STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **455974**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/19/2016**
NAME OF PROVIDER OF SUPPLIER **OAK CREST NURSING CENTER**		STREET ADDRESS, CITY, STATE, ZIP **1902 FM 3036 ROCKPORT, TX 78382**	

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 0157 **Level of harm -** Actual harm **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor and a family member of the resident 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 with the resident's Physician when there was a significant change in the resident's physical or psychosocial status or treatment and notify residents' legal representative or interested family member of treatment, status and room change and for five Residents (R #1, R #2, R #6, R #7 and R #10) of nine residents reviewed for abuse and neglect.
The DON received report of R #7's left Humorous (upper arm bone) fracture on 02/16/16 after 11:00 p.m. and she said she would take care of it in the morning. Day shift LVN J notified R#7's physician on 02/17/16 at 11:30 a.m. of the fracture as the DON did not notify the physician nor did she give instruction to nursing staff to notify the physician
The DON received report of R #10's femur (upper leg bone) fracture on 02/19/16 at 12:45 a.m. and said she would take care of it in the morning. Day shift LVN K notified R #10's physician on 02/19/16 at 8:00 a.m. of the fracture as the DON did not notify the physician nor did she give instruction to nursing staff to notify the physician
R #1's legal representative was not notified her room changed because of reported incident of abuse and neglect with roommated R #2.
R #2's physician was not consulted regarding inappropriate sexual behaviors was added to her Care Plan on 01/28/16.
R #1 and #2's physician was not consulted regarding R #2 putting her hands down R #1's pajama pants.
R #6's family was not notified timely after she was isolated and treated for [REDACTED].
These failures could affect 48 residents with a mental status of dementia by placing them at risk for abuse and neglect, delay in treatment and an avoidable decline in physical, mental, or psychosocial well-being.
The findings were:
R#7
Record review of R#7's Face Sheet dated 02/25/15 revealed a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE]. R#7 had the following Diagnoses: [REDACTED]. Ath. Usp. Graft, Chronic Asthma, [MEDICAL CONDITIONS]
Reflux, [MEDICAL CONDITION], and Chronic Pain.
Record review of R#7's Minimum Data Set ((MDS) dated [DATE] revealed R#7's [DIAGNOSES REDACTED]. R#7's MDS revealed she had
clear speech, usually understood, and usually understood others. R#7 needed extensive assistance from one person for physical assistance for dressing, toilet use, personal hygiene and bathing. R#7 was totally dependent on one person for physical assistance for bed mobility.
Record review of R#7's Nurse's Notes by LVN Jdated 02/16/16 1200 revealed upon assessment resident (R#7) guarding left arm and complaining of pain. Swelling noted to left shoulder (refuses to move). Reported to physician. awaiting new orders. Medicated for pain . assisted to bed .
Record review of R#7's Nurses Notes dated 02/16/16 2-10 pm revealed resident complained of severe left shoulder pain. Physician ordered x-ray. Taken at 8 pm ,no results yet. Resident observed for sleep in recliner in .area. Resident continues to hold left arm to her shoulder area.
Record review of R#7's Nurses Notes(by LVN J) dated 02/17/16 1530 revealed discoloration noted to left arm measuring approximately 1.3 cm (centimeter) Asked in report of origin of injury. Informed resident had been hitting and grabbing at arm. Informed that X-ray of possible fracture had been reported to DON. Informed DON of discoloration and pain. Call to physician. N.O. (new order) to transfer to local hospital for evaluation and treatment.
During a telephone interview on 02/17/16 at 3:30 p.m. ,LVN F (night nurse) stated
-had called the DON on 02/15/16 at 11:45 p.m to report R#7 was not able to move her left arm to assist with her own toileting.
- R#7 was screaming in pain and agitated but no bruising was noted
- R#7's baseline was no reported pain in her left arm and R#7 was able to use both arms to assist in her own toileting with out pain
R#7 was up all night her shift starting at 10:00 p.m. on 02/15/16 through 6:00 a.m on 02/16/16 and R#7 picked and grabbed at her left arm during that time
-she (LVNF) retrieved an X-ray result after 11:00 p.m.for R#7 from the fax machine and called the DON at that time to report a positive X-ray for a fracture to R#7's left Humerus.
-she (LVNF) stated the DON said she would call Physician (PHY) in the morning to report R#7's positive X-ray results.
-she (LVNF) was instructed to medicate R#7 for pain
-LVNF stated the facility's policy is to call the Physician with changes in resident condition
-she (LVNF) gave report to LVNJ at 6:00 a.m. on 02/17/16 regarding R#7's positive X-ray results and at that time the DON had not come to see R#7 and the Physician had not called with orders to treat R#7.
On 02/17/16 at 12:25 p.m., LVN Jstated she was told yesterday (2/16/16) that R#7 had arm pain. She (LVNJ) noted swelling and advised R#7's physician. This morning (02/17/16) she was told the X-ray report had come for R#7 at 8:56 p.m.on 02/16/16. LVNJ replied the night nurse (LVNF) had called the DON about R#7's X-ray result. LVNJ replied it was reported to her that the DON did not call the Physician about R#7's X-ray result. LVNJ said she had spoken to the DON about 7:30 to 8:00 a.m. on 02/17/16/.
LVN J said I called the physician on 02/17/16 at 11:30 a.m and asked if he (Physician) knew the results of R#7's X-ray report. LVNJ replied ,the Physician said no ;X-ray report was read to the Physician.
Review of Physicians's t.o. (telephone order) dated 02/17/16 1130 revealed transfer to local hospital for evaluation and treatment fracture left arm.
Review of R#7's Radiology Report with DOS (date of service) 02/16/16 (final report faxed to facility on 02/16/16 20:56) revealed
Conclusion
Subtle cortical disruption in left humeral neck suspicious of impacted non-displaced fracture, with modest inferior subluxation of left humeral head. F/U (follow -up) recommended.
R #10
Record review of R #10's Face Sheet dated 02/03/16 revealed a [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. R #10's physician was PHY U, the Medical Director for the facility.
Record review of R #10's current Minimum Data Set ((MDS) dated [DATE] revealed R #10's [DIAGNOSES REDACTED]. R #10's MDS
revealed she was incapable of speech, rarely or never made herself understood and rarely or never understood others. R

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 0157

Level of harm - Actual harm

Residents Affected - Some

(continued... from page 1)
#10's MDS revealed her cognitive skills for daily decision making was coded as severely impaired and she never or rarely made decisions. R #10 was totally dependent on one person for physical assistance for dressing, toilet use, personal hygiene and bathing. R #10 required extensive assistance from one person for bed mobility, locomotion in her wheelchair and eating.
Record review of R #10's Care Plan dated 01/30/16 revealed R #10 exhibited symptoms of decline on cognitive function related to dementia. R #10 was at risk for falls due to cognitive loss, lack of safety awareness as she slid forward in her wheelchair and tipped wheelchair backward. Interventions included assess for changes in medical status, pain status, mental status and report to the physician as indicated.
Record review of R #10's Nurses Notes dated 02/16/16 at 1:00 p.m. revealed R #10 had swelling and heat to the left lower extremity reported to and evaluated by Physician (PHY) U.
Record review of R #10's Nurses Notes dated 02/16/15 from the 2:00 p.m. to 10:00 p.m. shift revealed PHY U ordered a Venous Doppler (ultrasound that uses sound waves to produce pictures of the body's veins) to R #10's left leg due to swelling and redness.
Record review of R #10's Nurses Notes dated 02/17/16 at 7:00 a.m. revealed R #10 was assessed with [REDACTED].
Observation on 02/17/16 at 11:45 a.m. revealed R #10 sitting in her wheelchair in the dining room of the secured unit at a table with another resident. R #10 shifted in her wheelchair often and leaned on her right hip and the right arm rest of her wheelchair while she looked out the window. R # 10 pulled at and lifted the left corner of her shirt.
Record review of R #10's Nurses Notes dated 02/17/16 from the 2:00 p.m. to 10:00 p.m. shift revealed R #10 was assessed and continued to have swelling and redness to her left leg. R # 10's left leg had a slight discoloration to the area. The Venous Doppler to R #10's left leg was performed at 4:00 p.m. on 02/17/16 and the technician who performed the ultrasound stated to the nurse that results could take 24 hours to receive.
Observation on 02/18/16 at 7:45 a.m. revealed R #10 sitting in her wheelchair at a table in the dining room of the secured unit at a table with another resident. R #10 was able to feed herself and was restless as she shifted positions in her wheelchair.
Record review of R #10's Nurses Notes dated 02/18/16 at 12:00 p.m. revealed the results of R #10's Venous Doppler were given to PHY U and the nurse reported to PHY U that R #10's left leg remained swollen with multiple areas of dark discoloration. Discolored areas of R #10's left leg included her left knee, left outer leg, left heel, left outer thigh, left calf and left inner knee. LVN J documented she showed the discolored areas of R #10's left leg to the Assistant Director of Nursing (ADON) and LVN J reported the multiple areas of discoloration to the Director of Nursing (DON.)
Record review of R #10's physician's orders [REDACTED].#10 was to have X-rays of her left hip and left knee.
Record review of R #10's Nurses Notes dated 02/18/16 from the 2:00 p.m. to 10:00 p.m. shift revealed a new order from PHY U for an X-ray to R #10's left leg including her knee, ankle and foot. The DON was to be notified with the results of the X-ray. R #10 was assessed to have swelling and redness with skin discoloration noted to her left leg that were warm to touch.
Record review of R #10's Radiology Report faxed to the facility on [DATE] at 12:42 a.m. revealed R #10 had an acute left knee fracture that involved the left distal femur (long bone in the thigh close to the knee.)
Record review of R #10's Nurses Notes dated 02/19/16 at 12:30 a.m. signed by LVN W revealed the results of R #10's X-ray were reported to the DON. The documented response from the DON was that she would take care of this in the morning.
Record review of the facility Nursing Home to Hospital Transfer Form for R #10 dated 02/19/16 revealed R #10 was given two Tylenol Extra Strength 500 milligram (mg) tablets on 02/19/16 at 8:40 a.m. and her last set of vital signs was taken on 02/19/16 at 9:00 a.m.
Record review of R #10's Nurses Notes dated 02/19/16 at 1:30 p.m. by LVN W revealed R #10 was sent out to the hospital and transported by Emergency Medical Services (EMS.) A telephone follow-up to the local hospital revealed R #10 was a probable admit.
In an interview on 02/19/16 at 2:40 p.m. LVN K stated she worked in the secure unit 02/19/16 from 6:00 a.m. to 2:00 p.m. LVN K stated she took report this morning from LVN W that revealed that X-ray results received after midnight showed R #10 had a fractured left femur. LVN K stated she called PHY U at 8:00 a.m. on 02/19/16 as she had not been contacted by the DON regarding care for R #10. LVN K stated PHY U stated he was on call the night of 02/18/16 and early morning of 02/19/16 and he was not aware of the results of R #10's X-ray. LVN K stated PHY U ordered R #10 be sent to the hospital by EMS. LVN K stated she called R #10's family member and legal representative and they were not aware R #10 had a fractured femur. LVN K stated she saw the DON about 9:30 a.m. or 10:00 a.m. on 02/19/16 and informed the DON R #10 was sent out to the hospital as per PHY U orders. LVN K stated that the DON replied to her R #10 had pathological fractures (bone fracture caused by disease that led to weakness of the bone structure.) LVN K stated to the surveyor that regardless if it was one fracture or multiple fractures R #10 still needed to be treated because R #10 shouldn't have to hurt.
In an interview on 02/19/16 at 3:30 p.m., the DON stated she was aware that PHY U had ordered an X-ray for R #10 on 02/18/16 at 3:00 p.m. The DON stated LVN W called her at home at 12:45 a.m. on 02/19/16 with the results of R #10's X-ray and said that we needed to call the doctor. The DON stated she did not call PHY U regarding results of R #10's X-ray showing a fractured femur but that the floor nurse called and notified PHY U in the morning. The DON stated PHY U was not on call at that time on 02/19/16 but another physician. The DON stated PHY U was particular that nursing staff call him and not the physician on call regarding his residents' medical conditions.
In an interview on 02/17/16 at 3:30 p.m., LVN F stated PHY U will accept calls regarding his residents' change of condition while he is on call. LVN F stated PHY U did not want facility staff to call the on call physician for changes in his residents ' condition if PHY U was not on call. LVN F stated PHY U wanted to be the only physician to treat his residents. LVN F stated she used her nursing judgment to determine if a resident change of condition was an emergency and needed to be reported to the physician on call for PHY U.
Record review of a written Physician order [REDACTED].
Call me with All med changes made to ANY of my patients. If I am not on call, wait to call ME personally when I am back on call.
The order was delivered to the surveyor by the DON on 02/19/16 at 5:45 p.m. as requested documentation of PHY U orders to facility staff informing when staff were to notify PHY U of changes in condition or treatment for [REDACTED].
Record review of a written statement from PHY U dated 02/19/16 and received after 5:45 p.m. revealed PHY U was aware that R #10 had swelling in her left leg since 02/16/16 and he ordered a Venous Doppler to check if R #10 had a blood clot in her left leg. The Venous Doppler results revealed R #10 did not have a blood clot in her left leg on 02/18/16 so at that time he ordered an X-ray of R 10's left leg. PHY U stated R #10's X-ray report came in to the facility at 12:45 a.m. on 02/19/16 and he was called with the results at 8:00 a.m. on 02/19/16 regarding R #10's new [DIAGNOSES REDACTED]. PHY U stated he felt that R #10's X-ray represented a new [DIAGNOSES REDACTED]. PHY U stated he felt the notification he received at 8:00 a.m. on 02/19/16 was appropriate and timely and led to the proper treatment of [REDACTED].
In a telephone interview on 02/19/16 at 4:20 p.m., PHY U stated he was on call the night of 02/18/16 and morning of 02/19/16. PHY U stated when he is not on call he does not want facility staff to call the on call physician about his residents unless it is a true emergency. PHY U stated facility staff was to wait to notify him when he was back on call regarding changes in his residents' medical conditions or need for treatment changes.
In an interview on 02/19/16 at 5:00 p.m., the Assistant Director of Nursing (ADON) stated the facility did not instruct her on a requirement to report changes of condition only to PHY U and not to the physician on call regarding his residents at the facility. The ADON stated the facility did not instruct her on what PHY U considered an emergency condition that would require the consultation of the on call physician.
R #2
Record review of R #2's Face Sheet dated 12/05/15 revealed a [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED].
Record review of R #2's Care Plan revised on 01/28/16 revealed in a focus area that R #2 displayed inappropriate sexual behaviors at times. The goal for this behavior included R #2 would not exhibit at risk or inappropriate sexual behaviors that affected other patients, staff, or visitors. Facility staff interventions to meet this goal included the following:
-Review behavioral expectations with patient.
-Observe and report verbal and/or physical sexual behaviors exhibited and report to the licensed nurse immediately.

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F 0157

Level of harm - Actual harm

Residents Affected - Some

(continued... from page 2)
-Notify physician if sexually inappropriate behavior is exhibited.
-Observe and report change in mood state to licensed nurse immediately.
-Remove from common areas when sexually inappropriate behavior is exhibited
-Attempt to refocus the patient ' s behavior to something positive when he or she exhibits inappropriate sexual behavior.
-Assist the patient in identifying problem causing stimuli.
R #2's Care Plan included a focus area initiated and created on 01/14/16 by the Director of Nursing (DON) stating R #2 exhibited or was at risk for complications of infection related to a Urinary Tract Infection (UTI.) Facility staff intervention included facility staff was to assist resident with hand washing throughout the day as needed. R #2's Care Plan included a focus area initiated on 07/16/13 that stated R #2 resided in the Transitions Unit (secured unit) due to being at risk for elopement (leaving the facility.) Facility staff interventions included monitoring R #2 frequently to assure her safety. R #2's Care Plan included a focus area initiated on 07/16/13 that stated R #2 had poor safety awareness. Facility staff interventions included monitoring for changes in R #2's condition that may warrant increased supervision or assistance and notify the physician as needed. R #2's interventions included she needed adequate lighting to see at night. R #2's Care Plan included a focus area imitated on 07/16/13 that stated R #2 had difficulty making her own decisions. Facility staff interventions included assisting R #2 with decision making as needed and report any changes in R #2's level of consciousness to the physician.
Record review of R #2's Minimum Data Set ((MDS) dated [DATE] revealed R #2 had a Brief Interview for Mental Status (BIMS) score of four out of a possible 15 points. R #2 understood others with clear comprehension and was able to make herself understood. R #2 spoke clearly and had adequate hearing and vision. R #2's MDS was coded as she had no behaviors, hallucinations or delusions. R #2 was independent and required not assistance from staff for bed mobility, transfer or ambulation. R #2 required supervision and setup help only for dressing, eating, personal hygiene and bathing. R #2 was able to toilet herself with supervision only.
In a telephone interview on 02/17/16 at 3:10 p.m., LVN Fstated approximately one month prior at 5:00 a.m. she entered the room shared by R #1 and R #2 on the secured unit to give R #2 a scheduled medication. LVN F stated when she entered the room she saw R #2 standing beside R #1's bed with her hand in R #2's pajama bottoms. LVN F stated R #1's blankets were pulled down and she wore an incontinent brief. LVN F stated as soon as she entered the room shared by R #1 and R #2, R #2 removed her hand from R #1's pajama pants and crossed the room to sit on her bed and asked LVN F what do you have for me? LVN F stated she told R #2 that she had the [MEDICAL CONDITION] medication. LVN F stated R #2 said Oh yes, that one. LVN F stated she medicated R #2 and left the room with R #2 sitting on her bed and R #1 lying in her bed. LVN F stated she did not know how or where to document the incident she witnessed between R #2 and R #1 so at 5:15 a.m. on that morning she called the DON and informed the DON what she witnessed at 5:00 a.m. LVN F stated the DON told her to keep an eye on them and let me know if anything else happens. LVN F stated the DON did not tell her to write a report or call the physician. LVN F stated the DON told her We'll take care of it. LVN F stated she was not told nor was she aware that inappropriate sexual behaviors were added to R #1's Care Plan on 01/18/16. LVN F stated the facility staffing ratio for night shift; 10:00 p.m. to 6:00 a.m.; was to include two CNA's in the secure unit, one CNA for hall 200, one CNA for hall 300 and two nurses for the facility. LVN F stated they often only have one CNA in the secure unit, one CNA on hall 200, one CNA for hall 300 and two nurses to cover the entire facility during the 10:00 p.m. to 6:00 a.m. shift.
In an interview on 02/18/16 at 12:05 p.m., Physician (PHY) U stated he was not aware and was not consulted by the facility regarding R #2's inappropriate sexual behaviors or that inappropriate sexual behaviors were added to R #2's Care Plan on 01/28/16. PHY U stated he expected to be notified within a couple of days of the change to add inappropriate sexual behaviors to one of his patients Care Plan.
In an interview on 02/18/16 at 12:15 p.m., LVN D stated she did not know that R #2 had inappropriate sexual behaviors or that they were added to her Care Plan on 01/28/16. LVN D stated that change in R #2's Care Plan should have been communicated to staff. LVN D stated R #1 was moved out of the room with R #2 last month in January 2016 but she was not informed the reason for the roommate change.
In an interview on 02/18/16 at 3:25 p.m., the administrator (ADM) stated she was aware that R #2 had inappropriate sexual behaviors added to her Care Plan 02/18/16 but that she thought it needed to be reworded because it was misleading. The ADM stated the situation that prompted R #2's Care Plan to be changed was when a CNA witnessed R #2 assisting R #1 in their room. The ADM stated since R #1 did not appear distressed they added inappropriate sexual behaviors to R #2's Care Plan but I know it is wrong wording and should be interfere with care or over help other residents. The ADM stated that she added the inappropriate sexual behaviors to R #2's Care Plan to be better safe than sorry. The ADM stated the DON interviewed staff and determined the CNA did not see anything and R #1 was not distressed. The ADM stated the NPE went to the different halls of the facility with updates on care guides and the NPE was the mechanism the facility used to advise staff of changes necessary for resident care.
In an interview on 02/18/16 at 3:40 p.m., the DON stated she received a call the next day regarding the situation between R #1 and R #2. The DON stated they moved R #1 to another room because she was sick and she notified R #1's Court Appointed Guardian regarding her room change. The DON stated she did an internal investigation and determined there was no reason to report an incident to DADS.
In a telephone interview on 02/19/16 at 5:05 p.m., CNALstated she was in the hall of the secure unit at night in November and heard a noise in the room shared by R #1 and R #2. CNA L stated she entered the room and saw R #2 standing at R #1's bedside with her hand under R #1's covers.
Record review of a piece of paper received from the DON on 02/18/16 at 4:50 p.m. revealed a piece of paper with the date 11/14/15 at the top that stated the following:
I was contacted by (NPE) at 11:18 a.m. stated she was told (R #2) was touching roommate by (CNAL)
11:40 a.m. (NA G) - Reports (R #2) wakes up roommate throughout the night. No other behaviors noted
11:50 a.m. (LVN K) - states (R #2) is bossy tells other residents what to do but is re-directable. Sometimes paces.
11:50 a.m. (AA X) - states R #2 is affectionate with others no behaviors noted
12:10 p.m. (CNA L, LVN W, LVN Y) all interviewed with no sexual behaviors seen .
(R #1) assessed for injury with none noted. (R #1) moved to another room to reduce risk of any behaviors and reassess at next care plan meeting.
The paper was signed by the DON 02/18/16
Record review of R #1's Physician order [REDACTED].#1 was moved from bed A of the room she shared with R #2 into bed B of another room down the hall on 01/13/16 that was occupied by R #16.
Record review of R #16's Physician order [REDACTED].#16 was moved from bed B of the room R #1 was moved to on 01/13/16. R #16 was moved into the A bed of the room with R #2 on 01/13/16.
Record review of the facility daily census log for 01/08/16 revealed R #1 and R #2 shared a room. R #16 was listed as residing at the other end of the hall in bed B.
Record review of the facility daily census log for 01/09/16 revealed R #2 and R #16 shared a room. R #1 was listed as residing in bed B of the room R #16 was listed on 01/08/16.
In an interview on 02/18/16 at 4:50 p.m., the DON stated she did an internal investigation of the situation between R #1 and R #2 on 11/14/15 regarding R #2's behaviors and moved R #1 to another room on 11/14/15. The DON stated I moved R #1 in November 2015. I don ' t know why the Physicians Order says 01/13/16 because I moved her 11/14/15 .We moved (R #1.) Staff there helped me move her. Probably (LVN K) or (NA G.) I'm not sure. The DON stated she was notified of the situation between R #1 and R #2 on 11/14/15 and she had not received any other notifications from staff regarding R #1's behaviors toward R #2 since 11/14/15. The DON stated it was her decision to amend R #2's Care Plan for January 2016 to add sexually inappropriate behaviors on 01/28/16 but her decision was not related to the incident in November 2015. The DON stated I thought the inappropriate sexual behaviors were on (R #2's) old Care Plan so I added it from November (2015.) My thought it was a continuation we were not ready to resolve at that point. The DON stated she recalled the inappropriate sexual behaviors were in place on R #2's Care Plan prior to November 2015 on an old handwritten Care Plan so it was added in January 2016. The DON stated Now I advise it be taken off R #2's Care Plan. The DON stated staff had not notified her of any sexually inappropriate behaviors for R #2 since November 2015.
Record review of R #1's Resident Notification of Room Change dated 11/14/15 with a Late entry 02/18/16 revealed R #1 was moved on 11/14/15 and the responsible party was notified.

