by 07/08/20. She said she did not complete Resident #1's comprehensive care plans on time and as required because she was on vacation. She said the previous DON was her back up and it was not completed. She said she completed the comprehensive care plan on the evening of 07/23/20. A laboratory report dated 7/9/20 indicated Resident #1 had a urinalysis with 5-15 white blood cells (normal is negative) indicative of a urinary tract infection. A nursing note dated 07/10/20 at 3:23 p.m., completed by LVN G indicated Resident #1 had a fever of 101.2 and was administered Tylenol. The resident was checked 1 hour after Tylenol administration and her temperature was 98.4. The resident was clammy and flushed in the face and afebrile. The resident was checked during the next rounds and her temperature was 99.7. Resident #1 complained of a headache and had a productive wet cough, eyes red around the edges and center, dilated pupils, and did not want to eat or drink. The note indicated Resident #1's laboratory results indicated a UTI and dehydration. The physician was notified and the following new orders were received: *obtain 2 sets of blood cultures; *2 view chest X-ray; *1 liter of IV fluids of D5W at 50ml/hr; *health shakes three times a day; *start [MEDICATION NAME] (used to treat and prevent fungal infections) 150 mg now, then 150 mg by mouth in 72 hours then discontinue; *[MEDICATION NAME](antibiotic) 500 mg 1 tablet twice a day for 3 days pending culture and sensitivity results. *recheck for COVID-19; The note indicated the specimen for COVID-19 was collected and Resident #1 was fatigued and refused food and liquids. A physical therapy discharge summary completed 07/10/20 and signed 07/14/20 for Resident #1 indicated the resident received physical and occupational therapy from 06/25/20 through 07/10/20. The summary indicated Resident #1 was to be discharged to live with family/friends and assistance and support was to be provided by a care assistant in the morning and evening. The summary indicated the prognosis for Resident #1 to maintain her current level of function was good with strong family support. During an interview on 07/24/20 at 11:02 a.m., PT E said Resident #1 was assessed 07/10/20 and was able to get out of bed and walk to the shower with her walker. He said OT assessed Resident #1 as able to walk to the counter and brush her teeth. He said he thought she had family support available at home was not aware she was not able to care for herself and did not have assistance. An occupational therapy discharge summary completed 7/10 20 and signed 7/14/20 indicated the prognosis for Resident #1 to maintain her current level of function was excellent with strong family support, good with strong family support. The discharge recommendations for Resident #1 was 24-hour care, a low bed, and a shower bench. A microbiology culture and sensitivity report dated 7/11/20 indicated Resident #1 had a urinary tract infection caused by proteus mirabilis (bacteria) that was resistant to [MEDICATION NAME] (Cipro). A laboratory report dated 07/11/20 indicated Resident #1 tested positive for COVID-19 on 07/10/20. A nursing note dated 07/13/20 at 10:31 a.m., completed by LVN J indicated she called Physician I's office to report Resident #1 had a positive COVID-19 result and had a dry, scratchy cough. Physician I's office staff said she would talk to NP C, and call back for new orders. A nursing note dated for 07/14/20 at 9:49 a.m. and completed as a late entry on 07/17/20 at 9:51 a.m. by RN F (the previous DON) indicated he spoke with Resident #1's family by phone and the family was concerned the facility was discharging Resident #1 with a positive Covid-19 diagnosis. The note indicated RN F told the resident's family 07/14/20 was Resident #1's planned discharge date , she was her own responsible party, was able to make her own decisions, and the facility could not hold Resident #1 against her will. During an interview on 07/24/20 at 11:15 a.m., RN F (previous DON) said Resident #1 was diagnosed as positive for COVID-19 on 07/13/20. He said the ambulance transport refused to transport Resident #1 to her home on 07/14/20. He said Resident #1 was transported by ambulance to her home on 07/15/20. A social work note dated 07/14/20 at 11:19 a.m. and completed by SW B indicated Resident #1's 20th day was 07/13/20 and Resident #1 did not want to stay in the facility for additional days. The note indicated the resident said she already owed money to the facility and did not want to incur costs for additional days. A physician order [REDACTED].