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In an interview on 02/19/16 at 9:30 a.m., the ADM stated R #1 was moved from the room she shared with R #2 to another room on 11/14/15. The ADM stated the new computer system caused the change to not show up in the records until January 2016. The Facility Regional Vice President (RVP) was in the room and agreed that the new computer system caused the delay in recording R #1's move from 11/14/15 to January 2016.
In an interview on 02/19/16 at 10:15 a.m., the Medical Records Coordinator (MR) stated the new facility computer system was implemented in August 2015. MR stated telephone orders for room change are written at the time of the room change and usually the rooms assignments are updated daily.
In an interview on 02/19/16 at 10:30 a.m., LVN S stated the DON told her to update R #2's Care Plan and add inappropriate sexual behaviors in January 2016. LVN S stated there may have been an old hand written Care Plan from 2013 for R #2 that included inappropriate sexual behaviors. LVN S stated she would look through all of R #2's medical records.
In an interview on 02/19/16 at 11:30 a.m., NA G stated she assisted the DON move R #1 from the room she shared with R #2 in January 2016.
R #1
Record review of R #1's Face Sheet dated 12/23/15 revealed a [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED].
Record review of R #1's Care Plan initiated on 06/13/14 and created on 02/15/16 revealed in a focus area that R #1 exhibited aggressive behavior with Activities of Daily Living (ADLs.) Facility staff interventions included identifying causes for R #1's behavior and reduce factors that may provoke R #1. Facility staff was to monitor and document R #1's behavior. R #1's Care Plan included a focus stating R #1 was unable to remember names and faces and facility staff intervention included validating resident thoughts and feelings during daily care. R #1's Care Plan included a focus area that stated R #1 had feelings of restlessness and anxiety. Facility staff interventions included assisting R #1 to determine the source of her anxiety and encourage R #1 to verbalize when she was anxious. R #1 was to be referred for psychological consult as needed.
Record review of R #1's most recent quarterly Minimum Data Set ((MDS) dated [DATE] revealed R #1 was coded that she understood others with clear comprehension and was able to make herself understood. R #1's MDS was coded that she spoke clearly and had adequate hearing and vision. R #1's MDS was coded as she did not display behaviors. R #1 totally dependent and required the assistance from one person for bed mobility, dressing, eating, personal hygiene and bathing. R #1 required extensive assistance from one person for transfer and ambulation. R #1's 12/25/15 MDS was not completed for Brief Interview for Mental Status or Cognitive Patterns (BIMS.) R #1's most recent annual MDS dated [DATE] revealed R #1 was unable to complete the BIMS and her Cognitive Patterns were coded as moderately impaired with poor decisions requiring cues and supervision.
Record review of R #1's medical record did not reveal any entry for November 2015 through January 2016 regarding an assessment of R #1's urogenital area. There was no documentation regarding any incident between R #1 and R #2. R #1's medical record revealed R #1 had recurrent bladder infections and was admitted to the hospital 11/19/15 with the [DIAGNOSES REDACTED].)
In a telephone interview on 02/18/16 at 2:30 p.m., R #1's Responsible Party Representative (RPR) stated their official record of notifications from the facility regarding R #1 did not include a change of room for November 2015 or January 2016. The RPR stated there was no notification of R #2's hand under R #1's sheet in November 2015 nor of R #2's hand in R #1's brief in January 2016 received from the facility.
R #6
R #6's face sheet dated 04/23/15 revealed she was an 89 female admitted to the facility on [DATE]. R #6's [DIAGNOSES REDACTED].
Record review of R #6's quarterly MDS dated [DATE] revealed R #6 had a cognitive score of 3 which meant she was severely cognitively impaired.
Observed R #6 on 02/17/16 at 12:00 noon up in a wheelchair in her room

F 0224

Level of harm - Actual harm

Residents Affected - Some

Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview and record review, the facility failed to implement their policy and procedure that prohibits neglect for four Residents (R #1, R #2, R#7,and R #10) of nine Residents reviewed for neglect.
-The DON delayed treatment of [REDACTED].
-The DON delayed treatment of [REDACTED].
-The facility did not investigate, document, protect other residents or remove R #1 from the room she shared with R #2 when staff reported to the Director of Nursing (DON) that R #2 had her hand under R #1's sheet during the night shift in November 2015.
-The facility did not investigate, document or protect other residents when staff reported to the Director of Nursing (DON) that R #2 had her hands in R #1's pajama pants during the night shift in January 2016.
-The facility did not make staff aware that sexually inappropriate behaviors were added to R #2's Care Plan on 01/28/16 and staff did not know to monitor R #2 for those interventions.
-The facility did not notify R #1 and R #2's physician of the reported incident of R #2's hand under R #1's sheet in November 2015 nor of the incident of R #2's hand in R #1's brief in January 2016.
-The faiclity did not notify R #1's responsible party of R #1's room change in January 2016 nor of the reported incident of R #2's hand under R #1's sheet in November 2015 nor of the incident of R #2's hand in R #1's bried in January 2016.
-The facility did not follow their policy to report to the Texas Department of Aging and Disability Services (DADS) suspected or alleged neglect reported to the DON regarding the incidents of R #2's hand under R #1's sheet in November 2015 and of R #2's hand in R #1's brief in January 2016.
-The facility staffed the secure unit with one CNA on the night shift from 10:00 p.m. on 02/17/16 to 6:00 a.m. on 02/18/16 when their staffing schedule stated two CNAs were to be scheduled in the secure unit during the night shifts.
-The facility Nursing Practice Educator (NPE) did not assess R #1 when she didn't look right and R #1 sustained a fall while ambulating in the hall.
These failures could place 24 residents who resided in the secure unit of the facility at risk for neglect from the facility to not provide goods and services necessary to avoid physical harm, mental anguish or mental illness.
The findings were:
R#7
Record review of R#7's Face Sheet dated 02/25/15 revealed a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE]. R#7 had the following Diagnoses: [REDACTED]. Ath. Usp. Graft, Chronic Asthma, [MEDICAL CONDITIONS]
Reflux, [MEDICAL CONDITION], and Chronic Pain.
Record review of R#7's Minimum Data Set ((MDS) dated [DATE] revealed R#7's [DIAGNOSES REDACTED]. R#7's MDS revealed she had
clear speech, usually understood, and usually understood others. R#7 needed extensive assistance from one person for physical assistance for dressing, toilet use, personal hygiene and bathing. R#7 was totally dependent on one person for physical assistance for bed mobility.
Record review of R#7's Nurse's Notes by LVN Jdated 02/16/16 1200 revealed upon assessment resident (R#7) guarding left arm and complaining of pain. Swelling noted to left shoulder (refuses to move). Reported to physician. awaiting new orders. Medicated for pain . assisted to bed .
Record review of R#7's Nurses Notes dated 02/16/16 2-10 pm revealed resident complained of severe left shoulder pain. Physician ordered x-ray. Taken at 8 pm ,no results yet. Resident observed for sleep in recliner in .area. Resident continues to hold left arm to her shoulder area.
Record review of R#7's Nurses Notes(by LVN J) dated 02/17/16 1530 revealed discoloration noted to left arm measuring approximately 1.3 cm (centimeter) Asked in report of origin of injury. Informed resident had been hitting and grabbing at arm. Informed that X-ray of possible fracture had been reported to DON. Informed DON of discoloration and pain. Call to physician. N.O. (new order) to transfer to local hospital for evaluation and treatment.
During a telephone interview on 02/17/16 at 3:30 p.m. ,LVN F (night nurse) stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **455974**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/19/2016**

NAME OF PROVIDER OF SUPPLIER **OAK CREST NURSING CENTER**	STREET ADDRESS, CITY, STATE, ZIP **1902 FM 3036** **ROCKPORT, TX 78382**

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 0224

Level of harm - Actual harm

Residents Affected - Some

(continued... from page 4)
-had called the DON on 02/15/16 at 11:45 p.m to report R#7 was not able to move her left arm to assist with her own toileting.
- R#7 was screaming in pain and agitated but no bruising was noted
- R#7's baseline was no reported pain in her left arm and R#7 was able to use both arms to assist in her own toileting with out pain
R#7 was up all night her shift starting at 10:00 p.m. on 02/15/16 through 6:00 a.m on 02/16/16 and R#7 picked and grabbed at her left arm during that time
-she (LVNF) retrieved an X-ray result after 11:00 p.m.for R#7 from the fax machine and called the DON at that time to report a positive X-ray for a fracture to R#7's left Humerus.
-she (LVNF) stated the DON said she would call Physician (PHY) in the morning to report R#7's positive X-ray results.
-she (LVNF) was instructed to medicate R#7 for pain
-LVNF stated the facility's policy is to call the Physician with changes in resident condition
-she (LVNF) gave report to LVNJ at 6:00 a.m. on 02/17/16 regarding R#7's positive X-ray results and at that time the DON had not come to see R#7 and the Physician had not called with orders to treat R#7.
On 02/17/16 at 12:25 p.m., LVN Jstated she was told yesterday (2/16/16) that R#7 had arm pain. She (LVNJ) noted swelling and advised R#7's physician. This morning (02/17/16) she was told the X-ray report had come for R#7 at 8:56 p.m.on 02/16/16. LVNJ replied the night nurse (LVNF) had called the DON about R#7's X-ray result. LVNJ replied it was reported to her that the DON did not call the Physician about R#7's X-ray result. LVNJ said she had spoken to the DON about 7:30 to 8:00 a.m. on 02/17/16/.
LVN J said I called the physician on 02/17/16 at 11:30 a.m and asked if he (Physician) knew the results of R#7's X-ray report. LVNJ replied ,the Physician said no ;X-ray report was read to the Physician.
Review of Physicians's t.o. (telephone order) dated 02/17/16 1130 revealed transfer to local hospital for evaluation and treatment fracture left arm.
Review of R#7's Radiology Report with DOS (date of service) 02/16/16 (final report faxed to facility on 02/16/16 20:56) revealed
Conclusion
Subtle cortical disruption in left humeral neck suspicious of impacted non-displaced fracture, with modest inferior subluxation of left humeral head. F/U (follow -up) recommended.
R #10
Record review of R #10's Face Sheet dated 02/03/16 revealed a [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. R #10's physician was PHY U, the Medical Director for the facility.
Record review of R #10's current Minimum Data Set ((MDS) dated [DATE] revealed R #10's [DIAGNOSES REDACTED]. R #10's MDS
revealed she was incapable of speech, rarely or never made herself understood and rarely or never understood others. R #10's MDS revealed her cognitive skills for daily decision making was coded as severely impaired and she never or rarely made decisions. R #10 was totally dependent on one person for physical assistance for dressing, toilet use, personal hygiene and bathing. R #10 required extensive assistance from one person for bed mobility, locomotion in her wheelchair and eating.
Record review of R #10's Care Plan dated 01/30/16 revealed R #10 exhibited symptoms of decline on cognitive function related to dementia. R #10 was at risk for falls due to cognitive loss, lack of safety awareness as she slid forward in her wheelchair and tipped wheelchair backward. Interventions included assess for changes in medical status, pain status, mental status and report to the physician as indicated.
Record review of R #10's Nurses Notes dated 02/16/16 at 1:00 p.m. revealed R #10 had swelling and heat to the left lower extremity reported to and evaluated by Physician (PHY) U.
Record review of R #10's Nurses Notes dated 02/16/15 from the 2:00 p.m. to 10:00 p.m. shift revealed PHY U ordered a Venous Doppler (ultrasound that uses sound waves to produce pictures of the body's veins) to R #10's left leg due to swelling and redness.
Record review of R #10's Nurses Notes dated 02/17/16 at 7:00 a.m. revealed R #10 was assessed with [REDACTED].
Observation on 02/17/16 at 11:45 a.m. revealed R #10 sitting in her wheelchair in the dining room of the secured unit at a table with another resident. R #10 shifted in her wheelchair often and leaned on her right hip and the right arm rest of her wheelchair while she looked out the window. R # 10 pulled at and lifted the left corner of her shirt.
Record review of R #10's Nurses Notes dated 02/17/16 from the 2:00 p.m. to 10:00 p.m. shift revealed R #10 was assessed and continued to have swelling and redness to her left leg. R # 10's left leg had a slight discoloration to the area. The Venous Doppler to R #10's left leg was performed at 4:00 p.m. on 02/17/16 and the technician who performed the ultrasound stated to the nurse that results could take 24 hours to receive.
Observation on 02/18/16 at 7:45 a.m. revealed R #10 sitting in her wheelchair at a table in the dining room of the secured unit at a table with another resident. R #10 was able to feed herself and was restless as she shifted positions in her wheelchair.
Record review of R #10's Nurses Notes dated 02/18/16 at 12:00 p.m. revealed the results of R #10's Venous Doppler were given to PHY U and the nurse reported to PHY U that R #10's left leg remained swollen with multiple areas of dark discoloration. Discolored areas of R #10's left leg included her left knee, left outer leg, left heel, left outer thigh, left calf and left inner knee. LVN J documented she showed the discolored areas of R #10's left leg to the Assistant Director of Nursing (ADON) and LVN J reported the multiple areas of discoloration to the Director of Nursing (DON.)
Record review of R #10's physician's orders [REDACTED].#10 was to have X-rays of her left hip and left knee.
Record review of R #10's Nurses Notes dated 02/18/16 from the 2:00 p.m. to 10:00 p.m. shift revealed a new order from PHY U for an X-ray to R #10's left leg including her knee, ankle and foot. The DON was to be notified with the results of the X-ray. R #10 was assessed to have swelling and redness with skin discoloration noted to her left leg that were warm to touch.
Record review of R #10's Radiology Report faxed to the facility on [DATE] at 12:42 a.m. revealed R #10 had an acute left knee fracture that involved the left distal femur (long bone in the thigh close to the knee.)
Record review of R #10's Nurses Notes dated 02/19/16 at 12:30 a.m. signed by LVN W revealed the results of R #10's X-ray were reported to the DON. The documented response from the DON was that she would take care of this in the morning.
Record review of the facility Nursing Home to Hospital Transfer Form for R #10 dated 02/19/16 revealed R #10 was given two Tylenol Extra Strength 500 milligram (mg) tablets on 02/19/16 at 8:40 a.m. and her last set of vital signs was taken on 02/19/16 at 9:00 a.m.
Record review of R #10's Nurses Notes dated 02/19/16 at 1:30 p.m. by LVN W revealed R #10 was sent out to the hospital and transported by Emergency Medical Services (EMS.) A telephone follow-up to the local hospital revealed R #10 was a probable admit.
In an interview on 02/19/16 at 2:40 p.m. LVN K stated she worked in the secure unit 02/19/16 from 6:00 a.m. to 2:00 p.m. LVN K stated she took report this morning from LVN W that revealed that X-ray results received after midnight showed R #10 had a fractured left femur. LVN K stated she called PHY U at 8:00 a.m. on 02/19/16 as she had not been contacted by the DON regarding care for R #10. LVN K stated PHY U stated he was on call the night of 02/18/16 and early morning of 02/19/16 and he was not aware of the results of R #10's X-ray. LVN K stated PHY U ordered R #10 be sent to the hospital by EMS. LVN K stated she called R #10's family member and legal representative and they were not aware R #10 had a fractured femur. LVN K stated she saw the DON about 9:30 a.m. or 10:00 a.m. on 02/19/16 and informed the DON R #10 was sent out to the hospital as per PHY U orders. LVN K stated that the DON replied to her R #10 had pathological fractures (bone fracture caused by disease that led to weakness of the bone structure.) LVN K stated to the surveyor that regardless if it was one fracture or multiple fractures R #10 still needed to be treated because R #10 shouldn't have to hurt.
In an interview on 02/19/16 at 3:30 p.m., the DON stated she was aware that PHY U had ordered an X-ray for R #10 on 02/18/16 at 3:00 p.m. The DON stated LVN W called her at home at 12:45 a.m. on 02/19/16 with the results of R #10's X-ray and said that we needed to call the doctor. The DON stated she did not call PHY U regarding results of R #10's X-ray showing a fractured femur but that the floor nurse called and notified PHY U in the morning. The DON stated PHY U was not on call at that time on 02/19/16 but another physician. The DON stated PHY U was particular that nursing staff call him and not the physician on call regarding his residents' medical conditions.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAK CREST NURSING CENTER	**1902 FM 3036** **ROCKPORT, TX 78382**