#1 indicated a telephone order dated 7/14/20 at 8:40 a.m. to discharge the resident home with home health services, PT, OT, skilled nursing (nursing services to include catheter care and education, medication management, disease education and management) and a social work consult. The order sheet indicated the order source was a telephone order read back by SW B. During an interview on 07/23/20 at 3:07 p.m., SW B said she usually obtained a physician order [REDACTED]. She said the home health agency would get the signed order for services from the physician. She said she faxed the home health agency Resident #1's face sheet, history and physical, and all current orders on 07/14/20. She said she had proof on her phone she called the home health agency to confirm they received the fax, but she did not have a fax confirmation. She said Resident #1 was originally scheduled for discharge on 07/14/20. She said the transport ambulance refused to transport Resident #1 to her home on 7/14/20 because she was lethargic. The SW said she did not remember who she spoke with at the home health agency or when she contacted them about Resident #1. During an interview on 07/23/20 at 1:58 p.m., home health staff A said SW B contacted her on 07/15/20 and said Resident #1 would be ready for discharge that day. She said the home health agency was not allowed to be at the home waiting for the resident when they were dropped off. She said she found out on 7/16/20, Resident #1 was discharged home. She said the agency required a signed physician order [REDACTED].#1's regular physician would not order home health without a face to face visit because he had not seen her since January 2020. She said she tried to get in touch with the NP C but did not receive a return call. She said it usually was not a problem for the agency to get a signed order because the medical director of the facility was also the medical director of the home health agency. She said Resident #1's physician during her stay at the facility was not the medical director. She said Resident #1 was transported from home to the hospital before they could begin services. An unsigned patient discharge plan of care dated 07/14/20 for Resident #1 indicated the following: *You are being discharged : home alone *Services Provided: Home health agency and phone number *Required Equipment: blank *General Comments/Other instructions: blank *Scheduled Follow-up Appointments: blank *Dietary recommendations: blank *Wound Care Treatments: blank *Patient Instructions/Teaching: blank *Pharmacy Name/Phone: blank *Primary Physician Contact Information: blank **discharge date : 7/14/20 *Patient/Patient Representative Signature: blank A nursing note dated 07/14/20 at 12:17 p.m. completed by LVN G indicated she educated Resident #1 to continue to monitor for signs and symptoms of COVID-19 and Resident #1 was positive and stated, It's not that big of a deal I will be fine. The note indicated LVN G educated Resident #1 to report to home health daily any signs and symptoms. The note indicated Resident #1 understood and was able to verbalize her own needs and requested discharge around 2:00 p.m. that day. A nursing addendum note dated 07/15/20 at 7:47 p.m. (late entry) completed by LVN G indicated Resident #1 was set up to be discharged on [DATE] at 2:00 p.m. The note indicated the EMS service arrived at the facility at 4:30 p.m. on 7/14/20 and refused to transport the resident to her home because the resident had increased lethargy (impairment of consciousness resulting in reduced alertness and awareness) and would be going home alone with no one at the home waiting for her. The note indicated LVN G notified her supervisor and called Resident #1's physician and left a voice message asking for a return call. During an interview on 07/27/20 at 12:31 p.m., LVN G said she called NP C on 07/14/20 and left a voicemail message regarding Resident #1's lethargy and the EMS refusal of transport. She said she did not receive a response back from the NP before she left her shift that evening. During an interview on 07/24/20 at 11:46 a.m., LVN G said Resident #1 did not want to stay at the facility any longer because she did not want to pay for the stay. She said Resident #1 was supposed to go home on 07/14/20, but when the transport ambulance got to the facility to pick her up, the resident was very lethargic. She said the ambulance personnel said they were acting as an advocate and would not transport Resident #1 to her home because there was no one there to take care of her. She said Resident #1 had gotten a little weaker and more tired after she was diagnosed with [REDACTED].#1 was being discharged with a Foley catheter and she was concerned about Resident #1 going home with the catheter. She said Resident #1 had been performing self-catherization (emptying the bladder by inserting a urinary catheter into the bladder) for [AGE] years, but no one assessed Resident #1 to see if she was still able to do so before she discharged from the facility. She said she did not know if anyone assessed Resident #1 for Foley catheter care. She said she did not feel Resident #1 would be able to care of herself at home. LVN G said Resident #1's daughter was aware Resident #1 was scheduled for discharge to home. She said she asked Resident #1 if her daughter was going to help her and Resident #1 laughed and said her daughter did not help her. LVN G said when Resident #1 was discharged on [DATE] and the home health service would not be able to see her until at least the next day. She said she did not express her concerns to anyone. During an interview on 07/29/20 at 8:10 a.m., EMS Q said she was dispatched to the facility's COVID-19 unit to transport Resident #1 to her home on 07/14/20. She said the nurse did not know if Resident #1 had anyone to meet her at home. She said the nurse indicated Resident #1 lived alone. She said she went into Resident #1's room and called her name loudly and the resident moaned. She said she called Resident #1's name a second time and asked her name. She said Resident #1 could not say her name, pointed at the wall, and moaned. She said she asked Resident #1 if she was ready to go home and if there was anyone to meet her at home. She said Resident #1 did not respond to any questions. She said she asked the nurse if Resident #1 was continent and she was told the resident had a Foley catheter. She said the nurse did not say anything about