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 0224 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 5) In an interview on 02/17/16 at 3:30 p.m., LVN F stated PHY U will accept calls regarding his residents' change of condition while he is on call. LVN F stated PHY U did not want facility staff to call the on call physician for changes in his residents ' condition if PHY U was not on call. LVN F stated PHY U wanted to be the only physician to treat his residents. LVN F stated she used her nursing judgment to determine if a resident change of condition was an emergency and needed to be reported to the physician on call for PHY U. Record review of a written Physician order [REDACTED]. Call me with All med changes made to ANY of my patients. If I am not on call, wait to call ME personally when I am back on call. The order was delivered to the surveyor by the DON on 02/19/16 at 5:45 p.m. as requested documentation of PHY U orders to facility staff informing when staff were to notify PHY U of changes in condition or treatment for [REDACTED]. Record review of a written statement from PHY U dated 02/19/16 and received after 5:45 p.m. revealed PHY U was aware that R #10 had swelling in her left leg since 02/16/16 and he ordered a Venous Doppler to check if R #10 had a blood clot in her left leg. The Venous Doppler results revealed R #10 did not have a blood clot in her left leg on 02/18/16 so at that time he ordered an X-ray of R 10's left leg. PHY U stated R #10's X-ray report came in to the facility at 12:45 a.m. on 02/19/16 and he was called with the results at 8:00 a.m. on 02/19/16 regarding R #10's new [DIAGNOSES REDACTED]. PHY U stated he felt that R #10's X-ray represented a new [DIAGNOSES REDACTED]. PHY U stated he felt the notification he received at 8:00 a.m. on 02/19/16 was appropriate and timely and led to the proper treatment of [REDACTED]. In a telephone interview on 02/19/16 at 4:20 p.m., PHY U stated he was on call the night of 02/18/16 and morning of 02/19/16. PHY U stated when he is not on call he does not want facility staff to call the on call physician about his residents unless it is a true emergency. PHY U stated facility staff was to wait to notify him when he was back on call regarding changes in his residents' medical conditions or need for treatment changes. In an interview on 02/19/16 at 5:00 p.m., the Assistant Director of Nursing (ADON) stated the facility did not instruct her on a requirement to report changes of condition only to PHY U and not to the physician on call regarding his residents at the facility. The ADON stated the facility did not instruct her on what PHY U considered an emergency condition that would require the consultation of the on call physician. R #2 Record review of R #2's Face Sheet dated 12/05/15 revealed an [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Record review on 01/28/16 of R #2's Care Plan revised revealed in a focus area that R #2 displayed inappropriate sexual behaviors at times. The goal for this behavior included R #2 would not exhibit at risk or inappropriate sexual behaviors that affected other patients, staff, or visitors. Facility staff interventions to meet this goal included the following: -Review behavioral expectations with patient. -Observe and report verbal and/or physical sexual behaviors exhibited and report to the licensed nurse immediately. -Notify physician if sexually inappropriate behavior is exhibited. -Observe and report change in mood state to licensed nurse immediately. -Remove from common areas when sexually inappropriate behavior is exhibited -Attempt to refocus the patient's behavior to something positive when he or she exhibits inappropriate sexual behavior. -Assist the patient in identifying problem causing stimuli. on 01/14/16 R #2's Care Plan included a focus area initiated and created by the Director of Nursing (DON) stating R #2 exhibited or was at risk for complications of infection related to a Urinary Tract Infection (UTI.) Facility staff intervention included facility staff was to assist resident with hand washing throughout the day as needed. R #2's Care Plan included a focus area initiated on 07/16/13 that stated R #2 resided in the Transitions Unit (secured unit) due to being at risk for elopement (leaving the facility.) Facility staff interventions included monitoring R #2 frequently to assure her safety. R #2's Care Plan included a focus area initiated on 07/16/13 that stated R #2 had poor safety awareness. Facility staff interventions included monitoring for changes in R #2's condition that may warrant increased supervision or assistance and notify the physician as needed. R #2's interventions included she needed adequate lighting to see at night. R #2's Care Plan included a focus area imitated on 07/16/13 that stated R #2 had difficulty making her own decisions. Facility staff interventions included assisting R #2 with decision making as needed and report any changes in R #2's level of consciousness to the physician. Record review of R #2's current Minimum Data Set ((MDS) dated [DATE] revealed R #2 had a Brief Interview for Mental Status (BIMS) score of four out of a possible 15 points. R #2 understood others with clear comprehension and was able to make herself understood. R #2 spoke clearly and had adequate hearing and vision. R #2's MDS was coded as she had no behaviors, hallucinations or delusions. R #2 was independent and required no assistance from staff for bed mobility, transfer or ambulation. R #2 required supervision and setup help only for dressing, eating, personal hygiene and bathing. R #2 was able to toilet herself with supervision only. In a telephone interview on 02/17/16 at 3:10 p.m., LVN Fstated approximately one month prior at 5:00 a.m. she entered the room shared by R #1 and R #2 on the secured unit to give R #2 a scheduled medication. LVN F stated when she entered the room she saw R #2 standing beside R #1's bed. R #2 had her hand in R #1's pajama bottoms. LVN F stated R #1's blankets were pulled down and she wore an incontinent brief. LVN F stated as soon as she entered the room shared by R #1 and R #2, R #2 removed her hand from R #1's pajama pants and crossed the room to sit on her bed and asked LVN F what do you have for me? LVN F stated she told R #2 that she had the [MEDICAL CONDITION] medication. LVN F stated R #2 said Oh yes, that one. LVN F stated she medicated R #2 and left the room with R #2 sitting on her bed and R #1 lying in her bed. LVN F stated she did not know how or where to document the incident she witnessed between R #2 and R #1 so at 5:15 a.m. on that morning she called the Director of Nurses (DON) and informed the DON what she witnessed at 5:00 a.m. LVN F stated the DON told her to keep an eye on them and let me know if anything else happens. LVN F stated the DON did not tell her to write a report or call the physician. LVN F stated the DON told her We'll take care of it. LVN F stated she was not told nor was she aware that inappropriate sexual behaviors were added to R #1's Care Plan on 01/28/16. LVN F stated the facility staffing ratio for night shift; 10:00 p.m. to 6:00 a.m.; was to include two CNAs in the secure unit, one CNA for hall 200, one CNA for hall 300 and two nurses for the facility. LVN F stated they often only had one CNA in the secure unit, one CNA on hall 200, one CNA for hall 300 and two nurses to cover the entire facility during the 10:00 p.m. to 6:00 a.m. shift. On 02/18/16 record review of nurse's notes revealed there were no notes indicating LVN F called the DON to notify her of the situation. There were no notes indicating the physician or family had been notified. There were no incident reports, new assessments, or care plans updated. Observation on 02/18/16 at 5:50 a.m. revealed three residents ambulating in the hall of the secure unit and two residents seated in the dining room of the secure unit. CNA C was the only staff member on the secure unit. In an interview on 02/18/16 at 6:20 a.m., LVN D stated there was only one CNA scheduled on the secure unit during the shift from 10:00 p.m. on 02/17/16 to 6:00 a.m. on 02/18/16. LVN Dstated two CNAs were scheduled for the secure unit during the night shift because sometimes the residents wake up on the wrong side of the bed and start kicking at each other. In an interview on 02/18/16 at 6:30 a.m., CNA C stated she was the only CNA scheduled during the night shift from 10:00 p.m. on 02/17/16 to 6:00 a.m. on 02/18/16 in the secure unit. CNA C stated there were two CNAs scheduled in the secure unit about four to seven nights per week. CNA C stated one CNA could handle the secure unit when there were no problems. CNA C stated if she needed help at night on the secure unit she could press the call bell light or pull the call bell light from the wall and wait for help from staff in other parts of the facility. CNA C stated R #2 got up at night and was confused. CNA C stated she did not know that R #2 had inappropriate sexual behaviors or that it was added to her Care Plan on 01/28/16. In an interview on 02/18/16 at 8:45 a.m., LVN J stated she did not know that R #2 had inappropriate sexual behaviors or that they were added to her Care Plan on 01/28/16. In an interview on 02/18/16 at 10:05 a.m., AA E stated she did not know R #2 had inappropriate sexual behaviors added to her Care Plan on 01/28/16. AA E stated she expected to be informed of any changes or new behaviors to monitor for resident. In an interview on 02/18/16 at 11:30 a.m., LVN K stated she was not informed that R #2 had inappropriate sexual behaviors or that it was added to her Care Plan on 01/28/16. LVN K stated that when Care Plans were updated direct care staff needed to be notified of new behaviors to monitor. In an interview on 02/18/16 at 12:05 p.m., Physician (PHY) U stated he was not aware and was not consulted by the facility

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F 0224 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 6) regarding R #2's inappropriate sexual behaviors or that inappropriate sexual behaviors were added to R #2's Care Plan on 01/28/16. PHY U stated he expected to be notified within a couple of days of the change to add inappropriate sexual behaviors to one of his patient's Care Plan. In an interview on 02/18/16 at 12:15 p.m., LVN D stated she did not know that R #2 had inappropriate sexual behaviors or that they were added to her Care Plan on 01/28/16. LVN D stated that change in R #2's Care Plan should have been communicated to staff. LVN D stated R #1 was moved out of the room with R #2 last month in January 2016 but she was not informed the reason for the roommate change. In an interview on 02/18/16 at 3:25 p.m., the administrator (ADM) stated she was aware that R #2 had inappropriate sexual behaviors added to her Care Plan 01/18/16 but that she thought it needed to be reworded because it was misleading. The ADM stated the situation that prompted R #2 ' s Care Plan to be changed was when a CNA witnessed R #2 assisting R #1 in their room. The ADM stated since R #1 did not appear distressed they added inappropriate sexual behaviors to R #2's Care Plan but I know it is wrong wording and should be interfere with care or over help other residents. The ADM stated that she added the inappropriate sexual behaviors to R #2's Care Plan to be better safe than sorry. The ADM stated the DON interviewed staff and determined the CNA did not see anything and R #1 was not distressed. The ADM stated the NPE went to the different halls of the facility with updates on care guides and the NPE was the mechanism the facility used to advise staff of changes necessary for resident care. In an interview on 02/18/16 at 3:40 p.m., the DON stated she received a call the next day regarding the situation between R #1 and R #2. The DON stated they moved R #1 to another room because she was sick and she notified R #1's Court Appointed Guardian regarding her room change. The DON stated she did an internal investigation and determined there was no reason to report an incident to DADS. In a telephone interview on 02/19/16 at 5:05 p.m., CNALstated she was in the hall of the secure unit at night in November and heard a noise in the room shared by R #1 and R #2. CNA L stated she entered the room and saw R #2 standing at R #1's bedside with her hand under R #1's covers. Record review of a piece of paper dated 11/14/15 received from the DON on 02/18/16 at 4:50 p.m. revealed the following: I was contacted by (NPE) at 11:18 a.m. stated she was told (R #2) was touching roommate by (CNA L) 11:40 a.m. (Nurse Aid NA G) - Reports (R #2) wakes up roommate throughout the night. No other behaviors noted 11:50 a.m. (LVN K) - states (R #2) is bossy tells other residents what to do but is re-directable. Sometimes paces. 11:50 a.m. (AA X) - states R #2 is affectionate with others no behaviors noted 12:10 p.m. (CNA L, LVN W, LVN Y) all interviewed with no sexual behaviors seen . (R #1) assessed for injury with none noted. (R #1) moved to another room to reduce risk of any behaviors and reassess at next care plan meeting. The paper was signed o 02/18/16 by the DON. Record review of R #1's Physician order [REDACTED].#1 was moved from bed A of the room she shared with R #2 into bed B of another room down the hall on 01/13/16 that was occupied by R #16. Record review of R #16's Physician order [REDACTED].#16 was moved from bed B of the room R #1 was moved to on 01/13/16. R #16 was moved into the A bed of the room with R #2 on 01/13/16. Record review of the facility daily census log for 01/08/16 revealed R #1 and R #2 shared a room. R #16 was listed as residing at the other end of the hall in bed B. Record review of the facility daily census log for 01/09/16 revealed R #2 and R #16 shared a room. R #1 was listed as residing in bed B of the room R #16 was listed in 01/08/16. In an interview on 02/18/16 at 4:50 p.m., the DON stated she did an internal investigation of the situation between R #1 and R #2 on 11/14/15 regarding R #2's behaviors and moved R #1 to another room on 11/14/15. The DON stated I moved R #1 in November 2015. I don't know why the Physicians Order says 01/13/16 because I moved her 11/14/15 .We moved (R #1.) Staff there helped me move her. Probably (LVN K) or (NA G.) I'm not sure. The DON stated she was notified of the situation between R #1 and R #2 on 11/14/15 and she had not received any other notifications from staff regarding R #1's behaviors toward R #2 since 11/14/15. The DON stated it was her decision to amend R #2's Care Plan for January 2016 to add sexually inappropriate behaviors on 01/28/16 but her decision was not related to the incident in November 2015. The DON stated I thought the inappropriate sexual behaviors were on (R #2's) old Care Plan so I added it from November (2015.) My thought it was a continuation we were not ready to resolve at that point. The DON stated she recalled the inappropriate sexual behaviors were in place on R #2's Care Plan prior to November 2015 on an old handwritten Care Plan so it was added in January 2016. The DON stated Now I advise it be taken off R #2 ' s Care Plan. The DON stated staff had not notified her of any sexually inappropriate behaviors for R #2 since November 2015. Record review of R #1's Resident Notification of Room Change dated 11/14/15 with a Late entry 02/18/16 revealed R #1 was moved on 11/14/15 and the responsible party was notified. In an interview on 02/19/16 at 9:30 a.m., the ADM stated R #1 was moved from the room she shared with R #2 to another room on 11/14/15. The ADM stated the new computer system caused the change to not show up in the records until January 2016. The Facility Regional Vice President (RVP) was in the room and agreed that the new computer system caused the delay in recording R #1's move from 11/14/15 to January 2016. In an interview on 02/19/16 at 10:15 a.m., the Health Information Coordinator (HIC) stated the new facility computer system was implemented in August 2015. Medical Records (MR) stated telephone orders for room change were written at the time of the room change and usually the rooms assignments were updated daily. In an interview on 02/19/16 at 10:30 a.m., LVN S stated the DON told her to update R #2's Care Plan and add inappropriate sexual behaviors in January 2016. LVN S stated there may have been an old hand written Care Plan from 2013 for R #2 that included inappropriate sexual behaviors. LVN S stated she would look through all of R #2's medical records. In an interview on 02/19/16 at 11:30 a.m., NA G stated she assisted the DON move R #1 from the room she shared with R #2 in January 2016. In an interview on 02/19/16 at 54:00 p.m., LVN S stated she could not find any other Care Plan for R #2 that included inappropriate sexual behaviors other than the one dated 01/28/16. R #1 Record review of R #1's Face Sheet dated 12/23/15 revealed a [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED].
F 0225 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to thoroughly investigate and immediately report one injury of unknown origin to the Department of Aging and Disability Services (DADS) for one Resident (R #7) and two incidences of neglect for two residents (R #1 and R #2) of nine Residents reviewed for abuse and neglect. -The DON delayed treatment of [REDACTED]. -The facility did not investigate, document, protect other residents or remove R #1 from the room she shared with R #2 when staff reported to the Director of Nursing (DON) that R #2 had her hand under R #1's sheet during the night shift in November 2015. -The facility did not investigate, document or protect other residents when staff reported to the Director of Nursing (DON) that R #2 had her hands in R #1's pajama pants during the night shift in January 2016. -The facility did not make staff aware that sexually inappropriate behaviors were added to R #2's Care Plan on 01/28/16 and staff did not know to monitor R #2 for those interventions. -The facility did not notify R #1 and R #2's physician of the reported incident of R #2's hand under R #1's sheet in November 2015 nor of the incident of R #2's hand in R #1's brief in January 2016. -The facility did not notify R #1's responsible party of R #1's room change in January 2016 nor of the reported incident of R #2's hand under R #1's sheet in November 2015 nor of the incident of R #2's hand in R #1's brief in January 2016.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **455974**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/19/2016**

NAME OF PROVIDER OF SUPPLIER **OAK CREST NURSING CENTER**	STREET ADDRESS, CITY, STATE, ZIP **1902 FM 3036** **ROCKPORT, TX 78382**

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 0225

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 7)
-The facility did not follow their policy to report to the Texas Department of Aging and Disability Services (DADS) suspected or alleged neglect reported to the DON regarding the incidents of R #2's hand under R #1's sheet in November 2015 and of R #2's hand in R #1's brief in January 2016.
-The facility scheduled the Activity Aid (AA) E in the secured unit to perform tasks outside the secured unit and left only two staff to manage the secure unit during the day on 02/17/18. While the Certified Nurse Aid (CNA) performed scheduled resident personal care one LVN was left on the floor to intervene in a resident altercation during morning medication pass.
-The facility staffed the secure unit with one CNA on the night shift from 10:00 p.m. on 02/17/16 to 6:00 a.m. on 02/18/16 when their staffing schedule stated two CNAs were to be scheduled in the secure unit during the night shifts.
-The facility Nursing Practice Educator (NPE) did not assess R #1 when she didn't look right and R #1 sustained a fall while ambulating in the hall.
These failures could place 24 residents who resided in the secure unit of the facility at risk for neglect from the facility to not provide goods and services necessary to avoid physical harm, mental anguish or mental illness.
The findings were:
R#7
Record review of R#7's Face Sheet dated 02/25/15 revealed a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE]. R#7 had the following Diagnoses: [REDACTED]. Ath. Usp. Graft, Chronic Asthma, [MEDICAL CONDITIONS]
Reflux, [MEDICAL CONDITION], and Chronic Pain.
Record review of R#7's Minimum Data Set ((MDS) dated [DATE] revealed R#7's [DIAGNOSES REDACTED]. R#7's MDS revealed she had
clear speech, usually understood, and usually understood others. R#7 needed extensive assistance from one person for physical assistance for dressing, toilet use, personal hygiene and bathing. R#7 was totally dependent on one person for physical assistance for bed mobility.
Record review of R#7's Nurse's Notes by LVN Jdated 02/16/16 1200 revealed upon assessment resident (R#7) guarding left arm and complaining of pain. Swelling noted to left shoulder (refuses to move). Reported to physician. awaiting new orders. Medicated for pain . assisted to bed .
Record review of R#7's Nurses Notes dated 02/16/16 2-10 pm revealed resident complained of severe left shoulder pain. Physician ordered x-ray. Taken at 8 pm ,no results yet. Resident observed for sleep in recliner in .area. Resident continues to hold left arm to her shoulder area.
Record review of R#7's Nurses Notes(by LVN J) dated 02/17/16 1530 revealed discoloration noted to left arm measuring approximately 1.3 cm (centimeter) Asked in report of origin of injury. Informed resident had been hitting and grabbing at arm. Informed that X-ray of possible fracture had been reported to DON. Informed DON of discoloration and pain. Call to physician. N.O. (new order) to transfer to local hospital for evaluation and treatment.
During a telephone interview on 02/17/16 at 3:30 p.m. ,LVN F (night nurse) stated
-had called the DON on 02/15/16 at 11:45 p.m to report R#7 was not able to move her left arm to assist with her own toileting.
- R#7 was screaming in pain and agitated but no bruising was noted
- R#7's baseline was no reported pain in her left arm and R#7 was able to use both arms to assist in her own toileting with out pain
R#7 was up all night her shift starting at 10:00 p.m. on 02/15/16 through 6:00 a.m on 02/16/16 and R#7 picked and grabbed at her left arm during that time
-she (LVNF) retrieved an X-ray result after 11:00 p.m.for R#7 from the fax machine and called the DON at that time to report a positive X-ray for a fracture to R#7's left Humerus.
-she (LVNF) stated the DON said she would call Physician (PHY) in the morning to report R#7's positive X-ray results.
-she (LVNF) was instructed to medicate R#7 for pain
-LVNF stated the facility's policy is to call the Physician with changes in resident condition
-she (LVNF) gave report to LVNJ at 6:00 a.m. on 02/17/16 regarding R#7's positive X-ray results and at that time the DON had not come to see R#7 and the Physician had not called with orders to treat R#7.
On 02/17/16 at 12:25 p.m., LVN Jstated she was told yesterday (2/16/16) that R#7 had arm pain. She (LVNJ) noted swelling and advised R#7's physician. This morning (02/17/16) she was told the X-ray report had come for R#7 at 8:56 p.m.on 02/16/16. LVNJ replied the night nurse (LVNF) had called the DON about R#7's X-ray result. LVNJ replied it was reported to her that the DON did not call the Physician about R#7's X-ray result. LVNJ said she had spoken to the DON about 7:30 to 8:00 a.m. on 02/17/16/.
LVN J said I called the physician on 02/17/16 at 11:30 a.m and asked if he (Physician) knew the results of R#7's X-ray report. LVNJ replied ,the Physician said no ;X-ray report was read to the Physician.
Review of Physicians's t.o. (telephone order) dated 02/17/16 1130 revealed transfer to local hospital for evaluation and treatment fracture left arm.
Review of R#7's Radiology Report with DOS (date of service) 02/16/16 (final report faxed to facility on 02/16/16 20:56) revealed
Conclusion
Subtle cortical disruption in left humeral neck suspicious of impacted non-displaced fracture, with modest inferior subluxation of left humeral head. F/U (follow -up) recommended.
R #2
Record review of R #2's Face Sheet dated 12/05/15 revealed an [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED].
Record review on 01/28/16 of R #2's Care Plan revised revealed in a focus area that R #2 displayed inappropriate sexual behaviors at times. The goal for this behavior included R #2 would not exhibit at risk or inappropriate sexual behaviors that affected other patients, staff, or visitors. Facility staff interventions to meet this goal included the following:
-Review behavioral expectations with patient.
-Observe and report verbal and/or physical sexual behaviors exhibited and report to the licensed nurse immediately.
-Notify physician if sexually inappropriate behavior is exhibited.
-Observe and report change in mood state to licensed nurse immediately.
-Remove from common areas when sexually inappropriate behavior is exhibited
-Attempt to refocus the patient's behavior to something positive when he or she exhibits inappropriate sexual behavior.
-Assist the patient in identifying problem causing stimuli.
on 01/14/16 R #2's Care Plan included a focus area initiated and created by the Director of Nursing (DON) stating R #2 exhibited or was at risk for complications of infection related to a Urinary Tract Infection (UTI.) Facility staff intervention included facility staff was to assist resident with hand washing throughout the day as needed. R #2's Care Plan included a focus area initiated on 07/16/13 that stated R #2 resided in the Transitions Unit (secured unit) due to being at risk for elopement (leaving the facility.) Facility staff interventions included monitoring R #2 frequently to assure her safety. R #2's Care Plan included a focus area initiated on 07/16/13 that stated R #2 had poor safety awareness. Facility staff interventions included monitoring for changes in R #2's condition that may warrant increased supervision or assistance and notify the physician as needed. R #2's interventions included she needed adequate lighting to see at night. R #2's Care Plan included a focus area imitated on 07/16/13 that stated R #2 had difficulty making her own decisions. Facility staff interventions included assisting R #2 with decision making as needed and report any changes in R #2's level of consciousness to the physician.
Record review of R #2's current Minimum Data Set ((MDS) dated [DATE] revealed R #2 had a Brief Interview for Mental Status (BIMS) score of four out of a possible 15 points. R #2 understood others with clear comprehension and was able to make herself understood. R #2 spoke clearly and had adequate hearing and vision. R #2's MDS was coded as she had no behaviors, hallucinations or delusions. R #2 was independent and required no assistance from staff for bed mobility, transfer or ambulation. R #2 required supervision and setup help only for dressing, eating, personal hygiene and bathing. R #2 was able to toilet herself with supervision only.
In a telephone interview on 02/17/16 at 3:10 p.m., LVN Fstated approximately one month prior at 5:00 a.m. she entered the room shared by R #1 and R #2 on the secured unit to give R #2 a scheduled medication. LVN F stated when she entered the room she saw R #2 standing beside R #1's bed. R #2 had her hand in R #1's pajama bottoms. LVN F stated R #1's blankets were

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAK CREST NURSING CENTER	**1902 FM 3036 ROCKPORT, TX 78382**

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F 0225

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 8)
pulled down and she wore an incontinent brief. LVN F stated as soon as she entered the room shared by R #1 and R #2, R #2 removed her hand from R #1's pajama pants and crossed the room to sit on her bed and asked LVN F what do you have for me? LVN F stated she told R #2 that she had the [MEDICAL CONDITION] medication. LVN F stated R #2 said Oh yes, that one. LVN F stated she medicated R #2 and left the room with R #2 sitting on her bed and R #1 lying in her bed. LVN F stated she did not know how or where to document the incident she witnessed between R #2 and R #1 so at 5:15 a.m. on that morning she called the Director of Nurses (DON) and informed the DON what she witnessed at 5:00 a.m. LVN F stated the DON told her to keep an eye on them and let me know if anything else happens. LVN F stated the DON did not tell her to write a report or call the physician. LVN F stated the DON told her We'll take care of it. LVN F stated she was not told nor was she aware that inappropriate sexual behaviors were added to R #1's Care Plan on 01/28/16. LVN F stated the facility staffing ratio for night shift; 10:00 p.m. to 6:00 a.m.; was to include two CNAs in the secure unit, one CNA for hall 200, one CNA for hall 300 and two nurses for the facility. LVN F stated they often only had one CNA in the secure unit, one CNA on hall 200, one CNA for hall 300 and two nurses to cover the entire facility during the 10:00 p.m. to 6:00 a.m. shift.

On 02/18/16 record review of nurse's notes revealed there were no notes indicating LVN F called the DON to notify her of the situation. There were no notes indicating the physician or family had been notified. There were no incident reports, new assessments, or care plans updated.

Observation on 02/18/16 at 5:50 a.m. revealed three residents ambulating in the hall of the secure unit and two residents seated in the dining room of the secure unit. CNA C was the only staff member on the secure unit.

In an interview on 02/18/16 at 6:20 a.m., LVN D stated there was only one CNA scheduled on the secure unit during the shift from 10:00 p.m. on 02/17/16 to 6:00 a.m. on 02/18/16. LVN Dstated two CNAs were scheduled for the secure unit during the night shift because sometimes the residents wake up on the wrong side of the bed and start kicking at each other.

In an interview on 02/18/16 at 6:30 a.m., CNA C stated she was the only CNA scheduled during the night shift from 10:00 p.m. on 02/17/16 to 6:00 a.m. on 02/18/16 in the secure unit. CNA C stated there were two CNAs scheduled in the secure unit about four to seven nights per week. CNA C stated one CNA could handle the secure unit when there were no problems. CNA C stated if she needed help at night on the secure unit she could press the call bell light or pull the call bell light from the wall and wait for help from staff in other parts of the facility. CNA C stated R #2 got up at night and was confused. CNA C stated she did not know that R #2 had inappropriate sexual behaviors or that it was added to her Care Plan on 01/28/16.

In an interview on 02/18/16 at 8:45 a.m., LVN J stated she did not know that R #2 had inappropriate sexual behaviors or that they were added to her Care Plan on 01/28/16.

In an interview on 02/18/16 at 10:05 a.m., AA E stated she did not know R #2 had inappropriate sexual behaviors added to her Care Plan on 01/28/16. AA E stated she expected to be informed of any changes or new behaviors to monitor for resident.

In an interview on 02/18/16 at 11:30 a.m., LVN K stated she was not informed that R #2 had inappropriate sexual behaviors or that it was added to her Care Plan on 01/28/16. LVN K stated that when Care Plans were updated direct care staff needed to be notified of new behaviors to monitor.

In an interview on 02/18/16 at 12:05 p.m., Physician (PHY) U stated he was not aware and was not consulted by the facility regarding R #2's inappropriate sexual behaviors or that inappropriate sexual behaviors were added to R #2's Care Plan on 01/28/16. PHY U stated he expected to be notified within a couple of days of the change to add inappropriate sexual behaviors to one of his patient's Care Plan.

In an interview on 02/18/16 at 12:15 p.m., LVN D stated she did not know that R #2 had inappropriate sexual behaviors or that they were added to her Care Plan on 01/28/16. LVN D stated that change in R #2's Care Plan should have been communicated to staff. LVN D stated R #1 was moved out of the room with R #2 last month in January 2016 but she was not informed the reason for the roommate change.

In an interview on 02/18/16 at 3:25 p.m., the administrator (ADM) stated she was aware that R #2 had inappropriate sexual behaviors added to her Care Plan 01/18/16 but that she thought it needed to be reworded because it was misleading. The ADM stated the situation that prompted R #2 ' s Care Plan to be changed was when a CNA witnessed R #2 assisting R #1 in their room. The ADM stated since R #1 did not appear distressed they added inappropriate sexual behaviors to R #2's Care Plan but I know it is wrong wording and should be interfere with care or over help other residents. The ADM stated that she added the inappropriate sexual behaviors to R #2's Care Plan to be better safe than sorry. The ADM stated the DON interviewed staff and determined the CNA did not see anything and R #1 was not distressed. The ADM stated the NPE went to the different halls of the facility with updates on care guides and the NPE was the mechanism the facility used to advise staff of changes necessary for resident care.

In an interview on 02/18/16 at 3:40 p.m., the DON stated she received a call the next day regarding the situation between R #1 and R #2. The DON stated they moved R #1 to another room because she was sick and she notified R #1's Court Appointed Guardian regarding her room change. The DON stated she did an internal investigation and determined there was no reason to report an incident to DADS.

In a telephone interview on 02/19/16 at 5:05 p.m., CNALstated she was in the hall of the secure unit at night in November and heard a noise in the room shared by R #1 and R #2. CNA L stated she entered the room and saw R #2 standing at R #1's bedside with her hand under R #1's covers.

Record review of a piece of paper dated 11/14/15 received from the DON on 02/18/16 at 4:50 p.m. revealed the following:
I was contacted by (NPE) at 11:18 a.m. stated she was told (R #2) was touching roommate by (CNA L)
11:40 a.m. (Nurse Aid NA G) - Reports (R #2) wakes up roommate throughout the night. No other behaviors noted
11:50 a.m. (LVN K) - states (R #2) is bossy tells other residents what to do but is re-directable. Sometimes paces.
11:50 a.m. (AA X) - states R #2 is affectionate with others no behaviors noted
12:10 p.m. (CNA L, LVN W, LVN Y) all interviewed with no sexual behaviors seen .
(R #1) assessed for injury with none noted. (R #1) moved to another room to reduce risk of any behaviors and reassess at next care plan meeting.
The paper was signed o 02/18/16 by the DON.

Record review of R #1's Physician order [REDACTED].#1 was moved from bed A of the room she shared with R #2 into bed B of another room down the hall on 01/13/16 that was occupied by R #16.

Record review of R #16's Physician order [REDACTED].#16 was moved from bed B of the room R #1 was moved to on 01/13/16. R #16 was moved into the A bed of the room with R #2 on 01/13/16.

Record review of the facility daily census log for 01/08/16 revealed R #1 and R #2 shared a room. R #16 was listed as residing at the other end of the hall in bed B.

Record review of the facility daily census log for 01/09/16 revealed R #2 and R #16 shared a room. R #1 was listed as residing in bed B of the room R #16 was listed in 01/08/16.

In an interview on 02/18/16 at 4:50 p.m., the DON stated she did an internal investigation of the situation between R #1 and R #2 on 11/14/15 regarding R #2's behaviors and moved R #1 to another room on 11/14/15. The DON stated I moved R #1 in November 2015. I don't know why the Physicians Order says 01/13/16 because I moved her 11/14/15 .We moved (R #1.) Staff there helped me move her. Probably (LVN K) or (NA G.) I'm not sure. The DON stated she was notified of the situation between R #1 and R #2 on 11/14/15 and she had not received any other notifications from staff regarding R #1's behaviors toward R #2 since 11/14/15. The DON stated it was her decision to amend R #2's Care Plan for January 2016 to add sexually inappropriate behaviors on 01/28/16 but her decision was not related to the incident in November 2015. The DON stated I thought the inappropriate sexual behaviors were on (R #2's) old Care Plan so I added it from November (2015.) My thought it was a continuation we were not ready to resolve at that point. The DON stated she recalled the inappropriate sexual behaviors were in place on R #2's Care Plan prior to November 2015 on an old handwritten Care Plan so it was added in January 2016. The DON stated Now I advise it be taken off R #2 ' s Care Plan. The DON stated staff had not notified her of any sexually inappropriate behaviors for R #2 since November 2015.

Record review of R #1's Resident Notification of Room Change dated 11/14/15 with a Late entry 02/18/16 revealed R #1 was moved on 11/14/15 and the responsible party was notified.

In an interview on 02/19/16 at 9:30 a.m., the ADM stated R #1 was moved from the room she shared with R #2 to another room on 11/14/15. The ADM stated the new computer system caused the change to not show up in the records until January 2016. The Facility Regional Vice President (RVP) was in the room and agreed that the new computer system caused the delay in recording R #1's move from 11/14/15 to January 2016.

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F 0225

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 9)
In an interview on 02/19/16 at 10:15 a.m., the Health Information Coordinator (HIC) stated the new facility computer system was implemented in August 2015. Medical Records (MR) stated telephone orders for room change were written at the time of the room change and usually the rooms assignments were updated daily.
In an interview on 02/19/16 at 10:30 a.m., LVN S stated the DON told her to update R #2's Care Plan and add inappropriate sexual behaviors in January 2016. LVN S stated there may have been an old hand written Care Plan from 2013 for R #2 that included inappropriate sexual behaviors. LVN S stated she would look through all of R #2's medical records.
In an interview on 02/19/16 at 11:30 a.m., NA G stated she assisted the DON move R #1 from the room she shared with R #2 in January 2016.
In an interview on 02/19/16 at 54:00 p.m., LVN S stated she could not find any other Care Plan for R #2 that included inappropriate sexual behaviors other than the one dated 01/28/16.
R #1
Record review of R #1's Face Sheet dated 12/23/15 revealed a [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED].
Record review of R #1's Care Plan initiated on 06/13/14 and printed on 02/15/16 revealed in a focus area that R #1 exhibited aggressive behavior with Activities of Daily Living (ADLs.) Facility staff interventions included identifying causes for R #1's behavior and reduce factors that may provoke R #1. Facility staff was to monitor and document R #1's behavior. R #1's Care Plan included a focus stating R #1 was unable to remember names and faces and facility staff intervention included validating resident thoughts and feelings during daily care. R #1's Care Plan included a focus area that stated R #1 had feelings of restlessness and anxiety. Facility staff interventions included assisting R #1 to determine the source of her anxiety and encourage R #1 to verbalize when she was anxious. R #1 was to be referred for psychological consult as needed.
Record review of R #1's most recent quarterly Minimum Data Set ((MDS) dated [DATE] revealed R #1 was coded that she understood others with clear comprehension and was able to make herself understood. R #1's MDS was coded that she spoke clearly and had adequate hearing and vision. R #1's MDS was coded as she did not display behaviors. R #1 was totally dependent and required the assistance from one person for bed mobility, dressing, eating, personal hygiene and bathing. R #1 required extensive assistance from one person for transfer and ambulation. R #1's 12/25/15 MDS was not completed for Brief Interview for Mental Status or Cognitive Patterns (BIMS.) R #1's most recent annual MDS dated [DATE] revealed R #1 was unable to complete the BIMS and her Cognitive Patterns were coded as moderately impaired with poor decisions requiring cues and supervision.
Record review of R #1's medical record did not reveal any entry for November 2015 through January 2016 regarding an assessment of R #1's urogenital area. There was no documentation regarding any incident between R #1 and R #2. R #1's medical record revealed R #1 had recurrent bladder infections and was admitted to the hospital 11/19/15 with the [DIAGNOSES REDACTED].)
Observation on 02/17/16 at 10:30 a.m. revealed R #1 lying in bed alone in the room. R #1's eyes were closed and she was wearing her night clothes.
In an interview on 02/1716 at 10:30 a.m., LVN B stated R #1 was recently moved to her new room and that her episodes of uncontrollable crying had decreased since the move.
Observation on 02/17/16 at 12:00 p.m. revealed R #1 sitting on the couch in the secure unit with her eyes closed and arms crossed. R #1's breathing pattern could be heard by the surveyor standing six feet away. R #1 had scratches on the right side of her neck that appeared approximately 10 centimeters (cm) long from behind her right ear to her right clavicle (collar bone.) The scratches were dark pink in color with no drainage noted.
In an interview on 02/17/16 at 12:15 p.m. LVN J stated she notice the marks on R #1's neck when she got out of bed that morning.
Observation on 02/17/16 at 12:20 p.m. revealed R #1 opened her eyes when NA G asked her to open her mouth to take her temperature. R #1 closed her eyes and did not open her mouth.
Observation on 02/17/16 at 12:30 p.m. revealed R #1's bottom sheet had dark rust colored spots at the end of the bed where R #1's lower legs were when she was in bed. R #1's pillow case had a rust colored stain on the right corner where her neck was on the pillow.
Observation on 02/17/16 at 12:40 p.m. revealed R #1 sitting at a table in the dining room of the secured unit next to a table where R #2 was seated. R #1's eyes were closed and she was not eating. AA X attempted to assist R #1 with eating and R #1 took a small bite of food but did not chew. AA X asked NA G if R #1 was doing alright. NA G stated R #1 usually fed herself and must not be hungry.
In an interview on 02/17/16 at 1:05 p.m., NA G looked at the stains on R #1's pillow case and bottom sheet in her room and said of the stains looks like blood to me.
Observation on 02/17/16 at 1:15 p.m. revealed NA G in the hall bathroom with R #1 assisting her on the toilet. NA G looked at R #1's fingernails and observed R #1 did not have blood under her nails. NA G looked at R #1's lower legs and did not see any wounds on her legs to explain the stains on R #1's sheets. While NA G assisted R #1 with toileting the surveyor heard a faint knock on the bathroom door. No attempt was made to open the lock and no verbal request to enter was heard. NA G did not acknowledge she heard the knock on the door.
In an interview on 02/17/16 at 1:20 p.m., NA G stated she had never observed R #1 scratch or hurt herself. NA G stated she had requested the nurse assess R #1 and was waiting for a nurse to come to the bathroom. NA G stated R #1 looked flush and she was unable to get her temperature earlier. NA G stated she was going to escort R #1 to her room.
Observation on 02/17/16 at 1:23 p.m. revealed R #1 on the floor in the hallway lying on her left side with her face down to the floor. NA G stated She just collapsed. LVN J called EMS and R #1 was taken by EMS to the Emergency Department at 1:42 p.m.
In an interview on 02/17/16 at 1:50 p.m., LVN J stated she was on the phone and asked the NPE to assess R #1 in the bathroom because R #1 was flushed and just didn't look right. LVN J stated the NPE took the Blood Pressure cuff and went down the hall and returned soon after. LVN J stated the NPE told her NA G wouldn't let her in the bathroom and the DON was calling so she had to leave. LVN J stated she was still on the phone when the NPE left the Blood Pressure cuff on the desk.
Record review of R # 1's discharge instructions from the hospital dated 02/17/16 at 6:23 p.m. revealed R #1 had a UTI. The instructions for Urinary Tract Infection - Female encluded the following:
-Always wipe from front to back after a bowel movement
-Keep the genital area clean and dry
In an interview on 02/18/16 at 10:00 a.m., the NPE stated the morning of 02/17/16 LVN J was on the phone calling report and had asked NPE to get vital signs on R #1 who looked flushed and was in the hall bathroom. NPE stated she knocked on the door of the bathroom but she heard no one answered. NPE stated did not open the bathroom door to respect the privacy of R #1. NPE stated she knew the code to enter the bathrrom but did not attempt to enter the bathroom after she knocked. NPE stated she heard her name paged over the speaker system and LVN J was almost done with calling report so she left the secure unit.
In a telephone interview on 02/18/16 at 2:30 p.m., R #1's Responsible Party Representative (RPR) stated their official record of notifications from the facility regarding R #1 did not include a change of room for November 2015 or January 2016. The RPR stated there was no notification of R #2's hand under R #1's sheet in November 2015 nor of R #2's hand in R #1's brief in January 2016 received from the facility.
Observation on 02/18/16 at 9:50 a.m. revealed LVN J standing between R #2 and R #17 with her hands held up keeping a distance between the two residents to were leaning toward each other. R #17 was heard to say She pushed me. R #2 did not reply. LVN J said someone help me.
In an interview on 02/18/16 at 9:55 a.m., LVN J stated the Activity Aid (AA) was schedule to be out of the secure unit and LVN J was alone on the floor because the CNA was giving a resident a shower. LVN J stated she was not able to pass medications and monitor residents on the floor by herself. LVN J stated she did not witness R #2 or R #17 push each other but heard them yelling at each other and saw them standing very close to each other.
In an interview on 02/18/16 at 10:05 a.m., AA E stated she was scheduled every Thursday at 9:30 a.m. to lead a group activity in the facility outside of the secure unit. AA E stated she was not instructed by facility administration to get coverage for the time she was out of the secure unit. AA E stated she did not know that R #2 had inappropriate sexual behaviors added to her Care Plan on 01/28/16. AA E stated she would have expected to be informed of any changes or new

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NAME OF PROVIDER OF SUPPLIER **OAK CREST NURSING CENTER**	STREET ADDRESS, CITY, STATE, ZIP **1902 FM 3036** **ROCKPORT, TX 78382**

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 0225 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 10) behaviors to monitor for residents. Record review of the facility Staffing Patterns by Hall received 02/18/16 revealed the secure unit was to be staffed as follows: -6:00 a.m. to 2:00 p.m.; one licensed nurse, one CNA -8:00 a.m. to 5:00 p.m.; one AA (also a CNA) -2:00 p.m. to 10:00 p.m.; one licensed nurse, one CNA -10:00 p.m. to 6:00 a.m.; two CNAs The facility CMS for 802 dated 02/17/16 listed 24 residents on the secure unit.
F 0226 **Level of harm -** Actual harm **Residents Affected -** Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement their written policy and procedure that prohibits neglect for four Residents (R #1, R #2, R#7,and R #10) of nine Residents reviewed for neglect. -The DON delayed treatment of [REDACTED]. -The DON delayed treatment of [REDACTED]. -The facility did not investigate, document, protect other residents or remove R #1 from the room she shared with R #2 when staff reported to the Director of Nursing (DON) that R #2 had her hand under R #1's sheet during the night shift in November 2015. -The facility did not investigate, document or protect other residents when staff reported to the Director of Nursing (DON) that R #2 had her hands in R #1's pajama pants during the night shift in January 2016. -The facility did not make staff aware that sexually inappropriate behaviors were added to R #2's Care Plan on 01/28/16 and staff did not know to monitor R #2 for those interventions. -The facility did not notify R #1 and R #2's physician of the reported incident of R #2's hand under R #1's sheet in November 2015 nor of the incident of R #2's hand in R #1's brief in January 2016. -The facility did not notify R #1's responsible party of R #1's room change in January 2016 nor of the reported incident of R #2's hand under R #1's sheet in November 2015 nor of the incident of R #2's hand in R #1's brief in January 2016. -The facility did not follow their policy to report to the Texas Department of Aging and Disability Services (DADS) suspected or alleged neglect reported to the DON regarding the incidents of R #2's hand under R #1's sheet in November 2015 and of R #2's hand in R #1's brief in January 2016. -The facility scheduled the Activity Aid (AA) E in the secured unit to perform tasks outside the secured unit and left only two staff to manage the secure unit during the day on 02/17/18. While the Certified Nurse Aid (CNA) performed scheduled resident personal care one LVN was left on the floor to intervene in a resident altercation during morning medication pass. -The facility staffed the secure unit with one CNA on the night shift from 10:00 p.m. on 02/17/16 to 6:00 a.m. on 02/18/16 when their staffing schedule stated two CNAs were to be scheduled in the secure unit during the night shifts. -The facility Nursing Practice Educator (NPE) did not assess R #1 when she didn't look right and R #1 sustained a fall while ambulating in the hall. These failures could place 24 residents who resided in the secure unit of the facility at risk for neglect from the facility to not provide goods and services necessary to avoid physical harm, mental anguish or mental illness. The findings were: Record review of the facility OPS333-TX Abuse Prohibition-State of Texas dated 01/22/16 received from the facility stated If the suspected abuse is patient-to-patient, the patient who has in any way threatened or attacked another will be removed from the setting or situation. The family and physician will be notified and any follow-up recommended will be completed. Options for room changes will be provided based on the situation .Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, neglect, injuries of unknown origin .the Administrator of designee will perform the following including immediately, not to exceed 24 hours, notify (DADS) .and provide with the following: -If special supervision was required -The person's level of cognition -The person's pertinent medical history -If there was a history of similar or prior incidents -The date and time you first learned of the incident and a brief narrative summary of the reportable incident -The names of any alleged perpetrators or witnesses -The date, time and results of any assessment conducted, including findings of injury or adverse effects noted -The immediate action taken to protect other people and to prevent occurrences of similar incidents while you conduct and complete your investigation. The facility policy also stated the following: - Provide staff with information on how they may report concerns and incidents without fear of retribution and provide feedback regarding the expressed concerns. - Notify the families and attending Physician about all reports of suspected abuse or neglect. R#7 Record review of R#7's Face Sheet dated 02/25/15 revealed a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE]. R#7 had the following Diagnoses: [REDACTED]. Ath. Usp. Graft, Chronic Asthma, [MEDICAL CONDITIONS] Reflux, [MEDICAL CONDITION], and Chronic Pain. Record review of R#7's Minimum Data Set ((MDS) dated [DATE] revealed R#7's [DIAGNOSES REDACTED]. R#7's MDS revealed she had clear speech, usually understood, and usually understood others. R#7 needed extensive assistance from one person for physical assistance for dressing, toilet use, personal hygiene and bathing. R#7 was totally dependent on one person for physical assistance for bed mobility. Record review of R#7's Nurse's Notes by LVN Jdated 02/16/16 1200 revealed upon assessment resident (R#7) guarding left arm and complaining of pain. Swelling noted to left shoulder (refuses to move). Reported to physician. awaiting new orders. Medicated for pain . assisted to bed . Record review of R#7's Nurses Notes dated 02/16/16 2-10 pm revealed resident complained of severe left shoulder pain. Physician ordered x-ray. Taken at 8 pm ,no results yet. Resident observed for sleep in recliner in .area. Resident continues to hold left arm to her shoulder area. Record review of R#7's Nurses Notes(by LVN J) dated 02/17/16 1530 revealed discoloration noted to left arm measuring approximately 1.3 cm (centimeter) Asked in report of origin of injury. Informed resident had been hitting and grabbing at arm. Informed that X-ray of possible fracture had been reported to DON. Informed DON of discoloration and pain. Call to physician. N.O. (new order) to transfer to local hospital for evaluation and treatment. During a telephone interview on 02/17/16 at 3:30 p.m. ,LVN F (night nurse) stated -had called the DON on 02/15/16 at 11:45 p.m to report R#7 was not able to move her left arm to assist with her own toileting. - R#7 was screaming in pain and agitated but no bruising was noted - R#7's baseline was no reported pain in her left arm and R#7 was able to use both arms to assist in her own toileting with out pain R#7 was up all night her shift starting at 10:00 p.m. on 02/15/16 through 6:00 a.m on 02/16/16 and R#7 picked and grabbed at her left arm during that time -she (LVNF) retrieved an X-ray result after 11:00 p.m.for R#7 from the fax machine and called the DON at that time to report a positive X-ray for a fracture to R#7's left Humerus. -she (LVNF) stated the DON said she would call Physician (PHY) in the morning to report R#7's positive X-ray results. -she (LVNF) was instructed to medicate R#7 for pain -LVNF stated the facility's policy is to call the Physician with changes in resident condition -she (LVNF) gave report to LVNJ at 6:00 a.m. on 02/17/16 regarding R#7's positive X-ray results and at that time the DON had