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F 0660 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) bowel continence. She said she told the nurse she was not comfortable transporting Resident #1 home and did not feel it was safe. EMS Q said she called her supervisor and contacted the home health agency that was supposed to provide services for Resident #1 and the home health agency said Resident #1 was not a current patient. She said she would not transport Resident #1 to her home. A nursing noted dated 7/15/20 at 2:10 p.m., ADON M indicated Resident #1's culture and sensitivity (test used to determine what antibiotics are effective) of urine collected 7/9/20 was resistant [MEDICATION NAME](antibiotic). The note indicated Resident #1 was [MEDICATION NAME] mg twice a day for 3 days beginning 7/11/20. The note indicated the physician was made aware and would review and get back with the nurses with a new order. A nursing noted dated 7/15/20 at 4:11 p.m., completed by LVN J indicated Resident #1 sat the resident up to eat breakfast and the resident was not eating. The note indicated LVN J fed the resident a few bites, then checked on the resident about 30 minutes later and the resident had eaten approximately 50% of her meal. The note indicated Resident #1 said she was wanted to go home but .I just don't know about making meals . A nursing note dated 7/15/20 at 4:14 p.m., completed by LVN J indicated Resident #1 had a tele-med appointment with Physician I and a new order was received for [MEDICATION NAME] 875 mg 2 times a day for 7 days. The note indicated LVN K (physician I's nurse) would fax the order to a local pharmacy for Resident #1 to pick up. A nursing note dated 07/15/20 at 4:28 p.m., completed by LVN J indicated she received a fax from LVN K (Physician I's nurse) on 07/15/20 with instructions to schedule the resident a follow-up appointment with her primary care physician within 1-2 weeks after discharge, repeat the COVID-19 test after 14 days (notify PCP), and to setup home health service before the resident left the facility. During an interview on 07/24/20 at 12:37 p.m., LVN J said Resident #1 was forgetful. She said she was worried about Resident #1 being able to take her medications when she was discharged . She said the resident was more tired and confused after she was diagnosed as positive for COVID-19. During an interview on 07/27/20 at 2:24 p.m., LVN J said the only time the resident would get up and transfer or ambulate was with therapy. She said Resident #1 used a brief and the CNAs were changing her briefs because she was not able to get up and transfer or ambulate to the toilet. She said she did not notify the physician the resident was not able to transfer without assistance or go to the toilet. She said she did not inform the physician of Resident #1 not being able to care for herself. A nursing noted dated 7/15/20 at 5:11 p.m. by LVN H indicated EMS was at the facility to transport Resident #1 to her home. The note indicated home medications were sent with the resident and the office staff was notified of her discharge. The note indicated the resident was in stable condition. During an interview on 07/24/20 at 12:08 p.m., LVN H said the day Resident #1 was discharged on [DATE] and she was awake and alert and ready to go home. She said Resident #1 needed some assistance with care. She said she did not call Resident #1's daughter to let her know the resident was discharged because she thought it had already been taken care of by the administrative staff. She said she did not know Resident #1 was going home alone. She said she sent Resident #1's medication list home with her and instructions on how to take them. She said she was not aware Resident #1 had any medication changes or had any follow-up appointments. During an interview on 07/29/20 at 8:02 a.m., EMS P said the dispatch records dated 07/14/20 indicated the transport was delayed and cancelled. He said the dispatch records for 07/15/20 indicated the EMS staff did not feel comfortable leaving Resident #1 in her home due to poor living conditions and she was not able to stand unassisted. The record indicated the resident was taken into her home via stretcher, and left on the couch in the living room. A hospital ER record dated 07/17/20 at 3:52 p.m. indicated a wellness check was performed at Resident #1's residence (by local fire department) and she was found covered in feces. A Foley was noted, to gravity drainage (draining by force of gravity) and the urine was overflowing. The record indicated Resident #1 was responsive to voice, lucid, able to follow commands, confused, and unable to answer questions appropriately. A hospital ER nursing note dated 07/17/20 at 4:30 p.m. indicated Resident #1 covered in dried feces .reports per EMS report . was found lying in feces for unknown amount of time. A hospital ER record dated 07/17/20 Indicated: Resident #1 is resting comfortable .symptoms do not appear to be due to acute stroke, intercerebral hemorrhage or meningitis . unsure the acute [MEDICAL CONDITION] but may be secondary to COVID 19 . Resident #1 is unable to meet her ADLS . Although Resident #1 is maintaining an O2 SAT she is not able to take care of herself at home .will be admitted . An emergency room record dated 7/17/20 6:24 p.m. for Resident #1's [DIAGNOSES REDACTED]. A hospital progress note dated 07/17/20 for Resident #1 indicated: . assessment/plan - 1.UTI complicated ESBL (Extended Spectrum Beta-Lactamase - resistant to some antibiotics) 2. COVID [MEDICAL CONDITION] illness, 3. Dehydration . A hospital progress note dated 07/18/20 indicated Resident #1 was to receive IV fluids, IV antibiotics, and physical and occupational therapy. A hospital progress note dated 07/19 20 indicated Resident #1 was clear from a COVID/pulmonary/medical standpoint to discharge; however, she did not have a place to go and apparently could not return home with her family. The note indicated the hospital was unable to reach the nursing home Resident #1 was recently discharged from to see if they would consider readmitting her for skilled services versus custodial care. A hospital progress note dated 07/20/20 for Resident #1 indicated she remained on oxygen at 3L per nasal canula. A hospital progress note dated 07/22/20 for Resident #1 indicated she remained on room air. The note indicated a consult was placed for SNF due to the resident's deconditioning and the resident would be discharged on ce a placement was obtained. During an Interview on 7/23/20 at 8:47 a.m., a hospital case worker said Resident #1 remained a patient in the hospital. During an interview on 07/24/20 at 9:24 p.m., Resident #1's daughter said she received a call notifying her of Resident #1's planned discharge. She said she could not remember the date or who called, but told them Resident #1 was not able to care for herself and there was no family at her home to care for the resident. She said she called the facility because she did not know Resident #1 was discharged . She said the facility staff told her Resident #1 signed herself out on 07/15/20. She said she was not able to reach Resident #1 at home by phone on 07/15/20 or 07/16/20. She said she found Resident #1 late in the day on 07/16/20, lying in feces and unable to move off her bed. She said Resident #1 was supposed to receive home health services and she expected the home health staff would be at Resident #1's home on 07/15/20, 07/16/20, and 07/17/20. She said she was not able to contact Resident #1 at her home 07/17/20 and had a family friend go over to Resident #1's house. She said the family friend was not able to open the door and could not enter the home due to Resident #1's COVID-19 diagnosis. She said the family friend called the fire department to gain access and the fire department found Resident #1 laying in feces and unable to move. She said the fire department transported Resident #1 to the hospital on [DATE]. During an interview on 07/27/20 at 1:00 p.m., CNA N said Resident #1 was sleeping a lot more than usual the week of her discharge. She said Resident #1 would not eat or wake up and was very lethargic. She said the only time Resident #1 would transfer or walk was during therapy and with therapy staff. She said Resident #1 did not transfer to go to the toilet or walk with a walker to the toilet. She said Resident #1 wore a brief and would be incontinent of bowel. During an interview on 07/27/20 at 1:06 p.m., CNA O said Resident #1 was not able to transfer and could not walk to the toilet with her walker. She said Resident #1 wore a brief and was incontinent of bowel. She said Resident #1 was not eating and slept a lot, more than she had the previous week and prior to her discharge. During an interview on 07/27/20 at 12:19 p.m., LVN K (nurse for Physician I and NP C) said the facility never contacted her about told Resident #1's lethargy, not being able to care for herself, or not being able to self-transfer and ambulate without assistance. She said she was told the ambulance refused to take Resident #1 home on 07/14/20 because of her positive COVID-19 status. She said she learned of the change of condition when she called the facility on 07/15/20 to set up the telehealth visit. During an interview on 07/24/20 at 12:12 p.m., Physician I said during the telehealth visit 07/15/20 she was told Resident #1 and her family were ready to go home. She said she was under the impression Resident #1 would have family with her at home. She said the facility never contacted her about Resident #1 being lethargic or told her the ambulance refused to take the resident home the day before (07/14/20) the telehealth visit. She said she would not have discharged Resident #1 had she known of her decline and that she was going home with no support. During an interview on 7/23/20 the administrator said Resident #1 was her own responsible party and was discharged accordingly. A facility policy titled Discharge of the Patient dated 03/2019 indicated: Purpose .To provide safe departure from the Facility. Equipment: *patient's medical record *discharge order *medications *discharge instruction forms Procedure: *Explain discharge procedure to patient. Complete discharge home instructions. * The attending physician is required to write a discharge order. Telephone orders are acceptable. Documentation: *Patient status, physical and emotional. * Type of transportation; whether or not medication was given to patient . A facility Social Services policy dated 11/2016 indicated: 2. A patient Discharge Plan of care must be completed for each patient discharging to home or to another facility by the interdisciplinary team members. A copy of the patient Discharge Plan of care must be given to the Patient and/or Patient Representative at discharge .i. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the patient's follow-up care and any post-discharge medical and non-medical services to prevent readmissions .5. The facility must ensure that a transfer or discharge of the patient is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider. The facility's Patient care Management System dated 11/2017 indicated: A Comprehensive, Person-centered Plan of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675394	A. BUILDING _____ B. WING _____	**07/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKWOOD MANOR NURSING HOME	**225 S MAIN ST VIDOR, TX 77662**

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F 0660 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) Care, . must be completed by the 21st day after admission (or within 7 days of the CAA completion date) and must include discharge planning as appropriate. The administrator was notified on 07/24/2020 at 2:46 p.m., an IJ situation was identified due to the above failures and the IJ template was provided. On 07/25/20 at 10:38 a.m., the facility plan of removal was accepted and included: Please accept this as a Plan of Removal to lift the alleged Unsafe Discharge and Administration Immediate Jeopardy initiated at 2:46 pm on 7/24/2020 based on interviews and record reviews made by the survey team on 7/24/2020 related to discharge planning for Resident. The following corrective actions have been taken for Resident admitted on [DATE] with a [DIAGNOSES REDACTED]. Resident was discharged home on[DATE] thus the facility clinical team is not able to assess the current condition of the patient. Attending physician while patient was in facility was notified on 7/24/20. Social services personnel is suspended immediately on 7/24/20 pending outcome of internal investigation. RN Regional Director Clinical Services will in-service with return competency of understanding proper discharge planning procedures to licensed nursing team and leadership team in facility. Executive Director, ADON, Director of Rehab, Patient Care Coordinator, Medical Records. Unit Manager is currently working nights and DON is currently out sick with COVID-19 and were in-serviced via facetime. All education will be completed by 7/25/20 at 10:00 AM. Corporate Director of Social Services, will complete audit of discharge planning and provide outcome of audit with needed corrective action to facility Executive Director and Director of Nursing. 1. In-Services a. RN Regional Director Clinical Services will in-service with return competency of understanding proper discharge planning procedures to licensed nursing team and leadership team in facility. Completed by 7/25/20 at 10:00 AM. b. Validity of in-services will be demonstrated through competency regarding discharge planning to include: physician discharge orders; face to face physician evaluation for home health scheduled; notification to patient representative of discharge; discharge instructions and plan of care sent with patient and representative; follow-up contact with patient post discharge; provision or orders for home health service and durable medical equipment as needed/warranted. Completed by 7/25/20 at 10:00 AM. 2. QA Meeting conducted with Medical Director 7/24/2020 to review QA action plan and abatement plan. On 07/25/20 the surveyor confirmed the plan of removal had been implemented sufficiently to remove the IJ by: A quality assurance attendance record dated 7/24/20 indicated a meeting regarding discharge of residents was held and attended by the corporate RN, medical director and administrator. In-service training reports dated 07/24/20 and 07/25/20 presented to all licensed staff indicated staff must coordinate services and document discharge planning for all residents who are discharging from the facility. During interviews on 07/25/20, ADON/LVN, MDS Coordinator/LVN, medical records LVN, the Director of Rehabilitation Services, 2 LVNs and the administrator were knowledgeable of the requirements for discharge planning and stated they had received training regarding discharge planning and documentation. They were aware of the facility's systemic approach to discharge, the equipment and forms required, the procedure and the documentation required, the physician order [REDACTED]. During interviews on 07/25/20, the administrator and corporate RN, confirmed all licensed staff currently working at the facility had been trained on discharge planning and documentation of resident's discharge plans. The administrator said other staff would receive training before starting their next shift. On 07/25/20 at 11:45 a.m., the administrator was notified the IJ was removed. However, the facility remained out of compliance at actual harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.