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NAME OF PROVIDER OF SUPPLIER **OAK CREST NURSING CENTER**		STREET ADDRESS, CITY, STATE, ZIP **1902 FM 3036** **ROCKPORT, TX 78382**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0226 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 11) not come to see R#7 and the Physician had not called with orders to treat R#7. On 02/17/16 at 12:25 p.m., LVN Jstated she was told yesterday (2/16/16) that R#7 had arm pain. She (LVNJ) noted swelling and advised R#7's physician. This morning (02/17/16) she was told the X-ray report had come for R#7 at 8:56 p.m.on 02/16/16. LVNJ replied the night nurse (LVNF) had called the DON about R#7's X-ray result. LVNJ replied it was reported to her that the DON did not call the Physician about R#7's X-ray result. LVNJ said she had spoken to the DON about 7:30 to 8:00 a.m. on 02/17/16/. LVN J said I called the physician on 02/17/16 at 11:30 a.m and asked if he (Physician) knew the results of R#7's X-ray report. LVNJ replied ,the Physician said no ;X-ray report was read to the Physician. Review of Physicians's t.o. (telephone order) dated 02/17/16 1130 revealed transfer to local hospital for evaluation and treatment fracture left arm. Review of R#7's Radiology Report with DOS (date of service) 02/16/16 (final report faxed to facility on 02/16/16 20:56) revealed Conclusion Subtle cortical disruption in left humeral neck suspicious of impacted non-displaced fracture, with modest inferior subluxation of left humeral head. F/U (follow -up) recommended. R #10 Record review of R #10's Face Sheet dated 02/03/16 revealed a [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. R #10's physician was PHY U, the Medical Director for the facility. Record review of R #10's current Minimum Data Set ((MDS) dated [DATE] revealed R #10's [DIAGNOSES REDACTED]. R #10's MDS revealed she was incapable of speech, rarely or never made herself understood and rarely or never understood others. R #10's MDS revealed her cognitive skills for daily decision making was coded as severely impaired and she never or rarely made decisions. R #10 was totally dependent on one person for physical assistance for dressing, toilet use, personal hygiene and bathing. R #10 required extensive assistance from one person for bed mobility, locomotion in her wheelchair and eating. Record review of R #10's Care Plan dated 01/30/16 revealed R #10 exhibited symptoms of decline on cognitive function related to dementia. R #10 was at risk for falls due to cognitive loss, lack of safety awareness as she slid forward in her wheelchair and tipped wheelchair backward. Interventions included assess for changes in medical status, pain status, mental status and report to the physician as indicated. Record review of R #10's Nurses Notes dated 02/16/16 at 1:00 p.m. revealed R #10 had swelling and heat to the left lower extremity reported to and evaluated by Physician (PHY) U. Record review of R #10's Nurses Notes dated 02/16/15 from the 2:00 p.m. to 10:00 p.m. shift revealed PHY U ordered a Venous Doppler (ultrasound that uses sound waves to produce pictures of the body's veins) to R #10's left leg due to swelling and redness. Record review of R #10's Nurses Notes dated 02/17/16 at 7:00 a.m. revealed R #10 was assessed with [REDACTED]. Observation on 02/17/16 at 11:45 a.m. revealed R #10 sitting in her wheelchair in the dining room of the secured unit at a table with another resident. R #10 shifted in her wheelchair often and leaned on her right hip and the right arm rest of her wheelchair while she looked out the window. R # 10 pulled at and lifted the left corner of her shirt. Record review of R #10's Nurses Notes dated 02/17/16 from the 2:00 p.m. to 10:00 p.m. shift revealed R #10 was assessed and continued to have swelling and redness to her left leg. R # 10's left leg had a slight discoloration to the area. The Venous Doppler to R #10's left leg was performed at 4:00 p.m. on 02/17/16 and the technician who performed the ultrasound stated to the nurse that results could take 24 hours to receive. Observation on 02/18/16 at 7:45 a.m. revealed R #10 sitting in her wheelchair at a table in the dining room of the secured unit at a table with another resident. R #10 was able to feed herself and was restless as she shifted positions in her wheelchair. Record review of R #10's Nurses Notes dated 02/18/16 at 12:00 p.m. revealed the results of R #10's Venous Doppler were given to PHY U and the nurse reported to PHY U that R #10's left leg remained swollen with multiple areas of dark discoloration. Discolored areas of R #10's left leg included her left knee, left outer leg, left heel, left outer thigh, left calf and left inner knee. LVN J documented she showed the discolored areas of R #10's left leg to the Assistant Director of Nursing (ADON) and LVN J reported the multiple areas of discoloration to the Director of Nursing (DON.) Record review of R #10's physician's orders [REDACTED].#10 was to have X-rays of her left hip and left knee. Record review of R #10's Nurses Notes dated 02/18/16 from the 2:00 p.m. to 10:00 p.m. shift revealed a new order from PHY U for an X-ray to R #10's left leg including her knee, ankle and foot. The DON was to be notified with the results of the X-ray. R #10 was assessed to have swelling and redness with skin discoloration noted to her left leg that were warm to touch. Record review of R #10's Radiology Report faxed to the facility on [DATE] at 12:42 a.m. revealed R #10 had an acute left knee fracture that involved the left distal femur (long bone in the thigh close to the knee.) Record review of R #10's Nurses Notes dated 02/19/16 at 12:30 a.m. signed by LVN W revealed the results of R #10's X-ray were reported to the DON. The documented response from the DON was that she would take care of this in the morning. Record review of the facility Nursing Home to Hospital Transfer Form for R #10 dated 02/19/16 revealed R #10 was given two Tylenol Extra Strength 500 milligram (mg) tablets on 02/19/16 at 8:40 a.m. and her last set of vital signs was taken on 02/19/16 at 9:00 a.m. Record review of R #10's Nurses Notes dated 02/19/16 at 1:30 p.m. by LVN W revealed R #10 was sent out to the hospital and transported by Emergency Medical Services (EMS.) A telephone follow-up to the local hospital revealed R #10 was a probable admit. In an interview on 02/19/16 at 2:40 p.m. LVN K stated she worked in the secure unit 02/19/16 from 6:00 a.m. to 2:00 p.m. LVN K stated she took report this morning from LVN W that revealed that X-ray results received after midnight showed R #10 had a fractured left femur. LVN K stated she called PHY U at 8:00 a.m. on 02/19/16 as she had not been contacted by the DON regarding care for R #10. LVN K stated PHY U stated he was on call the night of 02/18/16 and early morning of 02/19/16 and he was not aware of the results of R #10's X-ray. LVN K stated PHY U ordered R #10 be sent to the hospital by EMS. LVN K stated she called R #10's family member and legal representative and they were not aware R #10 had a fractured femur. LVN K stated she saw the DON about 9:30 a.m. or 10:00 a.m. on 02/19/16 and informed the DON R #10 was sent out to the hospital as per PHY U orders. LVN K stated that the DON replied to her R #10 had pathological fractures (bone fracture caused by disease that led to weakness of the bone structure.) LVN K stated to the surveyor that regardless if it was one fracture or multiple fractures R #10 still needed to be treated because R #10 shouldn't have to hurt. In an interview on 02/19/16 at 3:30 p.m., the DON stated she was aware that PHY U had ordered an X-ray for R #10 on 02/18/16 at 3:00 p.m. The DON stated LVN W called her at home at 12:45 a.m. on 02/19/16 with the results of R #10's X-ray and said that we needed to call the doctor. The DON stated she did not call PHY U regarding results of R #10's X-ray showing a fractured femur but that the floor nurse called and notified PHY U in the morning. The DON stated PHY U was not on call at that time on 02/19/16 but another physician. The DON stated PHY U was particular that nursing staff call him and not the physician on call regarding his residents' medical conditions. In an interview on 02/17/16 at 3:30 p.m., LVN F stated PHY U will accept calls regarding his residents' change of condition while he is on call. LVN F stated PHY U did not want facility staff to call the on call physician for changes in his residents ' condition if PHY U was not on call. LVN F stated PHY U wanted to be the only physician to treat his residents. LVN F stated she used her nursing judgment to determine if a resident change of condition was an emergency and needed to be reported to the physician on call for PHY U. Record review of a written Physician order [REDACTED]. Call me with All med changes made to ANY of my patients. If I am not on call, wait to call ME personally when I am back on call. The order was delivered to the surveyor by the DON on 02/19/16 at 5:45 p.m. as requested documentation of PHY U orders to facility staff informing when staff were to notify PHY U of changes in condition or treatment for [REDACTED]. Record review of a written statement from PHY U dated 02/19/16 and received after 5:45 p.m. revealed PHY U was aware that R #10 had swelling in her left leg since 02/16/16 and he ordered a Venous Doppler to check if R #10 had a blood clot in her left leg. The Venous Doppler results revealed R #10 did not have a blood clot in her left leg on 02/18/16 so at that time

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F 0226 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 12)

he ordered an X-ray of R 10's left leg. PHY U stated R #10's X-ray report came in to the facility at 12:45 a.m. on 02/19/16 and he was called with the results at 8:00 a.m. on 02/19/16 regarding R #10's new [DIAGNOSES REDACTED]. PHY U stated he felt that R #10's X-ray represented a new [DIAGNOSES REDACTED]. PHY U stated he felt the notification he received at 8:00 a.m. on 02/19/16 was appropriate and timely and led to the proper treatment of [REDACTED].

In a telephone interview on 02/19/16 at 4:20 p.m., PHY U stated he was on call the night of 02/18/16 and morning of 02/19/16. PHY U stated when he is not on call he does not want facility staff to call the on call physician about his residents unless it is a true emergency. PHY U stated facility staff was to wait to notify him when he was back on call regarding changes in his residents' medical conditions or need for treatment changes.

In an interview on 02/19/16 at 5:00 p.m., the Assistant Director of Nursing (ADON) stated the facility did not instruct her on a requirement to report changes of condition only to PHY U and not to the physician on call regarding his residents at the facility. The ADON stated the facility did not instruct her on what PHY U considered an emergency condition that would require the consultation of the on call physician.

R #2

Record review of R #2's Face Sheet dated 12/05/15 revealed an [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED].

Record review on 01/28/16 of R #2's Care Plan revised revealed in a focus area that R #2 displayed inappropriate sexual behaviors at times. The goal for this behavior included R #2 would not exhibit at risk or inappropriate sexual behaviors that affected other patients, staff, or visitors. Facility staff interventions to meet this goal included the following:

-Review behavioral expectations with patient.
-Observe and report verbal and/or physical sexual behaviors exhibited and report to the licensed nurse immediately.
-Notify physician if sexually inappropriate behavior is exhibited.
-Observe and report change in mood state to licensed nurse immediately.
-Remove from common areas when sexually inappropriate behavior is exhibited
-Attempt to refocus the patient's behavior to something positive when he or she exhibits inappropriate sexual behavior.
-Assist the patient in identifying problem causing stimuli.

on 01/14/16 R #2's Care Plan included a focus area initiated and created by the Director of Nursing (DON) stating R #2 exhibited or was at risk for complications of infection related to a Urinary Tract Infection (UTI.) Facility staff intervention included facility staff was to assist resident with hand washing throughout the day as needed. R #2's Care Plan included a focus area initiated on 07/16/13 that stated R #2 resided in the Transitions Unit (secured unit) due to being at risk for elopement (leaving the facility.) Facility staff interventions included monitoring R #2 frequently to assure her safety. R #2's Care Plan included a focus area initiated on 07/16/13 that stated R #2 had poor safety awareness. Facility staff interventions included monitoring for changes in R #2's condition that may warrant increased supervision or assistance and notify the physician as needed. R #2's interventions included she needed adequate lighting to see at night. R #2's Care Plan included a focus area imitated on 07/16/13 that stated R #2 had difficulty making her own decisions. Facility staff interventions included assisting R #2 with decision making as needed and report any changes in R #2's level of consciousness to the physician.

Record review of R #2's current Minimum Data Set ((MDS) dated [DATE] revealed R #2 had a Brief Interview for Mental Status (BIMS) score of four out of a possible 15 points. R #2 understood others with clear comprehension and was able to make herself understood. R #2 spoke clearly and had adequate hearing and vision. R #2's MDS was coded as she had no behaviors, hallucinations or delusions. R #2 was independent and required no assistance from staff for bed mobility, transfer or ambulation. R #2 required supervision and setup help only for dressing, eating, personal hygiene and bathing. R #2 was able to toilet herself with supervision only.

In a telephone interview on 02/17/16 at 3:10 p.m., LVN Fstated approximately one month prior at 5:00 a.m. she entered the room shared by R #1 and R #2 on the secured unit to give R #2 a scheduled medication. LVN F stated when she entered the room she saw R #2 standing beside R #1's bed. R #2 had her hand in R #1's pajama bottoms. LVN F stated R #1's blankets were pulled down and she wore an incontinent brief. LVN F stated as soon as she entered the room shared by R #1 and R #2, R #2 removed her hand from R #1's pajama pants and crossed the room to sit on her bed and asked LVN F what do you have for me? LVN F stated she told R #2 that she had the [MEDICAL CONDITION] medication. LVN F stated R #2 said Oh yes, that one. LVN F stated she medicated R #2 and left the room with R #2 sitting on her bed and R #1 lying in her bed. LVN F stated she did not know how or where to document the incident she witnessed between R #2 and R #1 so at 5:15 a.m. on that morning she called the Director of Nurses (DON) and informed the DON what she witnessed at 5:00 a.m. LVN F stated the DON told her to keep an eye on them and let me know if anything else happens. LVN F stated the DON did not tell her to write a report or call the physician. LVN F stated the DON told her We'll take care of it. LVN F stated she was not told nor was she aware that inappropriate sexual behaviors were added to R #1's Care Plan on 01/28/16. LVN F stated the facility staffing ratio for night shift; 10:00 p.m. to 6:00 a.m.; was to include two CNAs in the secure unit, one CNA for hall 200, one CNA for hall 300 and two nurses for the facility. LVN F stated they often only had one CNA in the secure unit, one CNA on hall 200, one CNA for hall 300 and two nurses to cover the entire facility during the 10:00 p.m. to 6:00 a.m. shift.

On 02/18/16 record review of nurse's notes revealed there were no notes indicating LVN F called the DON to notify her of the situation. There were no notes indicating the physician or family had been notified. There were no incident reports, new assessments, or care plans updated.

Observation on 02/18/16 at 5:50 a.m. revealed three residents ambulating in the hall of the secure unit and two residents seated in the dining room of the secure unit. CNA C was the only staff member on the secure unit.

In an interview on 02/18/16 at 6:20 a.m., LVN D stated there was only one CNA scheduled on the secure unit during the shift from 10:00 p.m. on 02/17/16 to 6:00 a.m. on 02/18/16. LVN Dstated two CNAs were scheduled for the secure unit during the night shift because sometimes the residents wake up on the wrong side of the bed and start kicking at each other.

In an interview on 02/18/16 at 6:30 a.m., CNA C stated she was the only CNA scheduled during the night shift from 10:00 p.m. on 02/17/16 to 6:00 a.m. on 02/18/16 in the secure unit. CNA C stated there were two CNAs scheduled in the secure unit about four to seven nights per week. CNA C stated one CNA could handle the secure unit when there were no problems. CNA C stated if she needed help at night on the secure unit she could press the call bell light or pull the call bell light from the wall and wait for help from staff in other parts of the facility. CNA C stated R #2 got up at night and was confused. CNA C stated she did not know that R #2 had inappropriate sexual behaviors or that it was added to her Care Plan on 01/28/16.

In an interview on 02/18/16 at 8:45 a.m., LVN J stated she did not know that R #2 had inappropriate sexual behaviors or that they were added to her Care Plan on 01/28/16.

In an interview on 02/18/16 at 10:05 a.m., AA E stated she did not know R #2 had inappropriate sexual behaviors added to her Care Plan on 01/28/16. AA E stated she expected to be informed of any changes or new behaviors to monitor for resident.

In an interview on 02/18/16 at 11:30 a.m., LVN K stated she was not informed that R #2 had inappropriate sexual behaviors or that it was added to her Care Plan on 01/28/16. LVN K stated that when Care Plans were updated direct care staff needed to be notified of new behaviors to monitor.

In an interview on 02/18/16 at 12:05 p.m., Physician (PHY) U stated he was not aware and was not consulted by the facility regarding R #2's inappropriate sexual behaviors or that inappropriate sexual behaviors were added to R #2's Care Plan on 01/28/16. PHY U stated he expected to be notified within a couple of days of the change to add inappropriate sexual behaviors to one of his patient's Care Plan.

In an interview on 02/18/16 at 12:15 p.m., LVN D stated she did not know that R #2 had inappropriate sexual behaviors or that they were added to her Care Plan on 01/28/16. LVN D stated that change in R #2's Care Plan should have been communicated to staff. LVN D stated R #1 was moved out of the room with R #2 last month in January 2016 but she was not informed the reason for the roommate change.

In an interview on 02/18/16 at 3:25 p.m., the administrator (ADM) stated she was aware that R #2 had inappropriate sexual behaviors added to her Care Plan 01/18/16 but that she thought it needed to be reworded because it was misleading. The ADM stated the situation that prompted R #2 ' s Care Plan to be changed was when a CNA witnessed R #2 assisting R #1 in their room. The ADM stated since R #1 did not appear distressed they added inappropriate sexual behaviors to R #2's Care Plan but I know it is wrong wording and should be interfere with care or over help other residents. The ADM stated that she added the inappropriate sexual behaviors to R #2's Care Plan to be better safe than sorry. The ADM stated the DON interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **455974**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/19/2016**
NAME OF PROVIDER OF SUPPLIER **OAK CREST NURSING CENTER**		STREET ADDRESS, CITY, STATE, ZIP **1902 FM 3036** **ROCKPORT, TX 78382**	

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 0226 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 13) staff and determined the CNA did not see anything and R #1 was not distressed. The ADM stated the NPE went to the different halls of the facility with updates on care guides and the NPE was the mechanism the facility used to advise staff of changes necessary for resident care. In an interview on 02/18/16 at 3:40 p.m., the DON stated she received a call the next day regarding the situation between R #1 and R #2. The DON stated they moved R #1 to another room because she was sick and she notified R #1's Court Appointed Guardian regarding her room change. The DON stated she did an internal investigation and determined there was no reason to report an incident to DADS. In a telephone interview on 02/19/16 at 5:05 p.m., CNALstated she was in the hall of the secure unit at night in November and heard a noise in the room shared by R #1 and R #2. CNA L stated she entered the room and saw R #2 standing at R #1's bedside with her hand under R #1's covers. Record review of a piece of paper dated 11/14/15 received from the DON on 02/18/16 at 4:50 p.m. revealed the following: I was contacted by (NPE) at 11:18 a.m. stated she was told (R #2) was touching roommate by (CNA L) 11:40 a.m. (Nurse Aid NA G) - Reports (R #2) wakes up roommate throughout the night. No other behaviors noted 11:50 a.m. (LVN K) - states (R #2) is bossy tells other residents what to do but is re-directable. Sometimes paces. 11:50 a.m. (AA X) - states R #2 is affectionate with others no behaviors noted 12:10 p.m. (CNA L, LVN W, LVN Y) all interviewed with no sexual behaviors seen . (R #1) assessed for injury with none noted. (R #1) moved to another room to reduce risk of any behaviors and reassess at next care plan meeting. The paper was signed o 02/18/16 by the DON. Record review of R #1's Physician order [REDACTED].#1 was moved from bed A of the room she shared with R #2 into bed B of another room down the hall on 01/13/16 that was occupied by R #16. Record review of R #16's Physician order [REDACTED].#16 was moved from bed B of the room R #1 was moved to on 01/13/16. R #16 was moved into the A bed of the room with R #2 on 01/13/16. Record review of the facility daily census log for 01/08/16 revealed R #1 and R #2 shared a room. R #16 was listed as residing at the other end of the hall in bed B. Record review of the facility daily census log for 01/09/16 revealed R #2 and R #16 shared a room. R #1 was listed as residing in bed B of the room R #16 was listed in 01/08/16. In an interview on 02/18/16 at 4:50 p.m., the DON stated she did an internal investigation of the situation between R #1 and R #2 on 11/14/15 regarding R #2's behaviors and moved R #1 to another room on 11/14/15. The DON stated I moved R #1 in November 2015. I don't know why the Physicians Order says 01/13/16 because I moved her 11/14/15 .We moved (R #1.) Staff there helped me move her. Probably (LVN K) or (NA G.) I'm not sure. The DON stated she was notified of the situation between R #1 and R #2 on 11/14/15 and she had not received any other notifications from staff regarding R #1's behaviors toward R #2 since 11/14/15. The DON stated it was her decision to amend R #2's Care Plan for January 2016 to add sexually inappropriate behaviors on 01/28/16 but her decision was not related to the incident in November 2015. The DON stated I thought the inappropriate sexual behaviors were on (R #2's) old Care Plan so I added it from November (2015.) My thought it was a continuation we were not ready to resolve at that point. The DON stated she recalled the inappropriate sexual behaviors were in place on R #2's Care Plan prior to November 2015 on an old handwritten
F 0281 **Level of harm -** Actual harm **Residents Affected -** Some	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility Director of Nursing failed to provide services that met professional standards of quality for four Residents (R #1, R #2, R #7 and R #10) of nine Residents reviewed for neglect. -The Director of Nursing (DON) delayed treatment of [REDACTED]. -The DON delayed treatment of [REDACTED]. -The DON did not investigate, document, protect other residents or remove R #1 from the room she shared with R #2 when staff reported to the DON that R #2 had her hand under R #1's sheet during the night shift in November 2015. R #1 was hospitalized in November 2015 for Urosepsis (a severe illness that occurs when an infection starts in the urinary tract and spreads into the bloodstream.) -The DON did not investigate, document or protect other residents when staff reported that R #2 had her hands in R #1's pajama pants during the night shift in January 2016. -The DON did not make staff aware that sexually inappropriate behaviors were added to R #2's Care Plan on 01/28/16 and staff did not know to monitor R #2 for those interventions. -The DON did not notify R #1 and R #2's physician of the reported incident of R #2's hand under R #1's sheet in November 2015 nor of the incident of R #2's hand in R #1's brief in January 2016. -The DON did not notify R #1's responsible party of R #1's room change in January 2016 nor of the reported incident of R #2's hand under R #1's sheet in November 2015 nor of the incident of R #2's hand in R #1's brief in January 2016. -The DON did not follow the facility policy to report to the Texas Department of Aging and Disability Services (DADS) suspected or alleged neglect reported to the DON regarding the incidents of R #2's hand under R #1's sheet in November 2015 and of R #2's hand in R #1's brief in January 2016. These failures could place 24 residents who resided in the secure unit of the facility at risk for neglect from the facility to not provide goods and services necessary to avoid physical harm, mental anguish or mental illness. The findings included: Texas Administrative Code, Title 22, Part 11, Chapter 217, Standards of Nursing Practice: 217.11 The Texas Board of Nursing is responsible for regulating the practice of nursing within the State of Texas for Vocational Nurses, Registered Nurses, and Registered Nurses with advanced practice authorization. The standards of practice establish a minimum acceptable level of nursing practice in any setting for each level of nursing licensure or advanced practice authorization. Failure to meet these standards may result in action against the nurse's license even if no actual patient injury resulted. (1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall: (A) Know and conform to the Texas Nursing Practice Act and the board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice; (B) Implement measures to promote a safe environment for clients and others; (C) Know the rationale for and the effects of medications and treatments and shall correctly administer the same; (D) Accurately and completely report and document; . (ii) nursing care rendered; . (iv) administration of medications and treatments; 217.12. Unprofessional Conduct. The unprofessional conduct rules are intended to protect clients and the public from incompetent, unethical, or illegal conduct of licensees. The purpose of these rules is to identify unprofessional or dishonorable behaviors of a nurse which the board believes are likely to deceive, defraud, or injure clients or the public. Actual injury to a client need not be established. These behaviors include but are not limited to: (1) Unsafe Practice - actions or conduct including, but not limited to: (A) Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Rule 217.11; (B) Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings; . (4) Careless or repetitive conduct that may endanger a client's life, health, or safety. Actual injury to a client need not be established R#7

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAK CREST NURSING CENTER	**1902 FM 3036** **ROCKPORT, TX 78382**

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 0281

Level of harm - Actual harm

Residents Affected - Some

(continued... from page 14)
Record review of R#7's Face Sheet dated 02/25/15 revealed a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE]. R#7 had the following Diagnoses: [REDACTED]. Ath. Usp. Graft, Chronic Asthma, [MEDICAL CONDITIONS]
Reflux, [MEDICAL CONDITION], and Chronic Pain.
Record review of R#7's Minimum Data Set ((MDS) dated [DATE] revealed R#7's [DIAGNOSES REDACTED]. R#7's MDS revealed she had
clear speech, usually understood, and usually understood others. R#7 needed extensive assistance from one person for physical assistance for dressing, toilet use, personal hygiene and bathing. R#7 was totally dependent on one person for physical assistance for bed mobility.
Record review of R#7's Nurse's Notes by LVN Jdated 02/16/16 1200 revealed upon assessment resident (R#7) guarding left arm and complaining of pain. Swelling noted to left shoulder (refuses to move). Reported to physician. awaiting new orders. Medicated for pain . assisted to bed .
Record review of R#7's Nurses Notes dated 02/16/16 2-10 pm revealed resident complained of severe left shoulder pain. Physician ordered x-ray. Taken at 8 pm ,no results yet. Resident observed for sleep in recliner in .area. Resident continues to hold left arm to her shoulder area.
Record review of R#7's Nurses Notes(by LVN J) dated 02/17/16 1530 revealed discoloration noted to left arm measuring approximately 1.3 cm (centimeter) Asked in report of origin of injury. Informed resident had been hitting and grabbing at arm. Informed that X-ray of possible fracture had been reported to DON. Informed DON of discoloration and pain. Call to physician. N.O. (new order) to transfer to local hospital for evaluation and treatment.
During a telephone interview on 02/17/16 at 3:30 p.m. ,LVN F (night nurse) stated
-had called the DON on 02/15/16 at 11:45 p.m to report R#7 was not able to move her left arm to assist with her own toileting.
- R#7 was screaming in pain and agitated but no bruising was noted
- R#7's baseline was no reported pain in her left arm and R#7 was able to use both arms to assist in her own toileting with out pain
R#7 was up all night her shift starting at 10:00 p.m. on 02/15/16 through 6:00 a.m on 02/16/16 and R#7 picked and grabbed at her left arm during that time
-she (LVNF) retrieved an X-ray result after 11:00 p.m.for R#7 from the fax machine and called the DON at that time to report a positive X-ray for a fracture to R#7's left Humerus.
-she (LVNF) stated the DON said she would call Physician (PHY) in the morning to report R#7's positive X-ray results.
-she (LVNF) was instructed to medicate R#7 for pain
-LVNF stated the facility's policy is to call the Physician with changes in resident condition
-she (LVNF) gave report to LVNJ at 6:00 a.m. on 02/17/16 regarding R#7's positive X-ray results and at that time the DON had not come to see R#7 and the Physician had not called with orders to treat R#7.
On 02/17/16 at 12:25 p.m., LVN Jstated she was told yesterday (2/16/16) that R#7 had arm pain. She (LVNJ) noted swelling and advised R#7's physician. This morning (02/17/16) she was told the X-ray report had come for R#7 at 8:56 p.m.on 02/16/16. LVNJ replied the night nurse (LVNF) had called the DON about R#7's X-ray result. LVNJ replied it was reported to her that the DON did not call the Physician about R#7's X-ray result. LVNJ said she had spoken to the DON about 7:30 to 8:00 a.m. on 02/17/16/.
LVN J said I called the physician on 02/17/16 at 11:30 a.m and asked if he (Physician) knew the results of R#7's X-ray report. LVNJ replied ,the Physician said no ;X-ray report was read to the Physician.
Review of Physicians's t.o. (telephone order) dated 02/17/16 1130 revealed transfer to local hospital for evaluation and treatment fracture left arm.
Review of R#7's Radiology Report with DOS (date of service) 02/16/16 (final report faxed to facility on 02/16/16 20:56) revealed
Conclusion
Subtle cortical disruption in left humeral neck suspicious of impacted non-displaced fracture, with modest inferior subluxation of left humeral head. F/U (follow -up) recommended.
R #10
Record review of R #10's Face Sheet dated 02/03/16 revealed a [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. R #10's physician was PHY U, the Medical Director for the facility.
Record review of R #10's current Minimum Data Set ((MDS) dated [DATE] revealed R #10's [DIAGNOSES REDACTED]. R #10's MDS
revealed she was incapable of speech, rarely or never made herself understood and rarely or never understood others. R #10's MDS revealed her cognitive skills for daily decision making was coded as severely impaired and she never or rarely made decisions. R #10 was totally dependent on one person for physical assistance for dressing, toilet use, personal hygiene and bathing. R #10 required extensive assistance from one person for bed mobility, locomotion in her wheelchair and eating.
Record review of R #10's Care Plan dated 01/30/16 revealed R #10 exhibited symptoms of decline on cognitive function related to dementia. R #10 was at risk for falls due to cognitive loss, lack of safety awareness as she slid forward in her wheelchair and tipped wheelchair backward. Interventions included assess for changes in medical status, pain status, mental status and report to the physician as indicated.
Record review of R #10's Nurses Notes dated 02/16/16 at 1:00 p.m. revealed R #10 had swelling and heat to the left lower extremity reported to and evaluated by Physician (PHY) U.
Record review of R #10's Nurses Notes dated 02/16/15 from the 2:00 p.m. to 10:00 p.m. shift revealed PHY U ordered a Venous Doppler (ultrasound that uses sound waves to produce pictures of the body's veins) to R #10's left leg due to swelling and redness.
Record review of R #10's Nurses Notes dated 02/17/16 at 7:00 a.m. revealed R #10 was assessed with [REDACTED].
Observation on 02/17/16 at 11:45 a.m. revealed R #10 sitting in her wheelchair in the dining room of the secured unit at a table with another resident. R #10 shifted in her wheelchair often and leaned on her right hip and the right arm rest of her wheelchair while she looked out the window. R # 10 pulled at and lifted the left corner of her shirt.
Record review of R #10's Nurses Notes dated 02/17/16 from the 2:00 p.m. to 10:00 p.m. shift revealed R #10 was assessed and continued to have swelling and redness to her left leg. R # 10's left leg had a slight discoloration to the area. The Venous Doppler to R #10's left leg was performed at 4:00 p.m. on 02/17/16 and the technician who performed the ultrasound stated to the nurse that results could take 24 hours to receive.
Observation on 02/18/16 at 7:45 a.m. revealed R #10 sitting in her wheelchair at a table in the dining room of the secured unit at a table with another resident. R #10 was able to feed herself and was restless as she shifted positions in her wheelchair.
Record review of R #10's Nurses Notes dated 02/18/16 at 12:00 p.m. revealed the results of R #10's Venous Doppler were given to PHY U and the nurse reported to PHY U that R #10's left leg remained swollen with multiple areas of dark discoloration. Discolored areas of R #10's left leg included her left knee, left outer leg, left heel, left outer thigh, left calf and left inner knee. LVN J documented she showed the discolored areas of R #10's left leg to the Assistant Director of Nursing (ADON) and LVN J reported the multiple areas of discoloration to the Director of Nursing (DON.)
Record review of R #10's physician's orders [REDACTED].#10 was to have X-rays of her left hip and left knee.
Record review of R #10's Nurses Notes dated 02/18/16 from the 2:00 p.m. to 10:00 p.m. shift revealed a new order from PHY U for an X-ray to R #10's left leg including her knee, ankle and foot. The DON was to be notified with the results of the X-ray. R #10 was assessed to have swelling and redness with skin discoloration noted to her left leg that were warm to touch.
Record review of R #10's Radiology Report faxed to the facility on [DATE] at 12:42 a.m. revealed R #10 had an acute left knee fracture that involved the left distal femur (long bone in the thigh close to the knee.)
Record review of R #10's Nurses Notes dated 02/19/16 at 12:30 a.m. signed by LVN W revealed the results of R #10's X-ray were reported to the DON. The documented response from the DON was that she would take care of this in the morning.
Record review of the facility Nursing Home to Hospital Transfer Form for R #10 dated 02/19/16 revealed R #10 was given two Tylenol Extra Strength 500 milligram (mg) tablets on 02/19/16 at 8:40 a.m. and her last set of vital signs was taken on 02/19/16 at 9:00 a.m.
Record review of R #10's Nurses Notes dated 02/19/16 at 1:30 p.m. by LVN W revealed R #10 was sent out to the hospital and

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F 0281

Level of harm - Actual harm

Residents Affected - Some

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transported by Emergency Medical Services (EMS.) A telephone follow-up to the local hospital revealed R #10 was a probable admit.
In an interview on 02/19/16 at 2:40 p.m. LVN K stated she worked in the secure unit 02/19/16 from 6:00 a.m. to 2:00 p.m. LVN K stated she took report this morning from LVN W that revealed that X-ray results received after midnight showed R #10 had a fractured left femur. LVN K stated she called PHY U at 8:00 a.m. on 02/19/16 as she had not been contacted by the DON regarding care for R #10. LVN K stated PHY U stated he was on call the night of 02/18/16 and early morning of 02/19/16 and he was not aware of the results of R #10's X-ray. LVN K stated PHY U ordered R #10 be sent to the hospital by EMS. LVN K stated she called R #10's family member and legal representative and they were not aware R #10 had a fractured femur. LVN K stated she saw the DON about 9:30 a.m. or 10:00 a.m. on 02/19/16 and informed the DON R #10 was sent out to the hospital as per PHY U orders. LVN K stated that the DON replied to her R #10 had pathological fractures (bone fracture caused by disease that led to weakness of the bone structure.) LVN K stated to the surveyor that regardless if it was one fracture or multiple fractures R #10 still needed to be treated because R #10 shouldn't have to hurt.
In an interview on 02/19/16 at 3:30 p.m., the DON stated she was aware that PHY U had ordered an X-ray for R #10 on 02/18/16 at 3:00 p.m. The DON stated LVN W called her at home at 12:45 a.m. on 02/19/16 with the results of R #10's X-ray and said that we needed to call the doctor. The DON stated she did not call PHY U regarding results of R #10's X-ray showing a fractured femur but that the floor nurse called and notified PHY U in the morning. The DON stated PHY U was not on call at that time on 02/19/16 but another physician. The DON stated PHY U was particular that nursing staff call him and not the physician on call regarding his residents' medical conditions.
In an interview on 02/17/16 at 3:30 p.m., LVN F stated PHY U will accept calls regarding his residents' change of condition while he is on call. LVN F stated PHY U did not want facility staff to call the on call physician for changes in his residents ' condition if PHY U was not on call. LVN F stated PHY U wanted to be the only physician to treat his residents. LVN F stated she used her nursing judgment to determine if a resident change of condition was an emergency and needed to be reported to the physician on call for PHY U.
Record review of a written Physician order [REDACTED].
Call me with All med changes made to ANY of my patients. If I am not on call, wait to call ME personally when I am back on call.
The order was delivered to the surveyor by the DON on 02/19/16 at 5:45 p.m. as requested documentation of PHY U orders to facility staff informing when staff were to notify PHY U of changes in condition or treatment for [REDACTED].
Record review of a written statement from PHY U dated 02/19/16 and received after 5:45 p.m. revealed PHY U was aware that R #10 had swelling in her left leg since 02/16/16 and he ordered a Venous Doppler to check if R #10 had a blood clot in her left leg. The Venous Doppler results revealed R #10 did not have a blood clot in her left leg on 02/18/16 so at that time he ordered an X-ray of R 10's left leg. PHY U stated R #10's X-ray report came in to the facility at 12:45 a.m. on 02/19/16 and he was called with the results at 8:00 a.m. on 02/19/16 regarding R #10's new [DIAGNOSES REDACTED]. PHY U stated he felt that R #10's X-ray represented a new [DIAGNOSES REDACTED]. PHY U stated he felt the notification he received at 8:00 a.m. on 02/19/16 was appropriate and timely and led to the proper treatment of [REDACTED].
In a telephone interview on 02/19/16 at 4:20 p.m., PHY U stated he was on call the night of 02/18/16 and morning of 02/19/16. PHY U stated when he is not on call he does not want facility staff to call the on call physician about his residents unless it is a true emergency. PHY U stated facility staff was to wait to notify him when he was back on call regarding changes in his residents' medical conditions or need for treatment changes.
In an interview on 02/19/16 at 5:00 p.m., the Assistant Director of Nursing (ADON) stated the facility did not instruct her on a requirement to report changes of condition only to PHY U and not to the physician on call regarding his residents at the facility. The ADON stated the facility did not instruct her on what PHY U considered an emergency condition that would require the consultation of the on call physician.
R #2
Record review of R #2's Face Sheet dated 12/05/15 revealed an [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED].
Record review on 01/28/16 of R #2's Care Plan revised revealed in a focus area that R #2 displayed inappropriate sexual behaviors at times. The goal for this behavior included R #2 would not exhibit at risk or inappropriate sexual behaviors that affected other patients, staff, or visitors. Facility staff interventions to meet this goal included the following:
-Review behavioral expectations with patient.
-Observe and report verbal and/or physical sexual behaviors exhibited and report to the licensed nurse immediately.
-Notify physician if sexually inappropriate behavior is exhibited.
-Observe and report change in mood state to licensed nurse immediately.
-Remove from common areas when sexually inappropriate behavior is exhibited
-Attempt to refocus the patient's behavior to something positive when he or she exhibits inappropriate sexual behavior.
-Assist the patient in identifying problem causing stimuli.
on 01/14/16 R #2's Care Plan included a focus area initiated and created by the Director of Nursing (DON) stating R #2 exhibited or was at risk for complications of infection related to a Urinary Tract Infection (UTI.) Facility staff intervention included facility staff was to assist resident with hand washing throughout the day as needed. R #2's Care Plan included a focus area initiated on 07/16/13 that stated R #2 resided in the Transitions Unit (secured unit) due to being at risk for elopement (leaving the facility.) Facility staff interventions included monitoring R #2 frequently to assure her safety. R #2's Care Plan included a focus area initiated on 07/16/13 that stated R #2 had poor safety awareness. Facility staff interventions included monitoring for changes in R #2's condition that may warrant increased supervision or assistance and notify the physician as needed. R #2's interventions included she needed adequate lighting to see at night. R #2's Care Plan included a focus area imitated on 07/16/13 that stated R #2 had difficulty making her own decisions. Facility staff interventions included assisting R #2 with decision making as needed and report any changes in R #2's level of consciousness to the physician.
Record review of R #2's current Minimum Data Set ((MDS) dated [DATE] revealed R #2 had a Brief Interview for Mental Status (BIMS) score of four out of a possible 15 points. R #2 understood others with clear comprehension and was able to make herself understood. R #2 spoke clearly and had adequate hearing and vision. R #2's MDS was coded as she had no behaviors, hallucinations or delusions. R #2 was independent and required no assistance from staff for bed mobility, transfer or ambulation. R #2 required supervision and setup help only for dressing, eating, personal hygiene and bathing. R #2 was able to toilet herself with supervision only.
In a telephone interview on 02/17/16 at 3:10 p.m., LVN Fstated approximately one month prior at 5:00 a.m. she entered the room shared by R #1 and R #2 on the secured unit to give R #2 a scheduled medication. LVN F stated when she entered the room she saw R #2 standing beside R #1's bed. R #2 had her hand in R #1's pajama bottoms. LVN F stated R #1's blankets were pulled down and she wore an incontinent brief. LVN F stated as soon as she entered the room shared by R #1 and R #2, R #2 removed her hand from R #1's pajama pants and crossed the room to sit on her bed and asked LVN F what do you have for me? LVN F stated she told R #2 that she had the [MEDICAL CONDITION] medication. LVN F stated R #2 said Oh yes, that one. LVN F stated she medicated R #2 and left the room with R #2 sitting on her bed and R #1 lying in her bed. LVN F stated she did not know how or where to document the incident she witnessed between R #2 and R #1 so at 5:15 a.m. on that morning she called the Director of Nurses (DON) and informed the DON what she witnessed at 5:00 a.m. LVN F stated the DON told her to keep an eye on them and let me know if anything else happens. LVN F stated the DON did not tell her to write a report or call the physician. LVN F stated the DON told her We'll take care of it. LVN F stated she was not told nor was she aware that inappropriate sexual behaviors were added to R #1's Care Plan on 01/28/16. LVN F stated the facility staffing ratio for night shift; 10:00 p.m. to 6:00 a.m.; was to include two CNAs in the secure unit, one CNA for hall 200, one CNA for hall 300 and two nurses for the facility. LVN F stated they often only had one CNA in the secure unit, one CNA on hall 200, one CNA for hall 300 and two nurses to cover the entire facility during the 10:00 p.m. to 6:00 a.m. shift.
On 02/18/16 record review of nurse's notes revealed there were no notes indicating LVN F called the DON to notify her of the situation. There were no notes indicating the physician or family had been notified. There were no incident reports, new assessments, or care plans updated.
Observation on 02/18/16 at 5:50 a.m. revealed three residents ambulating in the hall of the secure unit and two residents seated in the dining room of the secure unit. CNA C was the only staff member on the secure unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **455974**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/19/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAK CREST NURSING CENTER	**1902 FM 3036 ROCKPORT, TX 78382**

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 0281 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 16) In an interview on 02/18/16 at 6:20 a.m., LVN D stated there was only one CNA scheduled on the secure unit during the shift from 10:00 p.m. on 02/17/16 to 6:00 a.m. on 02/18/16. LVN Dstated two CNAs were scheduled for the secure unit during the night shift because sometimes the residents wake up on the wrong side of the bed and start kicking at each other. In an interview on 02/18/16 at 6:30 a.m., CNA C stated she was the only CNA scheduled during the night shift from 10:00 p.m. on 02/17/16 to 6:00 a.m. on 02/18/16 in the secure unit. CNA C stated there were two CNAs scheduled in the secure unit about four to seven nights per week. CNA C stated one CNA could handle the secure unit when there were no problems. CNA C stated if she needed help at night on the secure unit she could press the call bell light or pull the call bell light from the wall and wait for help from staff in other parts of the facility. CNA C stated R #2 got up at night and was confused. CNA C stated she did not know that R #2 had inappropriate sexual behaviors or that it was added to her Care Plan on 01/28/16. In an interview on 02/18/16 at 8:45 a.m., LVN J stated she did not know that R #2 had inappropriate sexual behaviors or that they were added to her Care Plan on 01/28/16. In an interview on 02/18/16 at 10:05 a.m., AA E stated she did not know R #2 had inappropriate sexual behaviors added to her Care Plan on 01/28/16. AA E stated she expected to be informed of any changes or new behaviors to monitor for resident. In an interview on 02/18/16 at 11:30 a.m., LVN K stated she was not informed that R #2 had inappropriate sexual behaviors or that it was added to her Care Plan on 01/28/16. LVN K stated that when Care Plans were updated direct care staff needed to be notified of new behaviors to monitor. In an interview on 02/18/16 at 12:05 p.m., Physician (PHY) U stated he was not aware and was not consulted by the facility regarding R #2's inappropriate sexual behaviors or that inappropriate sexual behaviors were added to R #2's Care Plan on 01/28/16. PHY U stated he expected to be notified within a couple of days of the change to add inappropriate sexual behaviors to one of his patient's Care Plan. In an interview on 02/18/16 at 12:15 p.m., LVN D stated she did not know that R #2 had inappropriate sexual behaviors or that they were added to her Care Plan on 01/28/16. LVN D stated that change in R #2's Care Plan should have been communicated to staff. LVN D stated R #1 was moved out of the room with R #2 last month in January 2016 but she was not informed the reason for the roommate change. In an interview on 02/18/16 at 3:25 p.m., the administrator (ADM) stated she was aware that R #2 had inappropriate sexual behaviors added to her Care Plan 01/18/16 but that she thought it needed to be reworded because it was misleading. The ADM stated the situation that prompted R #2 ' s Care Plan to be changed was when a CNA witnessed R #2 assisting R #1 in their room. The ADM stated since R #1 did not appear distressed they added inappropriate sexual behaviors to R #2's Care Plan but I know it is wrong wording and should be interfere with care or over help other residents. The ADM stated that she added the inappropriate sexual behaviors to R #2's Care Plan to be better safe than sorry. The ADM stated the DON interviewed staff and determined the CNA did not see anything and R #1 was not distressed. The ADM stated the NPE went to the different halls of the facility with updates on care guides and the NPE was the mechanism the facility used to advise staff of changes necessary for resident care. In an interview on 02/18/16 at 3:40 p.m., the DON stated she received a call the next day regarding the situation between R #1 and R #2. The DON stated they moved R #1 to another room because she was sick and she notified R #1's Court Appointed Guardian regarding her room change. The DON stated she did an internal investigation and determined there was no reason to report an incident to DADS. In a telephone interview on 02/19/16 at 5:05 p.m., CNALstated she was in the hall of the secure unit at night in November and heard a noise in the room shared by R #1 and R #2. CNA L stated she entered the room and saw R #2 standing at R #1's bedside with her hand under R #1's covers. Record review of a piece of paper dated 11/14/15 received from the DON on 02/18/16 at 4:50 p.m. revealed the following: I was contacted by (NPE) at 11:18 a.m. stated she was told (R #2) was touching roommate by (CNA L) 11:40 a.m. (Nurse Aid NA G) - Reports (R #2) wakes up roommate throughout the night. No other behaviors noted 11:50 a.m. (LVN K) - states (R #2) is bossy tells other residents what to do but is re-directable. Sometimes paces. 11:50 a.m. (AA X) - states R #2 is affectionate with others no behaviors noted 12:10 p.m. (CNA L, LVN W, LVN Y) all interviewed with no sexual behaviors seen . (R #1) assessed for injury with none noted. (R #1) moved to another room to reduce risk of any behaviors and reassess at next care plan meeting. The paper was signed o 02/18/16 by the DON. Record review of R #1's Physician order [REDACTED].#1 was moved from bed A of the room she shared with R #2 into bed B of another room down the hall on 01/13/16 that was occupied by R #16. Record review of R #16's Physician order [REDACTED].#16 was moved from bed B of the room R #1 was moved to on 01/13/16. R #16 was moved into the A bed of the room with R #2 on 01/13/16. Record review of the facility daily census log for 01/08/16 revealed R #1 and R #2 shared a room. R #16 was listed as residing at the other end of the hall in bed B. Record review of the facility daily census log for 01/09/16 revealed R #2 and R #16 shared a room. R #1 was listed as residing in bed B of the room R #16 was listed in 01/08/16. In an interview on 02/18/16 at 4:50 p.m., the DON stated she did an internal investigation of the situation between R #1 and R #2 on 11/14/15 regarding R #2's behaviors and moved R #1 to another room on 11/14/15. The DON stated I moved R #1 in November 2015. I don't know why the Physicians Order says 01/13/16 because I moved her 11/14/15 .We moved (R #1.) Staff there helped me move her. Probably (LVN K) or (NA G.) I'm not sure. The DON stated she was notified of the situation between R #1 and R #2 on 11/14/15 and she had not received any other notifications from staff regarding R #1's behaviors toward R #2 since 11/14/15. The DON stated it was her decision to amend R #2's Care Plan for January 2016 to add sexually inappropriate behaviors on 01/28/16 but her decision was not related to the incident in November 2015. The DON stated I thought the inappropriate sexual behaviors were on (R #2's) old Care Plan so I added it from November (2015.) My thought it was a continuation we were not ready to resolve at that point. The DON stated she
F 0282 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide services according to the Physician's Orders (Physician's plan of care) and plans of care for one Resident (R#5) of 15 Residents reviewed to ensure care was being provided as ordered by the Physician and as care planned. R #5 did not receive a Modified [MEDICATION NAME] Swallow Study (MBSS) as ordered by the physician. These failures could place 72 residents at risk of not receiving care as ordered by the physician and as outlined in the plan of care which could cause a medical and/or mental decline. Findings included: R #5 Record review of R #5's face sheet dated 12/30/15 revealed a [AGE] year old female admitted on [DATE]. R #5's [DIAGNOSES REDACTED]. Record review of R #5's Physician's orders dated 01/04/16 revealed the following order: MBSS due to prolonged [DEVICE] (Gastrostomy tube, a tube inserted into the stomach for the prorisions of nutrition, fluids and medications). Record review of R #5's admission Minimum Data Set ((MDS) dated [DATE] indicated R #5 had a [DEVICE]. An observation on 02/17/16 at 12:00 p.m. revealed R #5 awake in bed. R #5's eyes were open but she did not make eye contact when spoken to. R #5 had a clamped [DEVICE]. A canister of [MEDICATION NAME] feeding supplement was hanging on a pole next to her bed. After R #5's wound care was completed Licensed Vocational Nurse (LVN) P' checked R #5's [DEVICE] placement and connected the feeding. In an interview on 02/17/16 at 12:40 p.m. LVN P stated R #5 was NPO (nothing by mouth) and took all of her nutrition and medications per the [DEVICE]. In an interview on 02/18/16 at 9:35 a.m. the Speech Therapist (ST) stated she did not receive an official order or a copy of the order dated 01/04/16 to perform the MBSS for R #5. The ST stated R #5 was not a candidate for a MBSS due to R #5 could not follow commands. In an interview on 02/18/16 at 9:40 a.m. the Director of Nursing (DON) confirmed the MBSS had not been performed because R #5 could not follow commands. The DON stated she would inform R #5's Physician that the MBSS had not been carried out.

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NAME OF PROVIDER OF SUPPLIER **OAK CREST NURSING CENTER**		STREET ADDRESS, CITY, STATE, ZIP **1902 FM 3036** **ROCKPORT, TX 78382**	

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 0282 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 17) Record review of the facility's policy Care Plans dated 01/02/14 revealed A comprehensive, individualized care plan will be developed by the interdisciplinary team for each patient. The care plan will include measurable objectives to meet patient needs and goals as identified by the assessment process . To provide necessary care and services to attain or maintain the patient's highest practicable physical, mental, and psychosocial well-being . . The facility's Center for Medicare/Medicaid Services (CMS) form 672 dated 02/17/16 listed a census of 73 residents.
F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement and maintain an Infection Prevention and Control Program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection for one Resident (R #1) of one resident reviewed for provision of care in that: Certified Nurse Aid (CNA) V did not perform hand hygiene after providing Resident (R) #1 with perineal incontinent care and before washing R #1's hair and dressing R #1. This failure could place 24 residents who resided in the secure unit of the facility at risk for infections and decreased quality of life. The findings included: R #1 Record review of R #1's Face Sheet dated 12/23/15 revealed a [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Record review of R #1's Care Plan initiated on 06/13/14 and created on 02/15/16 revealed in a focus area that R #1 exhibited aggressive behavior with Activities of Daily Living (ADLs.) Facility staff interventions included identifying causes for R #1's behavior and reduce factors that may provoke R #1. Facility staff were to monitor and document R #1's behavior. R #1's Care Plan revealed she required assistance for ADL care in bathing, grooming and dressing. Record review of R #1's most recent quarterly Minimum Data Set ((MDS) dated [DATE] revealed R #1 was coded that she understood others with clear comprehension and was able to make herself understood. R #1's MDS was coded that she spoke clearly and had adequate hearing and vision. R #1's MDS was coded as she did not display behaviors. R #1 totally dependent and required the assistance from one person for bed mobility, dressing, eating, personal hygiene and bathing. R #1 required extensive assistance from one person for transfer and ambulation. R #1's 12/25/15 MDS was not completed for Brief Interview for Mental Status or Cognitive Patterns (BIMS.) R #1's most recent annual MDS dated [DATE] revealed R #1 was unable to complete the BIMS and her Cognitive Patterns were coded as moderately impaired with poor decisions requiring cues and supervision. Record review of R # 1's discharge instructions from the hospital dated 02/17/16 at 6:23 p.m. revealed R #1 had a UTI. Observation on 02/18/16 at 3:50 p.m., CNA V assisted R #1 with her shower. R #1 wore an incontinent brief that CNA V removed before assisting R #1 onto the shower chair. CNA V wore gloves as she washed R #1 and performed perineal care. R #1 passed gas while CNA V performed per care. CNA V used her gloved hand she used to perform perineal care on R #1 to open the cabinet door and reach into the clean linen cabinet for a clean washcloth that she put to R #1's face for her to hold during hair care. CNA V rinsed R #1's hair with the same glove used for perineal care. CNA V removed her gloves after washing and rinsing all areas of R #1's body and did not perform hand hygiene before she donned another pair of gloves to dry and dress R #1. In an interview on 02/19/16 at 4:10 p.m., CNA V stated she should have changed gloves after she performed peri care on R #1. CNA V stated she was not aware of the meaning of the phrase clean to dirty when performing personal care for a resident. In an interview on 02/19/16 at 10:15 a.m., the Health Information Coordinator (HIC) who also had her CNA stated the proper order to assist a resident with a shower was clean to dirty (start with areas of the body that were not considered contaminated and end with peri care or areas with potential contamination.) The HIC stated gloves were to be changed after peri care. In an interview on 02/19/16 at 12:45 p.m., the Assistant Director of Nursing (ADON) stated nursing staff were supposed to change gloves and perform hand hygiene after perineal care even during a shower. According to the Texas Curriculum for Nurse Aids in Long-Term Care Facilities 2013 Fourth Edition, entitled Procedural Guideline #18-Tub or Shower Bath, page 156 and 157,Wash hands, Wear gloves and follow Standard Precautions (set of infection control practices used to prevent transmission of diseases) if contact with blood or body fluids is likely .Wash (with soap) and rinse entire body, working from clean to dirty areas .Remove gloves and wash hands after perineal care is completed. The facility's Centers for Medicare and Medicaid Services Form 802 dated 02/17/16 revealed 24 residents who resided in the secure unit.
F 0490 **Level of harm -** Actual harm **Residents Affected -** Some	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to be administered in a anner that enabled it to use its resources effectively and efficiently to attain or maintain the highest, practicable physical, mental, and psychosocial well-being of each resident for four Residents (R #1, R #2, # 7 and R #10) of nine Residents reviewed for neglect. The facility Administrator did not: - Implement policies and procedures that prohibit abuse, neglect and injuries of unknown origin. - Supervise the Director of Nurses to ensure she reported suspected abuse or neglect of R #1 and R #2 within 24 hours to officials in accordance with state law. - Notify the families and attending Physician (PHY) U about suspected abuse or neglect regarding R#1 and R#2. - Notify the Texas Department of Aging and Disability Services within 24 hours upon receiving information concerning a report of suspected or alleged abuse, mistreatment, neglect or injury of unknown origin. - Take immediate action to protect R #1 and prevent occurrences of similar incidents. - Initiate an investigation within 24 hours of an allegation of abuse or neglect that focused on whether abuse or neglect occurred and to what extent; clinical examination for sign of injuries, if indicated; causative factors and interventions to prevent further injury. - Ensure that documentation of witnessed interviews was conducted and included conduct interview using the Alleged Perpetrator Victim Interview Record and Witness Interview Record. The facility DON did not: - Implement policies and procedures that prohibit abuse, neglect and injuries of unknown origin. - Initiate an investigation within 24 hours of an allegation of abuse or neglect that focused on whether abuse or neglect occurred and to what extent; clinical examination for sign of injuries, if indicated; causative factors and interventions to prevent further injury. - Provide staff with information on how they may report concerns and incidents without fear of retribution and provide feedback regarding the expressed concerns. - Notify the families and attending Physician (PHY) U about suspected abuse or neglect regarding R #1 and R #2. - Take immediate action to protect R #1 and prevent occurrences of similar incidents. - Ensure that documentation of witnessed interviews was conducted and included conduct interview using the Alleged Perpetrator Victim Interview Record and Witness Interview Record. - Immediately consult R #2's attending physician of behavior changes that required increased Physician and staff monitoring. - Promptly notify R #1's legal representative that R #1 changed rooms and the reason for the move. - Promptly notify R #10's physician herself or provide staff instructions to promptly notify R #10's physician of X-ray results of a new fracture in R #10's femur (bone in upper leg.) These failures could place 24 residents who resided in the secure unit of the facility at risk for neglect from the facility to not provide goods and services necessary to avoid physical harm, mental anguish or mental illness. The findings were: R#7 Record review of R#7's Face Sheet dated 02/25/15 revealed a [AGE] year old female admitted to the facility on [DATE] and

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NAME OF PROVIDER OF SUPPLIER **OAK CREST NURSING CENTER**	STREET ADDRESS, CITY, STATE, ZIP **1902 FM 3036** **ROCKPORT, TX 78382**

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 0490 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 18) readmitted on [DATE]. R#7 had the following Diagnoses: [REDACTED]. Ath. Usp. Graft, Chronic Asthma, [MEDICAL CONDITIONS] Reflux, [MEDICAL CONDITION], and Chronic Pain. Record review of R#7's Minimum Data Set ((MDS) dated [DATE] revealed R#7's [DIAGNOSES REDACTED]. R#7's MDS revealed she had clear speech, usually understood, and usually understood others. R#7 needed extensive assistance from one person for physical assistance for dressing, toilet use, personal hygiene and bathing. R#7 was totally dependent on one person for physical assistance for bed mobility. Record review of R#7's Nurse's Notes by LVN Jdated 02/16/16 1200 revealed upon assessment resident (R#7) guarding left arm and complaining of pain. Swelling noted to left shoulder (refuses to move). Reported to physician. awaiting new orders. Medicated for pain . assisted to bed . Record review of R#7's Nurses Notes dated 02/16/16 2-10 pm revealed resident complained of severe left shoulder pain. Physician ordered x-ray. Taken at 8 pm ,no results yet. Resident observed for sleep in recliner in .area. Resident continues to hold left arm to her shoulder area. Record review of R#7's Nurses Notes(by LVN J) dated 02/17/16 1530 revealed discoloration noted to left arm measuring approximately 1.3 cm (centimeter) Asked in report of origin of injury. Informed resident had been hitting and grabbing at arm. Informed that X-ray of possible fracture had been reported to DON. Informed DON of discoloration and pain. Call to physician. N.O. (new order) to transfer to local hospital for evaluation and treatment. During a telephone interview on 02/17/16 at 3:30 p.m. ,LVN F (night nurse) stated -had called the DON on 02/15/16 at 11:45 p.m to report R#7 was not able to move her left arm to assist with her own toileting. - R#7 was screaming in pain and agitated but no bruising was noted - R#7's baseline was no reported pain in her left arm and R#7 was able to use both arms to assist in her own toileting with out pain R#7 was up all night her shift starting at 10:00 p.m. on 02/15/16 through 6:00 a.m on 02/16/16 and R#7 picked and grabbed at her left arm during that time -she (LVNF) retrieved an X-ray result after 11:00 p.m.for R#7 from the fax machine and called the DON at that time to report a positive X-ray for a fracture to R#7's left Humerus. -she (LVNF) stated the DON said she would call Physician (PHY) in the morning to report R#7's positive X-ray results. -she (LVNF) was instructed to medicate R#7 for pain -LVNF stated the facility's policy is to call the Physician with changes in resident condition -she (LVNF) gave report to LVNJ at 6:00 a.m. on 02/17/16 regarding R#7's positive X-ray results and at that time the DON had not come to see R#7 and the Physician had not called with orders to treat R#7. On 02/17/16 at 12:25 p.m., LVN Jstated she was told yesterday (2/16/16) that R#7 had arm pain. She (LVNJ) noted swelling and advised R#7's physician. This morning (02/17/16) she was told the X-ray report had come for R#7 at 8:56 p.m.on 02/16/16. LVNJ replied the night nurse (LVNF) had called the DON about R#7's X-ray result. LVNJ replied it was reported to her that the DON did not call the Physician about R#7's X-ray result. LVNJ said she had spoken to the DON about 7:30 to 8:00 a.m. on 02/17/16/. LVN J said I called the physician on 02/17/16 at 11:30 a.m and asked if he (Physician) knew the results of R#7's X-ray report. LVNJ replied ,the Physician said no ;X-ray report was read to the Physician. Review of Physicians's t.o. (telephone order) dated 02/17/16 1130 revealed transfer to local hospital for evaluation and treatment fracture left arm. Review of R#7's Radiology Report with DOS (date of service) 02/16/16 (final report faxed to facility on 02/16/16 20:56) revealed Conclusion Subtle cortical disruption in left humeral neck suspicious of impacted non-displaced fracture, with modest inferior subluxation of left humeral head. F/U (follow -up) recommended. R #10 Record review of R #10's Face Sheet dated 02/03/16 revealed a [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. R #10's physician was PHY U, the Medical Director for the facility. Record review of R #10's current Minimum Data Set ((MDS) dated [DATE] revealed R #10's [DIAGNOSES REDACTED]. R #10's MDS revealed she was incapable of speech, rarely or never made herself understood and rarely or never understood others. R #10's MDS revealed her cognitive skills for daily decision making was coded as severely impaired and she never or rarely made decisions. R #10 was totally dependent on one person for physical assistance for dressing, toilet use, personal hygiene and bathing. R #10 required extensive assistance from one person for bed mobility, locomotion in her wheelchair and eating. Record review of R #10's Care Plan dated 01/30/16 revealed R #10 exhibited symptoms of decline on cognitive function related to dementia. R #10 was at risk for falls due to cognitive loss, lack of safety awareness as she slid forward in her wheelchair and tipped wheelchair backward. Interventions included assess for changes in medical status, pain status, mental status and report to the physician as indicated. Record review of R #10's Nurses Notes dated 02/16/16 at 1:00 p.m. revealed R #10 had swelling and heat to the left lower extremity reported to and evaluated by Physician (PHY) U. Record review of R #10's Nurses Notes dated 02/16/15 from the 2:00 p.m. to 10:00 p.m. shift revealed PHY U ordered a Venous Doppler (ultrasound that uses sound waves to produce pictures of the body's veins) to R #10's left leg due to swelling and redness. Record review of R #10's Nurses Notes dated 02/17/16 at 7:00 a.m. revealed R #10 was assessed with [REDACTED]. Observation on 02/17/16 at 11:45 a.m. revealed R #10 sitting in her wheelchair in the dining room of the secured unit at a table with another resident. R #10 shifted in her wheelchair often and leaned on her right hip and the right arm rest of her wheelchair while she looked out the window. R # 10 pulled at and lifted the left corner of her shirt. Record review of R #10's Nurses Notes dated 02/17/16 from the 2:00 p.m. to 10:00 p.m. shift revealed R #10 was assessed and continued to have swelling and redness to her left leg. R # 10's left leg had a slight discoloration to the area. The Venous Doppler to R #10's left leg was performed at 4:00 p.m. on 02/17/16 and the technician who performed the ultrasound stated to the nurse that results could take 24 hours to receive. Observation on 02/18/16 at 7:45 a.m. revealed R #10 sitting in her wheelchair at a table in the dining room of the secured unit at a table with another resident. R #10 was able to feed herself and was restless as she shifted positions in her wheelchair. Record review of R #10's Nurses Notes dated 02/18/16 at 12:00 p.m. revealed the results of R #10's Venous Doppler were given to PHY U and the nurse reported to PHY U that R #10's left leg remained swollen with multiple areas of dark discoloration. Discolored areas of R #10's left leg included her left knee, left outer leg, left heel, left outer thigh, left calf and left inner knee. LVN J documented she showed the discolored areas of R #10's left leg to the Assistant Director of Nursing (ADON) and LVN J reported the multiple areas of discoloration to the Director of Nursing (DON.) Record review of R #10's physician's orders [REDACTED].#10 was to have X-rays of her left hip and left knee. Record review of R #10's Nurses Notes dated 02/18/16 from the 2:00 p.m. to 10:00 p.m. shift revealed a new order from PHY U for an X-ray to R #10's left leg including her knee, ankle and foot. The DON was to be notified with the results of the X-ray. R #10 was assessed to have swelling and redness with skin discoloration noted to her left leg that were warm to touch. Record review of R #10's Radiology Report faxed to the facility on [DATE] at 12:42 a.m. revealed R #10 had an acute left knee fracture that involved the left distal femur (long bone in the thigh close to the knee.) Record review of R #10's Nurses Notes dated 02/19/16 at 12:30 a.m. signed by LVN W revealed the results of R #10's X-ray were reported to the DON. The documented response from the DON was that she would take care of this in the morning. Record review of the facility Nursing Home to Hospital Transfer Form for R #10 dated 02/19/16 revealed R #10 was given two Tylenol Extra Strength 500 milligram (mg) tablets on 02/19/16 at 8:40 a.m. and her last set of vital signs was taken on 02/19/16 at 9:00 a.m. Record review of R #10's Nurses Notes dated 02/19/16 at 1:30 p.m. by LVN W revealed R #10 was sent out to the hospital and transported by Emergency Medical Services (EMS.) A telephone follow-up to the local hospital revealed R #10 was a probable

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NAME OF PROVIDER OF SUPPLIER **OAK CREST NURSING CENTER**	STREET ADDRESS, CITY, STATE, ZIP **1902 FM 3036 ROCKPORT, TX 78382**

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 0490 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 19)

admit.
In an interview on 02/19/16 at 2:40 p.m. LVN K stated she worked in the secure unit 02/19/16 from 6:00 a.m. to 2:00 p.m. LVN K stated she took report this morning from LVN W that revealed that X-ray results received after midnight showed R #10 had a fractured left femur. LVN K stated she called PHY U at 8:00 a.m. on 02/19/16 as she had not been contacted by the DON regarding care for R #10. LVN K stated PHY U stated he was on call the night of 02/18/16 and early morning of 02/19/16 and he was not aware of the results of R #10's X-ray. LVN K stated PHY U ordered R #10 be sent to the hospital by EMS. LVN K stated she called R #10's family member and legal representative and they were not aware R #10 had a fractured femur. LVN K stated she saw the DON about 9:30 a.m. or 10:00 a.m. on 02/19/16 and informed the DON R #10 was sent out to the hospital as per PHY U orders. LVN K stated that the DON replied to her R #10 had pathological fractures (bone fracture caused by disease that led to weakness of the bone structure.) LVN K stated to the surveyor that regardless if it was one fracture or multiple fractures R #10 still needed to be treated because R #10 shouldn't have to hurt.
In an interview on 02/19/16 at 3:30 p.m., the DON stated she was aware that PHY U had ordered an X-ray for R #10 on 02/18/16 at 3:00 p.m. The DON stated LVN W called her at home at 12:45 a.m. on 02/19/16 with the results of R #10's X-ray and said that we needed to call the doctor. The DON stated she did not call PHY U regarding results of R #10's X-ray showing a fractured femur but that the floor nurse called and notified PHY U in the morning. The DON stated PHY U was not on call at that time on 02/19/16 but another physician. The DON stated PHY U was particular that nursing staff call him and not the physician on call regarding his residents' medical conditions.
In an interview on 02/17/16 at 3:30 p.m., LVN F stated PHY U will accept calls regarding his residents' change of condition while he is on call. LVN F stated PHY U did not want facility staff to call the on call physician for changes in his residents ' condition if PHY U was not on call. LVN F stated PHY U wanted to be the only physician to treat his residents. LVN F stated she used her nursing judgment to determine if a resident change of condition was an emergency and needed to be reported to the physician on call for PHY U.
Record review of a written Physician order [REDACTED].
Call me with All med changes made to ANY of my patients. If I am not on call, wait to call ME personally when I am back on call.
The order was delivered to the surveyor by the DON on 02/19/16 at 5:45 p.m. as requested documentation of PHY U orders to facility staff informing when staff were to notify PHY U of changes in condition or treatment for [REDACTED].
Record review of a written statement from PHY U dated 02/19/16 and received after 5:45 p.m. revealed PHY U was aware that R #10 had swelling in her left leg since 02/16/16 and he ordered a Venous Doppler to check if R #10 had a blood clot in her left leg. The Venous Doppler results revealed R #10 did not have a blood clot in her left leg on 02/18/16 so at that time he ordered an X-ray of R 10's left leg. PHY U stated R #10's X-ray report came in to the facility at 12:45 a.m. on 02/19/16 and he was called with the results at 8:00 a.m. on 02/19/16 regarding R #10's new [DIAGNOSES REDACTED]. PHY U stated he felt that R #10's X-ray represented a new [DIAGNOSES REDACTED]. PHY U stated he felt the notification he received at 8:00 a.m. on 02/19/16 was appropriate and timely and led to the proper treatment of [REDACTED].
In a telephone interview on 02/19/16 at 4:20 p.m., PHY U stated he was on call the night of 02/18/16 and morning of 02/19/16. PHY U stated when he is not on call he does not want facility staff to call the on call physician about his residents unless it is a true emergency. PHY U stated facility staff was to wait to notify him when he was back on call regarding changes in his residents' medical conditions or need for treatment changes.
In an interview on 02/19/16 at 5:00 p.m., the Assistant Director of Nursing (ADON) stated the facility did not instruct her on a requirement to report changes of condition only to PHY U and not to the physician on call regarding his residents at the facility. The ADON stated the facility did not instruct her on what PHY U considered an emergency condition that would require the consultation of the on call physician.
R #2
Record review of R #2's Face Sheet dated 12/05/15 revealed an [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED].
Record review on 01/28/16 of R #2's Care Plan revised revealed in a focus area that R #2 displayed inappropriate sexual behaviors at times. The goal for this behavior included R #2 would not exhibit at risk or inappropriate sexual behaviors that affected other patients, staff, or visitors. Facility staff interventions to meet this goal included the following:
-Review behavioral expectations with patient.
-Observe and report verbal and/or physical sexual behaviors exhibited and report to the licensed nurse immediately.
-Notify physician if sexually inappropriate behavior is exhibited.
-Observe and report change in mood state to licensed nurse immediately.
-Remove from common areas when sexually inappropriate behavior is exhibited
-Attempt to refocus the patient's behavior to something positive when he or she exhibits inappropriate sexual behavior.
-Assist the patient in identifying problem causing stimuli.
on 01/14/16 R #2's Care Plan included a focus area initiated and created by the Director of Nursing (DON) stating R #2 exhibited or was at risk for complications of infection related to a Urinary Tract Infection (UTI.) Facility staff intervention included facility staff was to assist resident with hand washing throughout the day as needed. R #2's Care Plan included a focus area initiated on 07/16/13 that stated R #2 resided in the Transitions Unit (secured unit) due to being at risk for elopement (leaving the facility.) Facility staff interventions included monitoring R #2 frequently to assure her safety. R #2's Care Plan included a focus area initiated on 07/16/13 that stated R #2 had poor safety awareness. Facility staff interventions included monitoring for changes in R #2's condition that may warrant increased supervision or assistance and notify the physician as needed. R #2's interventions included she needed adequate lighting to see at night. R #2's Care Plan included a focus area imitated on 07/16/13 that stated R #2 had difficulty making her own decisions. Facility staff interventions included assisting R #2 with decision making as needed and report any changes in R #2's level of consciousness to the physician.
Record review of R #2's current Minimum Data Set ((MDS) dated [DATE] revealed R #2 had a Brief Interview for Mental Status (BIMS) score of four out of a possible 15 points. R #2 understood others with clear comprehension and was able to make herself understood. R #2 spoke clearly and had adequate hearing and vision. R #2's MDS was coded as she had no behaviors, hallucinations or delusions. R #2 was independent and required no assistance from staff for bed mobility, transfer or ambulation. R #2 required supervision and setup help only for dressing, eating, personal hygiene and bathing. R #2 was able to toilet herself with supervision only.
In a telephone interview on 02/17/16 at 3:10 p.m., LVN Fstated approximately one month prior at 5:00 a.m. she entered the room shared by R #1 and R #2 on the secured unit to give R #2 a scheduled medication. LVN F stated when she entered the room she saw R #2 standing beside R #1's bed. R #2 had her hand in R #1's pajama bottoms. LVN F stated R #1's blankets were pulled down and she wore an incontinent brief. LVN F stated as soon as she entered the room shared by R #1 and R #2, R #2 removed her hand from R #1's pajama pants and crossed the room to sit on her bed and asked LVN F what do you have for me? LVN F stated she told R #2 that she had the [MEDICAL CONDITION] medication. LVN F stated R #2 said Oh yes, that one. LVN F stated she medicated R #2 and left the room with R #2 sitting on her bed and R #1 lying in her bed. LVN F stated she did not know how or where to document the incident she witnessed between R #2 and R #1 so at 5:15 a.m. on that morning she called the Director of Nurses (DON) and informed the DON what she witnessed at 5:00 a.m. LVN F stated the DON told her to keep an eye on them and let me know if anything else happens. LVN F stated the DON did not tell her to write a report or call the physician. LVN F stated the DON told her We'll take care of it. LVN F stated she was not told nor was she aware that inappropriate sexual behaviors were added to R #1's Care Plan on 01/28/16. LVN F stated the facility staffing ratio for night shift; 10:00 p.m. to 6:00 a.m.; was to include two CNAs in the secure unit, one CNA for hall 200, one CNA for hall 300 and two nurses for the facility. LVN F stated they often only had one CNA in the secure unit, one CNA on hall 200, one CNA for hall 300 and two nurses to cover the entire facility during the 10:00 p.m. to 6:00 a.m. shift.
On 02/18/16 record review of nurse's notes revealed there were no notes indicating LVN F called the DON to notify her of the situation. There were no notes indicating the physician or family had been notified. There were no incident reports, new assessments, or care plans updated.
Observation on 02/18/16 at 5:50 a.m. revealed three residents ambulating in the hall of the secure unit and two residents seated in the dining room of the secure unit. CNA C was the only staff member on the secure unit.
In an interview on 02/18/16 at 6:20 a.m., LVN D stated there was only one CNA scheduled on the secure unit during the shift

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OAK CREST NURSING CENTER	**1902 FM 3036** **ROCKPORT, TX 78382**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 20) from 10:00 p.m. on 02/17/16 to 6:00 a.m. on 02/18/16. LVN Dstated two CNAs were scheduled for the secure unit during the night shift because sometimes the residents wake up on the wrong side of the bed and start kicking at each other. In an interview on 02/18/16 at 6:30 a.m., CNA C stated she was the only CNA scheduled during the night shift from 10:00 p.m. on 02/17/16 to 6:00 a.m. on 02/18/16 in the secure unit. CNA C stated there were two CNAs scheduled in the secure unit about four to seven nights per week. CNA C stated one CNA could handle the secure unit when there were no problems. CNA C stated if she needed help at night on the secure unit she could press the call bell light or pull the call bell light from the wall and wait for help from staff in other parts of the facility. CNA C stated R #2 got up at night and was confused. CNA C stated she did not know that R #2 had inappropriate sexual behaviors or that it was added to her Care Plan on 01/28/16. In an interview on 02/18/16 at 8:45 a.m., LVN J stated she did not know that R #2 had inappropriate sexual behaviors or that they were added to her Care Plan on 01/28/16. In an interview on 02/18/16 at 10:05 a.m., AA E stated she did not know R #2 had inappropriate sexual behaviors added to her Care Plan on 01/28/16. AA E stated she expected to be informed of any changes or new behaviors to monitor for resident. In an interview on 02/18/16 at 11:30 a.m., LVN K stated she was not informed that R #2 had inappropriate sexual behaviors or that it was added to her Care Plan on 01/28/16. LVN K stated that when Care Plans were updated direct care staff needed to be notified of new behaviors to monitor. In an interview on 02/18/16 at 12:05 p.m., Physician (PHY) U stated he was not aware and was not consulted by the facility regarding R #2's inappropriate sexual behaviors or that inappropriate sexual behaviors were added to R #2's Care Plan on 01/28/16. PHY U stated he expected to be notified within a couple of days of the change to add inappropriate sexual behaviors to one of his patient's Care Plan. In an interview on 02/18/16 at 12:15 p.m., LVN D stated she did not know that R #2 had inappropriate sexual behaviors or that they were added to her Care Plan on 01/28/16. LVN D stated that change in R #2's Care Plan should have been communicated to staff. LVN D stated R #1 was moved out of the room with R #2 last month in January 2016 but she was not informed the reason for the roommate change. In an interview on 02/18/16 at 3:25 p.m., the administrator (ADM) stated she was aware that R #2 had inappropriate sexual behaviors added to her Care Plan 01/18/16 but that she thought it needed to be reworded because it was misleading. The ADM stated the situation that prompted R #2 ' s Care Plan to be changed was when a CNA witnessed R #2 assisting R #1 in their room. The ADM stated since R #1 did not appear distressed they added inappropriate sexual behaviors to R #2's Care Plan but I know it is wrong wording and should be interfere with care or over help other residents. The ADM stated that she added the inappropriate sexual behaviors to R #2's Care Plan to be better safe than sorry. The ADM stated the DON interviewed staff and determined the CNA did not see anything and R #1 was not distressed. The ADM stated the NPE went to the different halls of the facility with updates on care guides and the NPE was the mechanism the facility used to advise staff of changes necessary for resident care. In an interview on 02/18/16 at 3:40 p.m., the DON stated she received a call the next day regarding the situation between R #1 and R #2. The DON stated they moved R #1 to another room because she was sick and she notified R #1's Court Appointed Guardian regarding her room change. The DON stated she did an internal investigation and determined there was no reason to report an incident to DADS. In a telephone interview on 02/19/16 at 5:05 p.m., CNALstated she was in the hall of the secure unit at night in November and heard a noise in the room shared by R #1 and R #2. CNA L stated she entered the room and saw R #2 standing at R #1's bedside with her hand under R #1's covers. Record review of a piece of paper dated 11/14/15 received from the DON on 02/18/16 at 4:50 p.m. revealed the following: I was contacted by (NPE) at 11:18 a.m. stated she was told (R #2) was touching roommate by (CNA L) 11:40 a.m. (Nurse Aid NA G) - Reports (R #2) wakes up roommate throughout the night. No other behaviors noted 11:50 a.m. (LVN K) - states (R #2) is bossy tells other residents what to do but is re-directable. Sometimes paces. 11:50 a.m. (AA X) - states R #2 is affectionate with others no behaviors noted 12:10 p.m. (CNA L, LVN W, LVN Y) all interviewed with no sexual behaviors seen . (R #1) assessed for injury with none noted. (R #1) moved to another room to reduce risk of any behaviors and reassess at next care plan meeting. The paper was signed o 02/18/16 by the DON. Record review of R #1's Physician order [REDACTED].#1 was moved from bed A of the room she shared with R #2 into bed B of another room down the hall on 01/13/16 that was occupied by R #16. Record review of R #16's Physician order [REDACTED].#16 was moved from bed B of the room R #1 was moved to on 01/13/16. R #16 was moved into the A bed of the room with R #2 on 01/13/16. Record review of the facility daily census log for 01/08/16 revealed R #1 and R #2 shared a room. R #16 was listed as residing at the other end of the hall in bed B. Record review of the facility daily census log for 01/09/16 revealed R #2 and R #16 shared a room. R #1 was listed as residing in bed B of the room R #16 was listed in 01/08/16. In an interview on 02/18/16 at 4:50 p.m., the DON stated she did an internal investigation of the situation between R #1 and R #2 on 11/14/15 regarding R #2's behaviors and moved R #1 to another room on 11/14/15. The DON stated I moved R #1 in November 2015. I don't know why the Physicians Order says 01/13/16 because I moved her 11/14/15 .We moved (R #1.) Staff there helped me move her. Probably (LVN K) or (NA G.) I'm not sure. The DON stated she was notified of the situation between R #1 and R #2 on 11/14/15 and she had not received any other notifications from staff regarding R #1's behaviors toward R #2 since 11/14/15. The DON stated it was her decision to amend R #2's Care Plan for January 2016 to add sexually inappropriate behaviors on 01/28/16 but her decision was not related to the incident in November 2015. The DON stated I thought the inappropriate sexual behaviors were on (R #2's) old Care Plan so I added it from November (2015.) My thought it was a continuation we were not ready to resolve at that point. The DON stated she recalled the inappropriate sexual behaviors were in place on R #2's Care Plan prior to November 2015 on an old handwritten Care Plan so it was added in January 2016. The DON stated Now I advise it be taken off R #2 ' s Care Plan. The DON stated staff had not notified her of any sexually inappropriate behaviors for R #2 since November 2015. Record review of R #1's Resident Notification of Room Change dated 11/14/15 with a Late entry 02/18/16 revealed R #1 was moved on 11/14/15 and the responsible party was notified. In an interview on 02/19/16 at 9:30 a.m., the ADM stated R #1 was moved from the room she shared with R #2 to another room on 11/14/15. The ADM stated the new computer system caused the change to not show up in the records until January 2016. The Facility Regional Vice President (RVP) was in the room and agreed that the new computer system caused the delay in recording R #1's move from 11/14/15 to January 2016. In an interview on 02/19/16 at 10:15 a.m., the Health Information Coordinator (HIC) stated the new facility computer system was implemented in August 2015. Medical Records (MR) stated telephone orders for room change were written at the time of the room change and usually the rooms assignments were updated daily. In an interview on 02/19/16 at 10:30 a.m., LVN S stated the DON told her to update R #2's Care Plan and add inappropriate sexual behaviors in January 2016. LVN S stated there may have been an old hand written Care Plan from 2013 for R #2 that included inappropriate sexual behaviors. LVN S stated she would look through all of R #2's me
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not maintain accurate clinical records for one Resident (R #5) of 15 residents whose medical records were reviewed. The facility did not accurately document the route R #5's medications were administered. R #5's Preadmission Screening and Resident Review II (PASRR II) assessment results were not in the Resident's medical chart or available for review. This failure placed 72 residents at risk of not having their records communicate their care needs to providers and placed them at risk for complications and/or a decline in health.

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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 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 21) Findings include: R #5 Record review of R #5's face sheet dated 12/30/15 revealed a [AGE] year old female admitted on [DATE]. R #5's [DIAGNOSES REDACTED]. An observation on 02/17/16 at 12:00 p.m. revealed R #5 awake in bed. R #5's eyes were open but she did not make eye contact when spoken to. R #5 had a clamped [DEVICE] (Gastrostomy tube, a tube inserted into the stomach for the provision of nutrition, fluids and medications). A canister of [MEDICATION NAME] feeding supplement was hanging on a pole next to her bed. After R #5's wound care was completed Licensed Vocational Njurse (LVN) P' checked R #5's [DEVICE] placement and connected the feeding. In an interview on 02/17/16 at 12:40 p.m. LVN P stated R #5 was NPO (nothing by mouth) and took all of her nutrition and medications per the [DEVICE]. Record review of R #5's Physician orders [REDACTED]. [MEDICATION NAME] 15 milligrams (mg) by mouth one time a day. [MEDICATION NAME] Sodium 100 mg by mouth at bedtime. Potassium Chloride 40 milliequivalents (meq) by mouth one time a day. Vitamin C 500 mg by mouth two times a day. Record review of R #5's Medication Administration Record [REDACTED] [MEDICATION NAME] 15 milligrams (mg) by mouth one time a day. [MEDICATION NAME] Sodium 100 mg by mouth at bedtime. Potassium Chloride 40 milliequivalents (meq) by mouth one time a day. Vitamin C 500 mg by mouth two times a day. In an interview on 02/18/16 at 8:30 a.m. LVN M stated R #5 received her medications per the [DEVICE]. LVN M stated it would not be safe to give R #5 anything by mouth without first having a Modified [MEDICATION NAME] Swallow Study (MBSS) test. In an interview on 02/18/16 at 9:50 a.m. the Director of Nursing (DON) stated R #5 did receive her medications per the [DEVICE] and not by mouth. The DON stated it would be too risky to give R #5 anything by mouth at this time. The DON confirmed the Physician orders [REDACTED].#5 was receiving medications by mouth. The DON stated it was a documentation error and it would be corrected. Record review of R #5's chart revealed no printed out PASRR II evaluation, assessment or recommendations of any special needs or equipment for R #5. Record review of R #5's PASRR I dated 12/31/15 revealed evidence of a intellectual disability, which indicated a PASRR II evaluation was necessary by the Local Intellectual/Developmental Disability authority (LA). Record review of R #5's Interdisciplinary Team Notes dated 01/28/16 revealed an entry stating PASRR representative recommends that resident stay in nursing facility. Will leave as service coordinator to visit every 6 months due to medical condition. In an interview on 02/19/16 at 9:00 a.m. the DON stated the LA came out and did an assessment on R #5. The DON stated the LA document and verbally inform the results of the assessment but they do not leave a printed out copy of the PASRR II. In an interview on 02/19/16 at 9:10 a.m. LVN S confirmed the LA did an evaluation assessment and also came for R #5's care plan meeting. LVN S confirmed there was not a printed out PASRR II for R #5. LVN S stated she would call the LA and have the PASRR II faxed over. LVN S stated she was not aware the PASRR II needed to be in the chart and available to review. In a telephone interview on 02/19/16 at 12:15 p.m. the LA stated the facility has the access to the computer system to print out the PASRR II. The LA stated the PASRR I and the PASRR II need to be in the resident's charts to ensure the facility's staff members and different departments such as Speech Therapy, Physical Therapy, Occupational Therapy and Dietary have access to the results and recommendations. The facility's Center for Medicare/Medicaid Services (CMS) form 672 dated 02/17/16 listed a census of 73 residents including one resident with [DEVICE] feeding and three residents with intellectual and/or developmental disability.